Geisinger Health Plan

Definitions

- **Agreement:** The Agreement to provide Health Care Services, together with any attachments, exhibits, applicable Provider Guide(s), Benefit Documents, as amended from time to time and made a part of this Agreement by reference between Participating Health Care Provider or Participating Provider and Health Plan.

- **Appeal:** For a Gold Member, an Appeal is a procedure that deals with the review of adverse initial decisions (organization determinations) on the Health Care Services a Member believes he/she is entitled to receive or any amounts that the Member must pay for a Covered Service.

- **Benefit Document(s):** The subscription certificate, schedule of benefits and any rider(s) thereto and/or summary plan document which sets forth the terms, conditions and benefits of coverage for Members enrolled in Geisinger Health Plan, GIIC, GQO or an Employer-Sponsored Program, as applicable.

- **Billed Charges:** Those charges, determined prior to deduction for discounts and contractual adjustments, which are usually and customarily billed by a provider to all its patients for a particular service, as adjusted from time to time.

- **Business Day:** A day other than Saturday, Sunday or a legal holiday when commercial banks in the Commonwealth of Pennsylvania are generally open for business.

- **Medical Management:** A method of managing a Member's health care by coordinating care, improving continuity and quality of care in the most efficient manner.

- **Clean Claim:** A claim for payment for a Covered Service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a Health Care Provider who is under investigation for fraud or abuse regarding that claim.

- **Clinical Guidelines:** Systematically developed statements to assist a provider and patient in making decisions about appropriate health care for specific clinical circumstances.

- **Coinsurance:** A form of cost sharing which requires the Member to pay a portion of the cost of Covered Services. A Coinsurance is a set percentage of this cost.

- **GIIC:** Shall mean Geisinger Indemnity Insurance Company.

- **Complaint:** A dispute or objection by a Member regarding a Participating Provider; coverage issues, including contract exclusions, limitations and benefits that are not covered; and the operations and\or management of Health Plan which has not been resolved by Health Plan and has been filed with the Health Plan or Department of Health or Pennsylvania Insurance Department. A Complaint does not include a Grievance.

- **Concurrent Review:** A medical management technique used by managed care organizations to ensure that Medically Necessary and appropriate care is delivered during a Member's hospitalization or other inpatient episode.

- **Copayment:** A form of cost sharing which requires the Member to pay a fixed amount of money for a Covered Service. Copayment amounts are due at the time and place such services are received by a Member, or may instead be subsequently billed by a Participating Provider, at Participating Provider's sole discretion.

- **Covered Service:** A Medically Necessary (unless otherwise indicated) service or supply specified in a Member's Subscription Certificate for which benefits will be provided pursuant to the terms of a Subscription Certificate or any Medically Necessary Supplemental Health Services set forth in any Riders supplementing a Subscription Certificate.

- **Deductible:** A specific dollar amount that must be incurred and paid by a Member or a Member's family before the Health Plan will assume any liability for all or part of the cost of Covered Services.

- **Direct Access Services:** The ability of a Gatekeeper Product Member to directly access certain designated Covered Services from a Participating Provider without prior authorization or Referral from a Primary Care Physician based on the Member's benefits. The directly accessed Covered Services shall be within the scope of practice of the selected Participating Provider, and the selected Participating Provider shall inform the Member's Primary Care Physician of all Covered Services provided.

- **Emergency:** A medical condition with acute symptoms of severity or severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the Member, or, with respect to a pregnant woman, the health of the Member or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any organ or body part.

- **Emergency Services:** Any Health Care Service provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    - Placing the health of the Member, or, with respect to a pregnant woman, the health of the Member or her unborn child, in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part.

  Transportation and related Emergency Services provided by a licensed ambulance service shall constitute an Emergency Service if the condition is as described in this definition.

- **Employer:** An employer who has an agreement with GIIC for the provision of Third Party Administrative services by GIIC, and access to Health Plan's Network for Employer's health benefits plan(s).

- **Employer-Sponsored Program:** A program established and maintained by an Employer for the purpose of providing its Members with health care benefits which may be subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

- **Gatekeeper Product:** A Health Plan product which requires its Members to: (i) pre-select a Primary Care Physician, and (ii) receive from such Primary Care Physician non-Emergency Covered Services, as may be required in accordance with a Member's applicable Benefit Document.

- **Gold:** Health Plan's benefit plan offered to individuals who are entitled to Medicare Part A and enrolled in Medicare Part B. Health Plan is under an agreement with the Centers for Medicare and Medicaid Services for the provision of these services.

- **Governmental Agency:** All government departments or their respective agents with direct responsibilities to access records for the purpose of quality assurance,

investigation of Complaints or Grievances, enforcement or other activities related to compliance with applicable laws and regulations and shall specifically include the National Committee for Quality Assurance, as applicable.

- **Grievance:** For a non-Gold Member, a Grievance is a request by a Member or Health Care Provider (with the consent of the Member) to have Health Plan or a certified utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a Health Care Service. A Grievance does not include a Complaint. For a Gold Member, a Grievance is a type of complaint expressing dissatisfaction with any aspect of the Health Plan's or Participating Provider's operations, activities or behavior. A Grievance for a Gold Member does not involve payment or coverage disputes.

