

GENERAL INFORMATION

We're committed to providing our members with access to high quality health care in the right setting at the right time, for the right cost. While most covered medical care can be obtained without our involvement, some services require prior authorization (approval in advance) by clinicians who apply evidence-based medical necessity guidelines to the request. Coverage decisions are based on benefit plan provisions and medical necessity, with only licensed physicians permitted to deny coverage based on lack of medical necessity. We do not compensate or provide incentives to any individuals, including practitioners, for denials of coverage or care. Financial incentives for prior authorization decision makers do not encourage decision that result in underutilization.

MEDICAL NECESSITY REQUIREMENTS

Services must be considered medically necessary in order to be covered under any benefit plan. The ordering of an item or service by a physician does not make it medically necessary or a covered benefit. Coverage is determined by the terms of your benefit plan as interpreted by the Health Plan or its delegates. Refer to your plan documents for information on covered benefits and any exclusions from coverage.

WHEN DO I NEED PRIOR AUTHORIZATION?

Whether you use participating or non-participating providers, some services require prior authorization. Your participating physician will request prior authorization when needed, but if you see a provider who does not participate in our network (including our contracted national provider network), you are responsible to ensure prior authorization is obtained, or you may be responsible for the cost of care you receive.

You can find the list of services requiring prior authorization on our website at myAHplan.com or by contacting Customer Service. Authorization requirements are subject to change, so please contact us any time you have questions.

EMERGENCY CARE SERVICES

You *never* need authorization for emergency care at *any* hospital, but if you are admitted to a *non-participating* hospital as part of your emergency care, please have someone contact us so we can authorize payment for your admission and help coordinate your care after you are stable.

TIME FRAME FOR AUTHORIZATION REQUESTS

Authorization decisions are made as quickly as your health requires – within fifteen (15) calendar days for standard pre-service requests or seventy-two (72) hours if your health or ability to regain maximum functioning would be jeopardized by applying the standard time frame. An extension to these time frames may apply if additional information is needed to make the decision.

If your authorization request is denied for any reason, you have the right to appeal the decision. A written notice will be provided to you if coverage is denied, including an explanation of your appeal rights and instructions on how to file an appeal.

QUESTIONS

If you have questions about any aspect of your health plan, there are several ways to contact us:

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 6 p.m.

By email

Send your questions or comments to: AHAP@HF.org

By fax

Send your fax to: 1.855.328.0062

By mail

Send correspondence to:

Customer Service

Health First Health Plans - AHAP

6450 U.S. Highway 1

Rockledge, FL 32955

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