22Health
A Division of
Community Care Plan

MEMBER HANDBOOK

HEALTHCARE THAT WORKS AS HARD AS YOU DO

11/3/25

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Welcome to 22 Health

This Member Handbook contains important information about the Healthcare Marketplace individual health benefits plans offered through 22 Health. It is designed to give you an overview of your benefits and how to use the plan. It provides general information about how your plan works.

More specific information about your health benefits plan, including covered services, exclusions, and your payment responsibilities, can be found in your plan documents, which include your Schedule of Benefits, Certificate of Insurance/Certificate of Coverage, and any riders and amendments that may be a part of your plan. You can view and print your plan at 22healthplan.com/for-members/documents-and-forms. You may also request a copy by calling our Member Services Department at (866) 357-4082.

This Handbook is not a legal document. For full benefit information, please refer to your Certificate of Insurance ("COI") or Certificate of Coverage ("COC"). In the event of any inconsistency between this booklet and your COI or COC, the terms of the COI/COC will control.

This Handbook is also available in Spanish. If you prefer to receive this and similar materials in Spanish, please call our Member Services Department at (866) 357-4082.

How to Contact Us

There may be times when you have a question about your health benefits plan, want to suggest how we can serve you better, need further assistance, or have a problem with the service you received. If you have a question about your health plan, or need information or materials, you can contact 22 Health on the internet or by phone.

On the Internet

At 22 Health's website, www.22Healthplan.com, you have access to important information related to your health plan account and benefits. This includes:

- A provider directory to search for participating providers, including physicians, specialists, hospitals, pharmacies, or urgent care centers;
- Pharmacy information, including a list of formulary medications or preferred drug list;
- Plan documents and forms, including your Member Handbook, Health Risk Assessment (HRA), Medical Claim Reimbursement form, Privacy Policy, and Schedule of Benefits;
- How to make premium payments and account changes;
- Access links to health and community resources;
- Contact information for 22 Health and our partners if you have a question or suggestion, or need to report a problem;

22 Health also offers MyChart, a secure member portal where you can manage your healthcare information and your personal health. After you register or log in, you can:

- Request a change in your primary care physician (PCP), if applicable;
- Request member identification (ID) card and print a temporary ID card;
- Find participating providers, including physicians, specialists, hospitals, pharmacies or urgent care centers;
- View recent claims and Explanation of Benefits ("EOB");
- Contact 22 Health through MyChart for any assistance, questions, suggestions or to report a problem. A customer service representative will respond to you on the next business day.

By Telephone

You can reach our Member Services Department by calling (866) 357-4082.

If you have a hearing or speech impairment and use a Telecommunications Device for the Deaf (TDD), dial 711, and you will be connected via telecommunications relay services.

If you need to speak with someone, a Member Services Representative is available at (866) 357-4082 to help you Monday through Friday from 8 AM to 5 PM. Representatives who speak English and Spanish are available, and a translation line is available for other languages.

By Mail

By mail, please send correspondence to:

22 Health
PO Box 849029
Pembroke Pines, FL 33084

By Email

Support@22Healthplan.com

Important Contact Numbers

Listed below are contact numbers for questions about your health plan or specific benefits that may apply:

Category	Phone Number
22 Health Member Services	(866) 357-4082
24-HourMental Health Crisis	988
24/7 Telemedicine with Teladoc	1-800-835-2362
Pharmacy Benefits	1-888-807-5695
22 Health Compliance Hotline	1-954-622-3482
Make a payment	1-866-285-3955
Sign up for 22 Health Insurance	1-954-800-9075

Health Plan Benefits

This section of the 22 Health Healthcare Marketplace Member Handbook provides a summary of important information on how to use your benefits. More specific information can be found in your plan documents, which include your Schedule of Benefits. You can view and print your plan documents online at 22 Health's website, 22healthplan.com/for-members/documents-and-forms. You may also request a copy by calling Member Services at (866) 357-4082.

22 Health plan offers comprehensive health benefits, including preventive care services. 22 Health's plans require the member to utilize physicians and other healthcare providers who participate in the 22 Health provider network to receive covered services. Exceptions to this include emergency services and care, or when out-of-network services are approved in advance by 22 Health.

22 Health Healthcare Marketplace plan may include the following features:

- Open Access, which allows you to receive covered services from a participating provider without a referral from your PCP;
- Deductibles that apply to both medical and prescription drug covered services;
- Covered services that require copayments only and covered services that require copayments or coinsurance after the deductible.

