22Health
A Division of Community Care Plan

Transparency in Coverage

(866) 357-4082 | 22HealthPlan.com
PO Box 849029 Pembroke Pines, FL 33084

At 22 Health, we want to make it as easy as possible for you to understand how your insurance coverage works. This document provides you with some basic information about the ideas, words, and documents that you might come across when you seek care. If you have questions about this document or your 22 Health plan more generally, please call us at (866) 357-4082.

In the paragraphs that follow, 22 Health and its affiliates are described as "We" or "Us," and our members and their enrolled dependents are described as "You."

Contents

22 Health
A Division of Community Care Plan

Out-of-Network Liability and Balance Billing

What is a provider network?

22 Health's "provider network" is the full list of health care professionals, listed in our Provider Directory, who have agreed to provide services to 22 Health members. An "in-network provider" is one of those providers – in other words, someone who has contracted with Us to provide services to our members (like You) at specific, pre-negotiated rates. An "out-of-network provider" is any other provider. In most cases, receiving services from an in-network provider will be less expensive for You.

Why are services from out-of-network providers usually more expensive?

Generally, if You receive services from an out-of-network provider, these services are not covered under Your 22 Health plan (although we may authorize exceptions). Your health plan will not pay for these services, and You are responsible for the out-of-network Provider's full costs. Charging any amount over what We pay, and Your cost-sharing amount is called balance billing. Unless You receive prior authorization for out-of-network services, or the out-of-network service is covered by the Federal No Surprises Act or similar state law, You will be responsible for the full amount.

Are there any exceptions?

If You receive out-of-network services for a medical emergency, We will treat those services as if You received them at an in-network provider. Balance billing may be waived for emergency services received at an out-of-network facility. In other words, in cases of emergency, You will only owe the applicable in-network cost-sharing amounts for benefits described in Your policy documents. You may also seek specific authorization to pay in-network rates for out-of-network services, if medically necessary services are not available to you from an in-network provider within certain time/distance requirements. Pre-certification requirements apply (see below).

Member Claim Submission

What is a claim?

A "claim" is a request that 22 Health pay for health care services provided to a member like You. When We "process" (pay) claims that are "filed" (submitted to Us) for these services, we follow federal and state rules, as well as the policies described in Your health plan documents.

Who is responsible for filing a claim?

Usually, providers file claims with Us on Your behalf.

Before seeking services, we recommend that you confirm, by checking our Provider Directory or contacting us at (866) 357-4082, whether the provider you wish to see is in-network. When you arrive at that provider and present Your 22 Health identification card, the provider will confirm that they are an in-network provider with 22 Health and that You are a 22 Health member. After you receive these services, the provider will file a claim with Us, and We will make payment directly to them. Usually, the payment that We make does not include the cost-sharing for which you are responsible (such as copayments, deductibles, coinsurance amounts), any payment for non-covered or excluded expenses, or any amounts over specifically limited benefits.

Out-of-network providers who may provide care to You because of a medical emergency, because We authorized such care, or because You elected to see them even though they are out-of-network may or may not file claims directly with Us. If they do, We will process the claim as described above. If they do not, You may choose to file the claim with Us directly.

How can You file a claim with Us?

If you received Covered Services for which you are eligible for reimbursement under this Plan and if that provider does not submit a claim to Us, you can file the claim directly.

To file a claim, email the following items to support@22Healthplan.com:

- The completed Member Claims Medical Reimbursement form, available on Our website,
- An itemized bill from the Provider, and
- Proof of payment, if applicable.

Alternatively, you can send the required items by:

- Fax to (954) 251-4607
- Mail to 22 Health
  PO Box 849029
  Pembroke Pines, FL 33084

Please note that this Plan generally covers services received from Participating Providers. Services received from Non-Participating Providers are covered only when specifically allowed under the terms of this Plan, such as Covered Emergency Services or other covered exceptions.

We will make payment to You of the billed 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), any non-covered or excluded Expenses, and amounts exceeding 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.

Explanation Of Benefits

How can You find more information about a particular claim?

Every claim that We process for services You receive appears on an Explanation of Benefits (EOB) statement that is available in your member portal after We pay Your claim. The EOB is not a bill. Instead, it explains what services We paid for, how much We paid under Your 22 Health plan, and any financial responsibility that You bear (which you would typically pay directly to the provider). The EOB also provides You with information about Your appeal rights if you disagree with how we processed the claim(s).

Retroactive Denials

Can a claim be denied even after it was paid?

In certain situations – usually, when you are found no longer to be eligible for coverage by 22 Health – a claim may be “reversed” (reprocessed and denied retroactively, even after it has been paid), meaning that You become responsible for payment to the provider. In most cases, You can prevent a retroactive denial by paying Your premiums on time and by promptly notifying Us or (if applicable) Your marketplace of changes in Your eligibility status.

How can You prevent retroactive denials?

You should talk to your provider about whether the service performed is a covered benefit. You can also avoid retroactive denials by obtaining your medical services from an in-network provider.

Medical Necessity, Prior Authorization Timeframes, and Member Responsibilities

How do We decide whether to pay a particular claim?

We pay claims according to applicable law, the network status of the provider, and the relevant plan documents as described above – as well as whether we have determined that the services in question were medically necessary.

