GEISINGER HEALTH PLAN

Employer administrative handbook

2023

Geisinger

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Section 1: Introduction

About this manual

Welcome! We're excited that your group has enrolled with Geisinger Health Plan (GHP).

This handbook is designed to be a helpful guide as you and your employees get acquainted with your new health plan. The group master policy, group subscription certificate and any applicable amendments or riders are the governing documents between the employer, employees and GHP. This manual may not be construed to modify those documents in any way.

Geisinger Health Plan and its departments are centrally located in Danville, Pa. If you have any questions or concerns, reach out to your account executive or the employer care team. They can point you in the right direction.

Contact us

You can reach us by mail or phone:
(Name of Department)
Geisinger Health Plan
100 N. Academy Ave.
Danville, PA 17822

Geisinger Gold: 800-498-9731
Self-funded plans: 800-504-0443
HMO plans: 800-447-4000
PPO plans: 800-504-0443

Who is Geisinger Health Plan?

Geisinger Health Plan, or GHP, provides quality, affordable healthcare benefits to more than 530,000 members right here in Pennsylvania. We're an essential part of Geisinger, which provides comprehensive healthcare services throughout 43 counties. But just because we're part of the Geisinger family doesn't mean you have to use Geisinger for your care. We also work with hundreds of non-Geisinger providers to better serve members across the country, so you can get the best care close to home.

GHP is composed of various departments that work together to provide quality service to employers and members. The remainder of this section lists those departments and describes their functions.

Departments

Sales

The employer's key contact point for information and assistance. Your health plan representative negotiates contractual issues, facilitates annual renewals, assists you in administering the plan for your employees and coordinates open enrollment.

Financial services

This department processes premium payments.

Billing/finance configuration

This department generates your monthly premium statements and performs a premium reconciliation on all accounts.

Customer care

Our customer care team has expertise in and responsibility for enrollment processing, claims processing and member services, under the direction of a supervisor.

The 800 number

This toll-free number connects members to the customer care team. The 800 number can be found on the back of the member's identification card (ID card). Representatives can answer questions about benefits and procedures and help members who have a problem or concern with the plan.

If an employee comes to you with a question or concern, don't hesitate to direct them to the customer care team. That will free up your time and make sure members get all the information they need. If you have questions about the plan or need to be involved with an employee's situation, contact your health plan sales representative.

Health services

The health services division in the plan is composed of complex care management, disease management, behavioral health (e.g., serious mental illness, addiction), special needs unit (high-risk pediatrics and OB), medical management, health and wellness, quality and medication therapy management (MTM). Because our members' needs vary based on each person's unique situation, we've developed this multidisciplinary model to collaboratively address them.

Medical management supports the member and provider through determination of coverage and discharge planning for hospital, skilled nursing facility, medical equipment, rehabilitation and other designated services requiring prior authorization, including services with a non-participating provider.

Quality and innovation researches and tracks quality-of-care concerns, collaborates with providers to be sure members are receiving recommended screening services, and educates members on the importance of having these services. The appeals department processes all appeals and grievances filed by our members.

GHP uses a **team-based care management model** which takes into consideration the clinical, behavioral health and social needs of its members. The framework drives quality interventions and solutions to impact total patient health. It's built on meeting the individualized needs of the population through an interdisciplinary approach. Through population segmentation, members with complex medical needs are identified and a personalized care plan is formed so they are connected to the right resources, not only limited to technology support (remote patient monitoring).

Furthermore, to impact members with the most complex needs, GHP developed the physician-led home-based model of care, **Geisinger at Home**. This model is composed of physicians, advanced practitioners, nurses and other care team members who provide in-depth care, leading to an overall reduction in emergency room visits and hospital admissions. The drivers for member use of hospitals and ERs are multifactorial and vary based on the unique needs and situations of each member. Experience has shown that some of the chronic conditions that place a person at a higher risk of a hospitalization include conditions like asthma, diabetes, heart failure, chronic obstructive pulmonary disease (COPD) and oncology. The care management team collaborates with the member and the provider to formulate a plan for the member to recognize early signs of impending exacerbation.

The comprehensive services offered through the Geisinger at Home model have led to a 30% reduction in hospital admissions and a 37% reduction in ED visits.