Refer to your plan documents for benefit features.

Covered Services

Covered services are medically necessary services delivered by healthcare professionals or other providers. These services may include professional medical, surgical, psychiatric, diagnostic, therapeutic and preventive services and supplies described in your plan documents. Your plan documents consist of the Certificate of Insurance/Certificate of Coverage, Schedule of Benefits and any applicable riders, amendments or endorsements. Covered services are subject to specific limitations and exclusions. If you have questions regarding whether a service is a covered service, contact Member Services at (866) 357-4082.

Participating Providers

A participating provider is any physician or healthcare professional, organization, supplier of healthcare items, or healthcare facility that has a written contract with 22 Health to provide medical services to a 22 Health member at the time services were provided.

A list of participating providers can be found in our Provider Directory. If you need a current copy of the directory, please visit us online at 22Healthplan.com and select Find a Provider or call Member Services at (866) 357-4082.

Because directory information is subject to change, when you make an appointment, make sure that the provider is a participating provider with 22 Health. Also, if you are not already a patient, please ask if the provider is accepting new patients.

Outpatient Hospital Facility - Freestanding Facilities

When you are referred for an outpatient service, ask the physician if the procedure can be done in a freestanding facility. Even though it is a freestanding facility, it may be a hospital-affiliated facility, and the facility may submit a claim under the hospital's taxpayer identification number, and you may be responsible for the Hospital copayments, coinsurance, and/or deductible if applicable. Please refer to your plan documents for member responsibility.

These facilities are listed in our Provider Directory at 22Healthplan.com.

Prescription Drugs

For complete details on your prescription drug benefits and to locate participating pharmacies, please refer to the 22 Health website, 22HealthPlan.com22HealthPlan.com/for-members/pharmacy/.

The medications that are covered by 22 Health are listed in our Prescription Drug List (PDL), also known as the formulary. 22 Health's PDL is designed to help your provider choose medications that are clinically effective and cost-efficient. 22 Health covers medications only when prescribed for Food and Drug Administration (FDA)-approved indications, and not when used for investigational or experimental purposes. The amount you pay depends on the medication chosen by your doctor and its tier level. The goal is to provide you with access to safe, effective, and affordable drugs.

Your co-pay may be as low as $0.00, depending on your prescription, its drug tier (Tier 1, Tier 2, Tier 3 or Tier 4, if applicable), and your health plan benefits. Preferred generic drugs usually cost less than preferred brand drugs. Medications that are not on the list are considered non-preferred.

Medications on the PDL are typically grouped into tiers based on their cost:

- Tier 1: Zero Cost Share Preventative Drugs/Essential Health Benefits
- Tier 2: Generic
- Tier 3: Preferred Brand
- Tier 4: Non-Preferred Brand
- Tier 5: Specialty Drugs

Creating medication tiers lets you and your provider determine your out-of-pocket costs in advance, potentially providing a less expensive option for you to consider before getting your medicines from the pharmacy. Generally, drugs in lower tiers have lower copays or coinsurance.

Mail order is available from a participating mail order pharmacy for plan-approved maintenance medications.

You can view or print a copy of the formulary from 22 Health's website at 22healthplan.com/formulary. Members will be notified of any formulary changes through the website or direct notification. We encourage you to share your pharmacy medication formulary information with your prescribers. The prescriber can select covered medications that could help you save money at the pharmacy.

For details regarding your prescription drug benefits, please visit the 22 Health website, 22HealthPlan.com. You can also go to www.medimpact.com to register with MedImpact, our Pharmacy Benefit Manager, or download their mobile app to:

- Access a wide network of retail and mail-order pharmacies available through the pharmacy locator tool
- Search or review coverage for generic and brand-name medications on the PDL
- Use cost-saving tools like the formulary lookup, PDL generic alternatives, cost comparisons between pharmacies, and more
- Find convenient mail-order delivery options
- Get support available from customer service team 24/7

Pharmacy Clinical Services

22 Health wants to help you manage medications and health conditions. We offer access to medication and chronic condition services. Our PBM MedImpact (MI) provides a free APP to members that can assists with healthy lifestyle changes and wellness. Based on the type of medications you take and the number of prescription medications you have, may qualify you for medication related services. Some of the services provided by 22Health include medication therapy Management (MTM); a clinical pharmacist from the health plan may contact you to review and discuss your

medications. This gives you the opportunity to speak with a pharmacist one on one about your medications. In addition, we offer the MedEmpower Fuel Oncology services. This service is available to enrollees living with cancer. You can find more information on these programs at the 22Health website.

