FLORIDA HOSPITAL CARE ADVANTAGE

Underwritten by Health First Commercial Plans

OUT-OF-NETWORK LIABILITY AND BALANCE BILLING

GENERAL INFORMATION

Every plan is different, and your financial obligations will vary based on your specific plan. You are responsible for your premium, along with any cost sharing your plan requires. Additionally, some medical services may not be covered by your plan. If you obtain services that are not covered by your plan, you will be financially responsible. Make sure to familiarize yourself with the benefits provisions, exclusions and limitations of your plan before you seek services so you don't incur unnecessary or unexpected expenses. To verify the cost sharing you will have for specific services, check your Schedule of Benefits for details, or you may contact us for assistance. Keep in mind that using participating providers and preferred drugs will help reduce your expenses significantly.

WHAT IS BALANCE BILLING?

The amount the plan pays for covered services is based on the **allowed amount**. The allowed amount is the maximum amount the Health Plan will pay for a covered health care service. If a non-participating provider charges more than the allowed amount, you may receive a bill to pay the difference. This is called **balance billing**. Balance billing occurs when an out-of-network provider bills an enrollee for charges, other than co-payments, coinsurance, or any amounts that may remain on a deductible.

For example*, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, the hospital may send you a bill to pay the $500 difference. Contracted providers may not balance bill you for covered services.*

Florida law prohibits out-of-network providers from balance billing you for:

- Covered emergency services and
- Covered non-emergency services that are:
  - Provided in a facility that has a contract for the nonemergency services with the Health Plan, and
  - Provided when you do not have the ability and opportunity to choose a participating provider at the facility available to treat you.

For these covered services, the Health Plan is responsible for the reimbursement of costs to out-of-network providers minus your cost share.

WHAT IS MY FINANCIAL RESPONSIBILITY?

In-Network Provider Services

- You are responsible for paying only your "in-network" coinsurance or copayments.

Out-of-Network Provider Services

- POS or PPO Plan: You are responsible for paying the higher "out-of-network" coinsurance and copayments. We do not have contracts with these providers limiting the amount they can charge for services, so if they charge more than our allowable amount, you may be responsible for the additional cost (also called "balance billing"). The Health Plan is liable for the payment of fees in excess of your cost share for emergency services and, in certain circumstances, covered non-emergency services, as described above.
  Note: Out-of-network providers are not required to see you and may require you to pay up-front for services and submit your own claim.

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- HMO Plan: Generally, you are not covered for services from out-of-network doctors. You are responsible for paying the full cost for unapproved services.

LIABILITY FOR OUT-OF-NETWORK SERVICES

- **Health Maintenance Organization (HMO)** plans offer comprehensive health benefits, including preventive care services. Most members have a standard HMO plan, which means that you must use participating physicians and other health care providers to receive benefits for covered services. Except for emergency or urgent services, all services must be obtained from a participating provider.
- One common variation of an HMO plan is a **Point of Service (POS) plan**. If you have a POS plan, your ID card will say "POS" on the front. Members with POS plans may choose to receive covered services from a non-participating provider, but will always have the highest level of coverage when using in-network care. The cost to members for out-of-network care is often substantially higher.
- **Preferred Provider Organization (PPO)** is similar to a POS plan because it allows you to use in-network or out-of-network providers for covered services. Members with PPO plans may choose to receive covered services from a non-participating provider, but will always have the highest level of coverage when using in-network care. The cost to members for out-of-network care is often substantially higher.

Keep in mind that certain services require prior approval, regardless of the benefit plan you have.

EXCEPTIONS TO OUT-OF-NETWORK LIABILITY

- Emergency Services
- Urgent Care Services

QUESTIONS

If you have questions about your health benefit plan, there are several ways to contact us to obtain the assistance you need:

By telephone
If you have questions about your plan or need assistance in a language other than English, please contact Customer Service.
Toll-free: 1.844.522.5279
TDD/TTY: 1.800.955.8771

Our Customer Service hours are: **Monday through Friday** from 8 a.m. to 5 p.m.

By email
Send your questions or comments to: FHCA@health-first.org.

By fax
Send your fax to: 1.855.328.0062

By mail
Send correspondence to:

Customer Service
Health First Health Plans - FHCA

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6450 US Highway 1
Rockledge, FL 32955

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