Members identified as being at high risk for an exacerbation that may lead to an avoidable hospitalization or ER visit are referred to a **case manager** (CM), who contacts the members via phone or in person to educate them on services available. Care provision is done via phone calls, video visits, in-person visits, mobile apps and educational pieces. The CM engages with the member's primary care physician. The goal is to involve the member in managing their condition by identifying their needs and goals and tailoring a management plan based on their unique circumstances, which addresses not only their condition(s), but also other holistic issues. Then the CM helps identify participants on the care team (e.g., CHA, pharmacist) who play a role in meeting the member's needs and supporting them.

Experience has shown that when working with members who are in the workforce, there is still a need to evaluate for barriers and **social determinants of health** for members and their families. This strategy is also implemented for other high-risk populations, such as pediatric members who require complex case management.

Outside the traditional care model, GHP identified members with defined needs that require focused care. The **Special Needs Unit** (SNU) was deployed, which is composed of specialty care team members that work in collaboration with specialists to create a care plan. For example, for pediatric members with an asthma diagnosis, a respiratory therapist works directly with the patient, parents, and support system to build a plan that works to identify early exacerbation. In addition, the SNU care team members work with specialists as applicable including nephrology, pulmonology, and cardiology.

GHP has a **high-risk women's health program** that consists of a team of nurse CMs, community health assistants (CHAs), and behavioral health case managers (LSWs/LCSWs/BHCMs). This program assists members with complex women's health issues, including high-risk pregnancy, and follows them throughout their pregnancy as well as postpartum. The CM focuses on the medical needs of the member while working in conjunction with the CHA and BHCM for any social, behavioral health, addiction or community support that may be required. This program also serves as an embedded model in high-volume clinical practices.

Geisinger Health Plan (GHP), using interactive voice response (IVR) and other innovative telemonitoring technology and solutions provided by AMC Health, has demonstrated a 44% reduction in 30-day readmissions compared to a control group, and increased case manager efficiency in monitoring patients transitioning from hospital to home. (2015)

GHP has designed a portfolio of technology to further impact the management of members. One part of this strategy includes a catalog of telemonitoring tools, at no additional cost to members, that are widely used to drive early identification of an exacerbation. Blood pressure and blood glucose are two examples of devices that are utilized for members with pregnancy-related hypertension or gestational diabetes.

- Bluetooth scale
- Bluetooth pulse oximeter
- Bluetooth blood pressure
- Bluetooth thermometer
- Continuous monitor (temperature, pulse, respiration, movement)

These remote devices promptly send an alert to the care team when the member may be showing signs of an exacerbation. These programs are optimized through the case manager's collaboration with specialists, such as an obstetrician, to effectively manage and monitor high-risk members.

Additionally, the Chronic Disease Management Command Center is transforming care coordination for patients with chronic conditions by leveraging digital technology to support communication between members and their care teams. The ConnectedCare365 app uses remote monitoring and patient-reported outcomes to empower patients to better manage chronic conditions. Overall, remote monitoring provides the care team with regular, consistent readings, leading to better health outcomes.

Wellness

Wellness works hand in hand with your employees to provide knowledge, tools and motivation to make sustainable changes aimed at creating a healthy lifestyle.

Questions about these services? Contact our customer care team at the phone number on the back of your insurance card.

GEISINGER HEALTH PLAN

Enrolling in the employer portal

Geisinger

Our online employer portal (EP) allows you to securely access critical information wherever and whenever you need it. This innovative and secure tool is available for employers and provides a direct connection for up-to-date information for everything your group needs.

Account setup: How do I enroll in the EP?

First, the employer who wants access to the EP will need to submit an employer group admin registration form to begin the enrollment process. Once the form is submitted and processed, the admin user will receive a registration email with further instructions on how to log into the employer portal.

Employer group admin users hold the power

After activating their account, the admin user will be responsible for managing their group's access. The admin user can add and remove users by clicking on the "Manage User Access" button. This page will list all current users that you granted access to your company's information.

Broker access

Your brokers now have native access to service your employer group from the broker portal. That means you don't need to grant any other access to your broker through the employer portal. The EP has functionality that will let you change some access/visibility.

Log into the employer portal

- Go to the employer portal login.

Access granted

Once you have access to the EP, you can use an interactive pop-up tool called **Need Help?** to assist you with navigating through our site. Located on the sidebar of your screen, it will guide you through functions like:

- Enrollments/disenrollments
- Change employee demographics/primary care provider (PCP)
- View and request ID cards
- Premium invoice statements/make payments (fully insured groups)
- View invoice statements (Geisinger Funding Alternative groups)
- Financial funding reports for self-funded/ASO groups
- Manage user access

Questions? We can help.