Plan Service Area

As a 22 Health member, you must live in the service area and can only receive covered services in the designated service area for your benefits plan unless the services are for an emergency medical condition or are approved by 22 Health in advance.

The service area for your health benefits plan is Broward County.

Primary Care Physician (PCP)

When you enroll in a 22 Health Healthcare Marketplace plan, you may choose a primary care physician (PCP) from 22 Health's provider network at 22Healthplan.com. A Primary Care Physician (PCP) is a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Choosing a PCP

When choosing a PCP, consider your individual needs. Carefully selecting a PCP minimizes the need for change, which could disrupt continuity of care. Here are a few factors to consider when choosing a PCP:

- Location - Is the physician's office conveniently located? Would you prefer an office located near where you live or where you work? If traveling by mass transit, is there a bus stop nearby?
- Specialty - Would an internal medicine physician or family practitioner best suit your needs? If selecting a PCP for your child, would a pediatrician or family practitioner be best?
- Medical group or independent practice - Is the physician a member of a medical group or in independent practice?
- Hospital affiliation - Does the physician admit patients at the participating hospital that is in-network?
- Language - Can the physician (or a staff member) communicate in the language that you speak and understand?

Changing your PCP

You may change your PCP for any reason at any time. Refer to our Provider Directory available on our website, 22Healthplan.com, to select a new PCP that meets your needs. You may request the PCP change through the Contact Us page our website, 22Healthplan.com, in our MyChart member portal, or by calling Member Services at (866) 357-4082. Our Member Services Representatives can help you select a new PCP and will make sure that the PCP you select is accepting new patients.

PCP changes will be effective on the first day of the next month. For example, if you request a change on any day in January, the change will be effective on February 1.

Receiving Care from your PCP

If you are not already a patient of the PCP, we encourage you to make an appointment to see your new PCP as soon as possible so he or she can get to know you and become familiar with your healthcare needs. In addition to providing much of your care, your PCP will help arrange or coordinate the covered services you receive. This includes X-rays, laboratory tests, therapies, specialist office visits, hospital admissions, and follow-up care. In some cases, your PCP will also need to obtain prior authorization from 22 Health. Since your PCP will provide and coordinate your medical care, you should have all of your medical records sent to your new PCP's office.

Using Your Benefits

This section of the Member Handbook provides a summary of important information on how to use your coverage. More specific information can be found in your plan documents. This includes your Schedule of Benefits, Certificate of Insurance/Certificate of Coverage and any applicable riders, amendments and endorsements. You can view and print your plan documents online at our website, www.22Healthplan.com. You may also request a copy by calling our Member Services Department.

Member Identification Card

You will receive a 22 Health member ID card for yourself and for each enrolled dependent. Present the ID card to the healthcare provider whenever you seek medical services or to the pharmacy when filling a prescription. The card has the information the provider or pharmacy needs to verify your benefits and submit claims to 22 Health for the services you receive. Take it with you when you travel in case of an emergency.

If you or one of your enrolled dependents did not receive an ID card, or if a card is lost, you can request a new one online at 22 Health's website (www.22Healthplan.com), in our

MyChart member portal or by calling Member Services at (866) 357-4082. A virtual ID card can also be printed from our MyChart member portal.

Direct Access Services

All members have direct access to in-network providers, including certain specialty services, without the need for a referral.

Prior Authorization

Some services require approval from 22 Health in advance, called prior authorization. In most cases, when you receive care from an in-network provider, the healthcare provider will be responsible for obtaining prior authorization for services.

Our Utilization Management (UM) trained clinical staff work with providers to connect members with the right care at the right time through service pre-authorization and concurrent review. They pre-authorize certain types of services, including hospital care. For example, our nurses work with the hospital to review services while a member is in the hospital and during the discharge planning process. They also help coordinate post-discharge support for members who need this assistance. Our goal is to help members access needed services and ensure the most effective and efficient utilization of provider resources.

You should always show your 22 Health member ID card to your provider prior to receiving services. If you use out-of-network, non-participating providers, you are responsible for obtaining prior authorization or making sure the treating non-participating provider obtains prior authorization for your covered service. If prior authorization is not obtained when it is required, certain services may be subject to a penalty or denied, and you will be responsible for the payment.

If you receive care from your PCP or through a referral from your PCP, the PCP will obtain any necessary approvals for you. If you have been referred to a specialist, the specialist may obtain prior authorization. Below is a partial list of services that may require prior authorization.