To determine medical necessity, in some cases, We require that You or Your treating provider pre-certify the medical necessity of Your care. Pre-certification is sometimes called “pre-authorization” or “prior authorization.” Please note that pre-certification relates only to the medical necessity of care; it does not mean that Your care will be covered under the plan. Pre-certification also does not mean that we have been paid all monies (usually premiums) necessary for coverage to be in force on the date that services or supplies are rendered.

It is Your responsibility to ensure that You or Your provider obtains pre-certification. In some cases, Your provider will initiate the pre-certification process for You. You should be sure to check with Your provider to confirm whether pre-certification has been obtained. Generally, if pre-certification is required and not obtained, you may have to pay up to the full amount of the charges under the plan.

To minimize the potential for care delays, We recommend that Prior Authorization requests be received through our secure online portal, PlanLink, within the following timeframes when feasible:

- At least 15 days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility
- At least 30 days prior to the initial evaluation for organ transplant Services
- At least 30 days prior to receiving clinical trial services
- At least 15 days prior to a scheduled inpatient behavioral health or substance use disorder treatment admission
- At least 15 days prior to the start of home healthcare services.

For approvals, 22 Health will provide written notification of our decision within two (2) business days of our decision. For denials (Adverse Determinations), we will provide written notification within one (1) business day of our determination.

Coordination of Benefits

Who pays Your claims if You have more than one health insurance plan?

If You have more than one health insurance plan, those plans work together through a process called "coordination of benefits" to make sure You get the most from Your coverage. One plan is designated as Your primary plan and pays Your claims according to its rules, Your secondary plan then pays toward the remaining cost according to its rules, and so on. This process maximizes Your benefits and may lower Your out-of-pocket costs. Further information about Coordination of Benefits can be found in your Evidence of Coverage under the Coordination of Benefits Section within the Order of Benefit Determination Rules provision.

Grace Periods and Claims Pending

When do I owe payment for my 22 Health coverage?

In general, Your payment for each month of coverage is due on the first day of that month.

Is there a grace period if I miss the deadline? What happens if I receive services after the missed payment was due?

If You purchased an individual plan through the health insurance marketplace and You are receiving advance payments of tax credits (“APTC”) and/or cost sharing reductions in accordance with the Affordable Care Act, there is a grace period of three months for all monthly premium payments after the initial premium payment.

If You pay a monthly payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim You submit for benefits will be placed in a “pending status” (suspended) on the first day of the second month of the grace period and then processed by the plan only when all periodic monthly payments due during the grace period are received.

If You fail to pay in full all periodic monthly payments due and payable before the end of the grace period for those coverage periods, Your coverage under the plan will be retroactively canceled back to the last day of the first month of the grace period. Failure to timely pay premium payments is not considered a special open enrollment event that would allow You to re-enroll outside of open enrollment periods.

For all other members, there is a grace period of 31 days for all monthly premium payments after the initial premium payment. If You pay a monthly payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim You submit for benefits will be placed in a “pending status” (suspended) and then processed by the plan only if your monthly payment is received within the grace period. If You fail to pay Your monthly payment within the grace period, Your coverage under the plan will be retroactively canceled back to the last day of the last month for which You made payment.

Failure to timely pay premium payments does not qualify You for a trigger is not a special open enrollment event for later coverage under the plan.

Recoupment of Overpayments

What can You do if You think We billed you incorrectly?

If You believe that We have overbilled you for your premium, or made any other error in billing or payment, please contact us at (866) 357-4082.

Drug Exception Timeframes and Member Responsibilities

How do You check which drugs are covered under Your 22 Health plan?

The list of drugs covered by your 22 Health plan can be found at 22healthplan.com in For Members/Pharmacy - Formulary or Preferred Drug List.

What if a drug that You want is not on our Formulary?

You may need access to drugs that aren't listed as covered on Our formulary (drug list). If Your drug is not covered and You think it should be, You may ask Us to make an exception to the drug coverage rules. We will review Your request through the formulary exception review process. If Your request qualifies as urgent, You may submit an expedited exception request. In support of Your request, Your doctor or other prescriber must give Us a statement explaining the medical reasons for requesting an exception. You or Your Provider may submit the request to Us by calling 1-888-807-5695, or by submitting the necessary form to Us. To find this form, please visit Us at 22healthplan.com select the "22 Health Drug Prior Authorization Form" in the "Documents & Forms" section.

To request an expedited review for urgent circumstances, select the "Urgent" option in the "Priority" section of the form.

We will give You a response within 72 hours, or 24 hours for expedited exception requests, of receiving all information needed to make the decision.

If We deny Your request, We will send You a denial letter, and You may request an internal appeal. Then, if You feel We have denied the non-formulary request incorrectly, You may submit the case for an external review by an impartial, third-party reviewer known as an independent review organization (IRO). Your denial letter will contain all the necessary information for initiating this external review with the IRO. You may also contact us by phone, at (866) 357-4082 to initiate the external review with the IRO. We must follow the IRO's decision.

Please call Us at (866) 357-4082 and We'll help You initiate your IRO.

What if a drug that was requested is denied?

If a drug or service is denied, You have the right to request an administrative appeal and, if needed, an external review by an Independent Review Organization (IRO). Your denial letter will include instructions for both options. If you need help with these requests, please contact us at (866) 357-4082.