If you're interested in learning more and becoming a registered user, reach out to your GHP sales account executive.

If you need EP support after you register, give us a call at 866-488-6653.

Section 2: Enrollment operations

Joining Geisinger Health Plan

Who can enroll?

Employees must meet the eligibility criteria outlined under the group-specific enrollment information at the front of this handbook before they can enroll in the plan. Employees are eligible for enrollment in the plan on the same date they become eligible for your health insurance benefits, as long as they reside in the service area. Enrollments should be submitted to the plan within 60 days of the effective date.

- The eligibility criteria for your group is relevant to the group master policy between your company and the plan. The plan requires notification of any changes in your policy for benefits determination that affect this policy.
- Service area: We are required by the Pennsylvania Department of Health and Insurance to provide services within a defined region. That way, we can provide high-quality, convenient care to all members. To be eligible for Geisinger Health Plan, members must reside within our service area or meet out-of-area guidelines. Coverage is available for out-of-area dependents, but a First Health Network out-of-area dependent class must be in place. If it isn't, contact your account executive to have the First Health Network out-of-area dependent class set up. Reference Section 9 of this document for more details.

Note: Except for students or dependents covered by court order, any member absent from the service area more than 90 consecutive days will no longer be considered a resident of this plan's service area and coverage will be terminated. Employees and dependents can enroll in an out-of-area First Health Network class if they meet the out-of-area guidelines. Reference Section 9 of this document for more details.

When can they enroll?

Once employees meet the eligibility criteria for your group, they must enroll within the allotted time frames described in this section. Each employee who enrolls in the plan is called a "subscriber." Their family members are called "family dependents." Both subscribers and family dependents are called "members."

- **New hires:** Give your new employees information on the plan before requiring them to make their health insurance decisions. Contact your health plan representative for more information packets.

When a newly hired employee chooses the plan, coverage becomes effective the day the employee meets the eligibility criteria discussed earlier. The first day of the new hire waiting period begins on the date of hire. They must submit their applications within 60 days of the effective date.

- **Open enrollment:** Each year you will renew your policy with the plan on the renewal date given under the group-specific information at the front of this handbook. Before the renewal date, your health plan representative will coordinate an open enrollment period with you. During open enrollment, employees who did not previously choose the plan can do so, if they've already met the eligibility criteria. They must submit their application during the open enrollment period, and their coverage will become effective on the renewal date.
- **Change of status:** An employee can enroll with the plan outside new hire and open enrollment periods only if a qualifying event occurs causing the employee to lose coverage under another group health benefits plan. Qualifying events also include marriage, birth, or adoption. For confirmation on whether an event qualifies as a change of status, contact your health plan representative.

The employee must submit an application within 60 days of the change of status event. A signed statement must accompany the application. The statement must outline the cause of the change and the date it occurred. The effective date will be the day after loss of coverage to prevent a lapse in coverage, or in the case of another qualifying event, the date of the event (e.g., birth of a child).

- **Return from leave/recall from layoff:** An employee returning from layoff or leave is eligible to enroll if they were covered by the plan before their departure and they meet eligibility criteria. When the new application is submitted, write "recalled from layoff" across the top. The effective date will be the day they return to work.

Family dependent coverage

Eligibility

To be eligible to enroll as a family dependent, an individual must be either:

- The spouse of a subscriber under an existing marriage legally recognized under the laws of the Commonwealth of Pennsylvania
- A subscriber's child (married or unmarried) who is not yet 26 years old

Eligible children of the subscriber include:

- Natural children
- Stepchildren

Eligible child of the subscriber and/or the subscriber's spouse who is an enrolled member under this plan include:

- Children legally placed for adoption
- Children awarded coverage pursuant to an order of court
- Legally adopted children
- Foster children who are placed by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction

Spouses

- A legal spouse (recognized under the laws of Pennsylvania) is an eligible dependent under the plan.
- Domestic partners may be eligible for coverage if the employer has requested this rider at their renewal, the employee signs a notarized affidavit certifying that the requirements of a domestic partner, as defined in the rider, have been fulfilled and the partnership was entered into after Jan. 1, 2005.