- Hospital admissions and skilled nursing facility confinements;
- Non-emergency outpatient hospital services, including but not limited to, surgical, laboratory, and diagnostic procedures;
- Braces, prosthetics, orthotics;
- Diagnostic Imaging
- Dialysis;
- Durable Medical Equipment;
- Hospice care;

- Home Health;
- Non-emergency transportation;
- Pain management

For the complete list, please visit the 22 Health website, www.22Healthplan.com.

Physician office-administered medications must be requested via the pharmacy benefit. Prescribers in the 22 Health network will be notified via the prescriber website of the medication requesting process.

Members are not required to obtain prior authorization before seeking emergency services and care.

Please review our website, www.22Healthplan.com, or call Member Services for specific requirements, as services requiring prior authorization may change.

It is your responsibility to verify that prior authorization has been obtained prior to the service being provided. Prior authorization is not a guarantee of coverage. Members must be eligible for coverage at the time the services are rendered.

Alcohol and Substance Abuse Services

You do not need a referral from your PCP to receive care for alcohol or substance abuse services covered under your benefit plan. To arrange services, or if you have any questions, call the Member Services Department at 1-866-357-4082, TDD/TTY 711, Monday to Friday, 8am to 5pm. Refer to your plan documents for member responsibility.

Healthcare Management Programs

22 Health believes that preventive healthcare is important to keep members healthy. Taking care of yourself and your family before you get sick will help promote greater wellness. One way to stay healthy is to know about recommended immunizations and preventive screenings for adults and children. To help you do this, guidelines are based on recommendations from national medical associations and authorities. 22 Health suggests that you work closely with your doctor to discuss and develop an appropriate health maintenance plan that meets your specific needs. If you would like to review suggested preventive health guidelines, please visit www.healthcare.gov/coverage/preventive-care-benefits/. These guidelines should not replace the advice of your doctor.

22 Health also offers programs designed to help members manage preventive care and care of chronic illnesses. 22 Health offers a suite of services and programs that complement doctors and hospitals by providing education, communication, and local expertise. Members

may benefit from one or multiple programs. These programs are provided at no additional cost to our members but should not replace advice or treatment from your doctor.

22 Health Programs provide the support needed to help members achieve the best state of health through self-management and treatment compliance.

- **Disease Management (DM)** programs for members with Asthma, Diabetes, and Hypertension (high blood pressure) provide helpful information about managing diseases as well as preventing complications. For those who participate in our programs, we provide educational materials to help members manage their disease as well as targeted reminders to members who may be past due for certain tests or services related to their condition. Our highest-risk members work with a DM coach who provides education and support to help the member better manage their chronic conditions and follow their treatment plan. For more information on enrolling in a disease management program with 22 Health, please call our Member Services Department.
- **Care Management** provides care coordinators who assist and encourage members to pursue their best state of health. Members and their providers work with nurses trained to help and support patients with condition management.
- **Maternity Management** provides pregnant women with a care coordinator who works with the woman throughout her pregnancy and following delivery to help her get needed care and complete essential prenatal and post-partum visits. The care coordinator helps the pregnant woman, and her OB provider coordinate her health care services and social supports, provides and reviews educational materials about pregnancy, childbirth, and newborn care, and provides referrals to local programs such as breastfeeding support groups.
- **MedEmpower Fuel Oncology program** provides enrollees diagnosed with cancer personalized support to assist with their holistic care. Eligible members will be contacted by our MedImpact clinical team and enrolled into the program. The program provides an application (APP) called MedEmpower Fuel. This App provides access to counselors, nutritional information, weight management support, and many other helpful tools. There is no cost to You to use this service.
- **MedEmpower Fuel App** will also be available to non-oncology members but with limited access and at no cost.

Going to a Hospital

Except for an emergency, your physician is responsible for coordinating any hospital care you need. You, or someone on your behalf, may call Member Services to ensure that the admitting physician has received prior authorization for your hospitalization. Your physician or an assigned hospitalist will manage your care, coordinate diagnostic tests and treatment, and plan for your discharge. In addition, 22 Health clinical staff will work with your physician to help coordinate services to maintain continuity of care when you are discharged from the hospital.

Medical Emergency

An emergency medical condition is an illness, injury, symptom, and/or condition so serious that a reasonable person would seek care right away to avoid severe harm.