- **Health Care Provider:** A licensed Hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide Health Care Services under any applicable law including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services.

- **Health Care Services:** Any covered treatment, admission, procedure, medical supplies and equipment, or other services, including behavioral health, prescribed or otherwise provided or proposed to be provided by a Health Care Provider to a Member as deemed Medically Necessary.

- **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** A federal law, as may be amended from time-to-time, which provides, in part, privacy and security standards regulating the use and disclosure of protected health information and administrative simplification standards governing electronic health care transactions.

- **Health Maintenance Organization (HMO):** An organized system that combines the delivery and financing of health care and which provides or arranges for the provision of basic health services to voluntarily enrolled Members for a fixed prepaid fee.

- **Medical Director:** The licensed physician designated by the Health Plan to direct the medical and scientific aspects of the Health Plan and to monitor and oversee the quality and appropriateness of managed health services.

- **Medically Necessary or Medical Necessity means Covered Services rendered by a Health Care Provider that the Health Plan determines are:** (i) appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or

injury; (ii) provided for the diagnosis and the direct care and treatment of the Member's condition, illness, disease or injury; (iii) in accordance with current standards of good medical treatment practiced by the general medical community; (iv) not primarily for the convenience of the Member, or the Member's Health Care Provider; and (v) the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

- **Medical and/or Professional Services:** Those services normally provided by a PCP or SCP in the diagnosis and treatment of Members to the extent that they are Medically Necessary and covered under the terms of a Member's applicable Benefit Document. This includes supplies, injections, diagnostic tests and other services and procedures within the scope of the practitioner's professional competence and normal practice.

- **Medicare (Program):** The programs of health care for the aged and disabled established by Title XVIII of the United States Social Security Act of 1965, as may be amended from time to time.

- **Member or Covered Person:** An individual eligible to receive Covered Services or other benefits under the terms of the applicable Benefit Documents as the Subscriber or an eligible enrolled family dependent.

- **Network:** The Participating Providers who have entered into a written agreement with Health Plan to provide Covered Services to its Members.

- **Non-Covered Services:** Any service not covered under the terms of a Member's Benefit Document.

- **Participating Health Care Provider or Participating Provider:** A physician, medical group, pharmacy, Hospital, Facility or other provider of health services, licensed, certified or otherwise regulated under the laws of the state in which it operates, that has an agreement with Health Plan to provide Covered Services to Members.

- **Payor:** An Employer, ERISA plan sponsor or trust fund insurance carrier or any other entity that accepts fiduciary responsibility for an established program of health benefits to Payor's insureds/Members, or any other entity which has contracted with Health Plan to use Health Plan's Network.

- **Preferred Provider Organization (PPO):** GIIC's Network-based health care program that offers benefits of coverage for certain Covered Services when obtained by a Member, at the Member's option, either in or out-of-Network, subject to the terms and conditions of coverage set forth in the Member's Benefit Document. PPO means Geisinger Quality Options, Inc.

- **Primary Care Physician (PCP):** A Participating Provider physician who, within the scope of the physician's practice: (i) supervises, coordinates, prescribes or otherwise provides Health Care Services to a Member and initiates a Gatekeeper Product Member's Referral for specialty care, as may be required in accordance with a Member's applicable Benefit Document; (ii) maintains continuity of care; and (iii) is so designated by the Health Plan.

- **Referral:** An authorization by a Participating Provider (generally a Primary Care Physician) for a Member to be evaluated and/or treated by another Participating Provider, prior to such services being performed.

- **Solicitation:** Any conduct by a Participating Provider, its agents, employees, assignees or successors, which may be reasonably interpreted as an attempt to persuade Members, Employers, Groups or others to: (i) discontinue their enrollment with Geisinger Health Plan, GIIC, Geisinger Quality Options, Inc. and/or an Employer-Sponsored Program but continue to obtain Health Care Services from the Participating Provider; and/or (ii) encourage Members to participate in any other prepaid health plan or program of third party reimbursement.

- **Specialty Care Provider:** A Participating Provider Specialist who provides the necessary evaluation, treatment and follow-up care for Health Plan Members.

- **Subscriber or Policy Holder:** An individual who meets the requirements for eligibility, who has enrolled in the Health Plan, and for whom payment has actually been received by the Health Plan. A Subscriber is also a Member.

- **Third Party Administrator (TPA):** An organization which performs administrative services such as claims processing, claims payment, membership services and utilization review for employee health benefits plans. GIIC is a TPA for Employers**.**

- **Transportation Services:** Conveyance of Members from one place to another by Provider as covered under the terms of a Member's Benefit Document to include:
    - Emergency Transportation Services initiated through any emergency 911 communications center, subject to the terms set forth in this Agreement; and

- Non-Emergency Transportation Services which shall include Urgent Care and planned Transportation Services when Medically Necessary and authorized by the Health Plan in accordance with the terms set forth in this Agreement.