If you have an emergency medical condition, dial "911" for immediate help, or go directly to the nearest emergency room, hospital, or participating urgent care center. If you are out of the service area, you should dial "911" for immediate help or go directly to the nearest emergency room or hospital.

If you obtain services through an emergency room, 22 Health encourages you, or someone on your behalf, to notify 22 Health within 48 hours of the emergency room visit, or as soon as reasonably possible, so that your follow-up care can be coordinated.

Once you are discharged from the emergency room or the hospital, remember to schedule all follow-up care with your PCP. Even if the emergency room physician instructs you to return to the hospital for follow-up, you should check with your PCP first. Failure to coordinate follow-up care with your PCP may result in denied claims, and you may be responsible for payment.

Please note that your claim may be denied if you go to the emergency room when you do not have an emergency medical condition.

Telehealth

22 Health members are eligible for telehealth visits. Telehealth is a virtual visit with a doctor using a cell phone, tablet, or computer anytime for non-emergency care. No appointment necessary!

Use telehealth for non-emergency care for conditions, such as:

- Behavioral Health
- Cough and Flu
- Dermatology
- Ear Infection
- Migraines
- Pink Eye
- Rash
- Seasonal Allergies
- Sinusitis
- Urinary Tract Infections

Teladoc is a telehealth service offered by 22 Health to treat non-emergency issues (allergies, flu, eye issues, sinus infections, rashes, sore throat, and more).

Teladoc provides virtual visits or care with a licensed doctor from a smartphone or computer 24 hours/day, seven days/week.

For more information or to sign up, visit Teladoc.com.

Urgent Care

Urgent Care is care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. Some examples of urgent care cases are:

- Non-severe bleeding;
- Simple cuts that require stitches;
- Sprains.

If you have an unexpected illness or injury that requires immediate treatment, please call your healthcare provider for guidance.

After-Hours Care

If you develop an urgent health problem after office hours or on the weekend, you should call your physician, unless your health condition is an emergency medical condition. In the case of an emergency medical condition, please go to the nearest emergency room or call “911” immediately.

Receiving Care Outside the Service Area

Your benefit plan's service area is defined in the Plan Service Area section. If you need care outside the service area, your coverage typically includes emergency services and care. If you have questions about what medical care is covered when you travel, please call Member Services.

Transition of Care

As a new 22 Health member, you need to be aware of our transition of care process to ensure a smooth transition from your previous health plan to 22 Health. This process ensures that all authorizations to new participating providers and facilities for planned treatments are in place. In most cases, members need to receive treatment from participating providers for services to be covered at the in-network level of benefits.

Please be aware that not all health plans cover services in the same way. If you are receiving treatment for an ongoing condition, review your 22 Health plan documents to understand how your care will be covered. If your treatment was approved by a previous plan, it may still require authorization from 22 Health to receive benefits. Only services approved by 22 Health will count toward your out-of-pocket maximum (MOOP); non-covered services do not apply.

If you are currently receiving ongoing treatment for a medical condition or are scheduled for medical services after your effective date with 22 Health, please call Member Services Department at (866) 357-4082.

Claims and Reimbursement

Member Responsibilities

You have certain payment responsibilities as detailed in your plan documents. Please refer to these documents for specific information.

In addition to your premium, you may be responsible for copayments, deductibles, and/or coinsurance amounts listed in your Schedule of Benefits up to your annual out-of-pocket maximum. If you meet the annual out-of-pocket maximum, your plan will pay for services as described in your plan documents. The costs for any services received above your plan’s maximum benefit are also your responsibility.

Copayments

Some health plans include a copayment, which is a fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service. The most common copayment amounts are listed on your ID card.

Deductible

Some health plans have a deductible, which is the amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Coinsurance

Some health plans have coinsurance, which is your share of the costs of a covered healthcare service, calculated as a percent (for example, 40%) of the allowed amount for the service. You pay coinsurance plus any deductible you owe. For example, if the health plan's allowed amount for an office visit is $100 and you have met your deductible, your coinsurance payment of 40% would be $40. The health plan pays the rest of the allowed amount.

Benefit Maximum

Some health benefits may include an annual visit maximum, which means that 22 Health will pay up to the annual maximum visit per benefit year. The costs for any services received above the maximum benefit are your responsibility.

You are responsible for paying for services that are not covered by your health plan.

If your health plan is subject to a deductible or coinsurance, or if 22 Health denies payment because the services are not covered by your plan, an Explanation of Benefits (EOB) will be generated. EOBs explain how each claim was processed by 22 Health, including any amounts paid by the plan and your member responsibility. EOBs are available to you electronically through your secure member portal, MyChart. You may view, download, or print your EOBs at any time. If you prefer to receive a paper copy, you may request one by contacting Member Services at (866) 357-4082.

Bills from Participating Providers

Florida law specifies that, except for copayments, deductibles, or coinsurance, HMO members cannot be responsible for any bills from participating providers for covered services. Therefore, you should not receive a bill for covered services except for any copayments, deductibles, or coinsurance that you are responsible for as described in your

plan documents or for non-covered services. If you do receive a bill, please contact Member Services.

Filing Claims for Payment

Whenever you see a participating provider for covered services, the provider will send a claim to 22 Health. You are only responsible for your copayment, deductible, or any coinsurance required by your benefits plan. You do not have to file a claim for payment. If you see a non-participating provider we have approved under your coverage, the provider may submit the claim for you or may require that you pay the bill. If you pay the bill, you may submit a request to 22 Health for reimbursement as explained in the Requesting Reimbursement section.

Requesting Reimbursement

If you received approved services from an out-of-network Provider, and if that provider does not submit a claim to us, you can file the claim directly. To do so, send us a copy of your paid, itemized bill, along with a completed claim form available on our website: 22healthplan.com/for-members/documents-and-forms.

You can send the information by mail to:

22 Health
PO Box 849029
Pembroke Pines, FL 33084

Alternatively, you can send the information by email to support@22Healthplan.com or by fax at (954) 251-4607.

We will make payment to you of the billed expense amount for covered services as defined in your policy documents, unless We are directed otherwise or as required by applicable state or federal law. You will be responsible for any applicable cost-sharing amounts (such as copayments, deductibles, and coinsurance amounts), any non-covered or excluded expenses, and amounts over specifically limited benefits.

Please note that to receive any payment to which You may be entitled, You must submit your claim within six (6) months from the date of the service in question, unless your health plan Evidence of Coverage provides a longer time to submit your out-of-network provider claim.

Patient Safety and Confidentiality

Your Safety when Receiving Treatment

Staying safe and avoiding possible medical errors means taking an active role in your healthcare. 22 Health encourages you to follow these five important steps to enhance your safety when receiving treatment in a healthcare facility.

1. Speak up if you have questions or concerns. Choose a doctor with whom you feel comfortable talking about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. Remember, it is okay to ask questions and to expect answers you can understand.
2. Keep a list of all the medicines you take. Tell your doctor and pharmacist about all the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbal supplements. Discuss any drug allergies you have. Ask the pharmacist about potential side effects and any foods or substances to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different from what you expected, ask the pharmacist about it.
3. Make sure you get the results of any test or procedure. Ask your healthcare provider or nurse when and how you will get the results of tests or procedures. If you do not get them when expected—in person, on the phone, or in the mail—don't assume the results are fine. Call your physician and ask for them. Ask what the results mean for your care.
4. Talk with your doctor about your options if you need hospital care. If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals treat a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results are often better at hospitals that perform a lot of these procedures. Also, before you leave the hospital, be sure to ask about follow-up care, and be sure that you understand the instructions.
5. Make sure you understand what will happen if you need surgery. Ask your doctor and surgeon:
    - Who will take charge of my care while I am in the hospital?
    - Exactly what will they be doing?
    - How long will my surgery take?
    - What will happen after the surgery?
    - How can I expect to feel after recovery?

Our Confidentiality Statement

22 Health recognizes that the privacy of personal health information (PHI) is a significant concern for you. We are committed to keeping your health records confidential. For this reason, we have policies and procedures in place to protect your personal health records. To manage your health insurance benefits, we may need to look at PHI. We often use this data to coordinate care, measure quality improvement, and send bills correctly. We will not use or release your information beyond the routine uses of treatment, payment, or other healthcare operations without your authorization. For those members who are unable to act on their own behalf and are unable to give consent, a personal representative legally authorized to act on their behalf must give this consent.

We have taken a number of steps to protect your PHI. We protect access to our buildings and computer systems. We restrict access to PHI only to those employees who need this information to carry out their job duties. These employees are assigned special security levels that give access to this data. All 22 Health employees sign contracts agreeing to follow our confidentiality policies. If an employee violates these policies, we will take disciplinary action up to and including termination of employment. Whenever possible, we limit the use of data that may identify a member.

Provider Malpractice Information

Florida law requires certain physicians/providers to carry malpractice insurance coverage. As a condition of maintaining their license, providers are required to post a notice if they do not carry medical malpractice insurance stating, “Your physician has decided not to carry medical malpractice insurance. This notice is provided pursuant to Florida law.”

Member Rights and Responsibilities

The following rights and responsibilities are set forth under Florida law. Florida law requires that your healthcare provider or healthcare facility recognize your rights while you are receiving medical care and that you respect the healthcare provider's or healthcare facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility.

Member Rights

- You have the right to be treated with courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy.
- You have the right to participate in health care decisions.
- You have the right to privacy, respect, consideration, and dignity.
- You have the right to refuse to participate in research.
- You have the right to request interpreter services, as necessary.
- You have the right to a prompt and reasonable response to questions and requests.
- You have the right to know who is providing medical services and who is responsible for your care.
- You have the right to know what member support services are available, including whether an interpreter is available if you do not speak English.
- You have the right to know what rules and regulations apply to your conduct.
- You have the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- You have the right to refuse any treatment, except as otherwise provided by law.
- You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- If you are eligible for Medicare, you have the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
- You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- You have the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- You have the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- You have the right to know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.

- You have the right to see the provider's credentials.
- You have the right to express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility that served you and to the appropriate state licensing agency.

Member Responsibilities

- You are responsible for providing to the healthcare provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- You are responsible for reporting unexpected changes in your condition to the healthcare provider.
- You are responsible for reporting to the healthcare provider whether you comprehend a contemplated course of action and what is expected of you.
- You are responsible for following the treatment plan recommended by the healthcare provider.
- You are responsible for keeping appointments and, when you are unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
- You are responsible for treating health care providers, staff, and others with respect.
- You are responsible for your actions if you refuse treatment or do not follow the healthcare provider's instructions.
- You are responsible for assuring that the financial obligations of your healthcare are fulfilled as promptly as possible.
- You are responsible for following healthcare facility rules and regulations affecting your care and conduct.
- You are responsible for informing providers about living wills, medical power of attorney, or other directives affecting care.

If You Miss a Premium Payment (Grace Periods)

If you miss the due date for your premium payment, you may still have time before your coverage ends. This is called a grace period.

- If you don't get premium help (no subsidy), you have 31 days after your due date to pay your premium.
- If you get premium help through the Marketplace (APTC subsidy), you have a three-month grace period, as long as you've already paid one full month's premium.

Your coverage stays active during this time, but if you don't pay the full amount you owe by the end of the grace period, your coverage will end — and some claims may not be paid.

If you're ever unsure about your payment status or coverage, please call us immediately so we can help you stay covered.

Your Privacy Matters

We understand the importance of keeping your personal and health information secure and private. In compliance with the Health Insurance Portability and Accountability Act (HIPAA), 22 Health provides you with important information about how your medical and personal information may be used and about how you can access this information. This notice informs you of your rights regarding the privacy of your personal information and how we may use and share your personal information.

We will make sure that your personal information is only used and shared in the manner described. We may, at times, update this notice. Changes to this notice will apply to the information that we already have about you, as well as any information that we may receive or create in the future. Our current notice is posted on our website, 22healthplan.com/privacy-policy. You may request a copy at any time. Throughout this notice, examples are provided. Please note that all of these examples may not apply to the services 22 Health provides to your particular health benefit plan.

Types of Personal Information We Collect

To best serve your benefits, we need information about you. This information may come from you, your employer, other payors, or health benefits plan sponsors, and our affiliates. Examples include your name, address, phone number, Social Security number, date of birth, marital status, employment information, or medical history. We also receive information from healthcare providers and others about you. Examples include the healthcare services you receive. This information may be in the form of healthcare claims and encounters, medical information, or a service request. We may receive your information in writing, by telephone, or electronically.

How We Protect Your Personal Information

Keeping your information safe is one of our top priorities. We limit access to your personal information to those who need it. We maintain appropriate safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Compliance Office also ensures that our staff receives training on our privacy and security policies. Learn more at 22healthplan.com/privacy-policy/.

Sharing Information and What Happens If You Are No Longer Enrolled

We will obtain your written permission to use or share your health information for reasons not identified by this notice and not otherwise permitted or required by law. If you withdraw your permission, we will no longer use or share your health information for those reasons. We do not destroy your information when your coverage ends. It is necessary to use and share your information for many of the purposes described above, even after your coverage ends. However, we will continue to protect your information regardless of your coverage status.

How to File a Complaint, Grievance or an Appeal.

To find out how to exercise any of your rights listed in this notice, or if you have any questions about this notice, please contact Member Services at (866) 357-4082. If you believe we have not followed the terms of this notice, you may file a grievance with us or with the Florida Office of Insurance Regulation

To file a complaint with the plan, You can call our Member Services department at 1-866-357-4082, 8 am - 5 pm Monday through Friday. A Member Services Representative will research your concerns and call you with their resolution by the end of the next business day. If the Member Services Representative is unable to resolve your issue, then they will let you know how to file a grievance.

To file a grievance or an appeal, please complete the Grievance & Appeals Form on our website, 22healthplan.com/for-members/documents-and-forms. You may also file a grievance or an appeal in writing by submitting your grievance to the Grievance and Appeals department via:

Fax: 954-251-4848
Email: GAdepartment@22Health.com

Grievances may be submitted at any time and will be acknowledged in writing within 5 business days and resolved in writing within 30 calendar days.

You may submit an appeal up to 180 calendar days following any incident or action that is the subject of the member's dissatisfaction. Appeals will be acknowledged in writing within five (5) business days and resolved within 30 calendar days.

You may request an expedited appeal if Your life, health, or ability to regain maximum function would be placed in jeopardy by delay due to a non-urgent appeal review.

Expedited appeals may be requested orally or in writing. You may also request an expedited external appeal at the same time that You request an expedited internal appeal.

22 Health's Physician reviewer, or Your treating Physician will decide if the expedited appeal criteria apply. We will provide written notification of our decision regarding Your expedited appeal within 72 hours of receiving Your request.

22 Health's system addresses the linguistic and cultural needs of its member population, as well as those of members with disabilities. 22 Health ensures there is no discrimination against a Member (including cancellation of the contract) on the grounds that the Member filed a Grievance or Complaint. Grievances and Complaints will be addressed and resolved according to state regulations.

If You have any questions regarding a Complaint, Grievance, or appeal concerning the health care services You have been provided, which have not been satisfactorily addressed by Your Plan, You may contact the Florida Office of Insurance Regulation at any time. Information regarding the Florida Office of Insurance Regulation may be found by accessing the Web Page at floir.com. No insured who exercises the right to file a complaint or an appeal shall be subject to disenrollment or otherwise penalized due to the filing of a complaint or appeal.

The Florida Office of Insurance Regulation may be contacted as follows:

Florida Office of Insurance Regulation

Division of Consumer Services

200 East Gaines Street

Tallahassee, FL 32399-0322

For More Information or to File a HICS Complaint

If you have a complaint about your health insurance, such as issues with claims, coverage, provider services, or the quality of car, you can file it through the Health Insurance Casework System (HICS). Here's how:

1. Contact 22 Health (if you haven't already):
   Before submitting a complaint through HICS, try resolving the issue directly with 22 Health. We are required to have a formal grievance and appeals process.
2. Submit a Complaint to the Appropriate Agency:
   If the issue isn't resolved or you're not satisfied with the outcome, you can file a complaint by contacting the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325). Ask to have your issue escalated through HICS.
3. Provide Detailed Information:
   When filing a complaint, be prepared to provide:
   - Your name and contact information
   - Policy or plan number
   - A clear description of the issue
   - Any relevant documents (denial letters, bills, provider notes, etc.)
4. Follow Up:
   Once submitted, your case will be reviewed, and you may be contacted for more information. You can follow up through the agency you filed with.

Advance Directives and Living Wills

Under Florida law, every competent adult (18 years of age or older) may decide what kind of care they want. This law makes sure your rights and wishes are carried out the way you want. You can decide what medical and mental health care you do and do not want if you get very sick. You can ask not to have certain help. You can also ask not to be kept alive with special care. If the law changes, we will let you know within 90 days of any change.

An advance directive is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are a/an:

- Living Will
- Health Care Surrogate Designation
- Anatomical Donation

You will not be discriminated against for not having an Advance Directive. 22 Health does not limit the implementation of advance directives as a matter of conscience.

If you have an advance directive, your wishes will be carried out the way you want. If you have questions, speak to your doctor about this and call Member Services.

The following forms are available at:
www.floridahealthfinder.gov/reports-guides/advance-directives.aspx

- Living Will
- Designation of Health Care Surrogate
- Designation of Health Care Surrogate for a Minor
- Donor Form
- Wallet Card about your Advance Directive

If your directive is not being followed, you can call the State's Complaint Hotline at 1-888-419-3456.