Children

- **Eligibility:** A dependent child is a natural child, adopted child or any other child of whom the subscriber or the subscriber's spouse is the custodial parent, legal guardian or legal custodian. A dependent child must be younger than 26. Otherwise, a dependent child is eligible for coverage if they meet the age criteria outlined under the group-specific information at the front of this handbook, are unmarried and are living within the service area.
- **A dependent child** who resides outside the service area is eligible for coverage. Be aware, however, that dependent children outside the service area may only be covered for emergency services depending on the plan. Contact your account executive for plan details.
- **Disabled children:** An unmarried dependent child who exceeds the maximum dependent age but is both incapable of self-sustaining employment by reason of mental or physical disability which meets the criteria under §88.41of Title 31, PA Code and chiefly dependent upon the subscriber for support and maintenance, may enroll or continue to be enrolled under family coverage for the duration of such disability and dependence. A dependent certification form will be forwarded to the plan subscriber for completion by the dependent's physician. If the form is not returned, the dependent will not be enrolled, or eligibility will not be continued. Geisinger Health Plan will periodically require documentary proof of such disability and dependency, but no more frequently than every six months for the first two years, and annually thereafter.
- **Grandchildren:** A child born to a family dependent is automatically covered under this certificate for 31 days from the date of birth. To continue coverage of such child, the newborn child must a) be a child who is natural born, adopted or legally placed for adoption, or under the legal guardianship or legal custodianship of the subscriber or the subscriber's eligible dependent spouse; or b) the newborn's parent(s), legal guardian, or legal custodian may convert to a separate individual policy, offering similar benefits, on behalf of the newborn. To have the newborn covered beyond the 31 days under the existing certificate, the subscriber must submit an enrollment request accompanied by the court order for addition to family coverage to the plan within 60 days of the date of birth and pay the required premium.
- **Court-ordered coverage:** A parent who has been court-ordered to provide health coverage for a child for whom they do not have custody may cover the child on their policy. In this circumstance the child does not have to reside in the service area to qualify, but may still be required to use the established provider network and may only be covered for emergency services out of the area depending on the plan. Contact your account executive for plan details.

Note: The subscriber who has been court-ordered to carry the insurance will provide the primary insurance in a coordination of benefits situation. A court order overrides all other methods of determination (e.g., birthday rule).

Group subscriber application

Once employees and any dependents are eligible to enroll for coverage, employees must complete the group subscriber application. They must fill out the form completely, accurately, and legibly. Enrollment may be delayed if the application is not completed properly. The following information will help you review the form.

- **For office use only:** The first section (group number, subgroup, class number, effective date) should be completed by your office before forwarding the application to the plan. Your group number can be found under the group specific information at the front of this handbook. You must indicate the effective date — the date coverage will begin. You do not designate an insurance ID number in this section.
- **General information:** If a subscriber has an HMO plan, they must indicate the name, location, and code number for the primary care physician they will be using. The code numbers are found in the provider list or on our website at geisingerhealthplan.com/providersearch. A primary care physician must be indicated for each dependent, even if the entire family will be using the same primary care physician (each family member may choose a different primary care physician). All other information should be completed, including date of employment.

- **Geisinger medical record number (if any):** If the subscriber has been treated in a Geisinger facility in the past, a Geisinger medical record number was assigned. If they have such a number, it should be indicated.
- **Other insurance information:** If the subscriber and/or their spouse will have any other type of health insurance it should be indicated here. This information will allow the plan to coordinate benefits with other insurers when appropriate.
- **Dependent information:** Dependents must meet the eligibility criteria outlined previously in this section. The appropriate relationship should be checked for each dependent.

The application must be signed and dated within the time lines allowed by the qualifying event, (e.g., the defined open enrollment period, within 60 days of the date of marriage) by the subscriber and the benefits administrator for your company. When it's complete, forward it to the plan as soon as possible to allow time for the member ID cards and information to be sent to the subscriber. Your health plan representative can provide you with the mailing information for returning applications.

Links:
Small group subscriber application (1–50 group size)
Large group subscriber application (51+ group size)

Changing information

The subscriber application change form

Any changes to subscriber or dependent information or eligibility must be communicated to the plan using a subscriber application change form. It is the employee's responsibility to submit a subscriber application change form through your office for the following:

- Adding dependents
- Name change
- Change of address or telephone number
- Change of primary care physician (member's responsibility to transfer medical records)
- Change in marital status
- Dependents losing eligibility
- Disenrollment (terminating coverage)
- Class changes (if qualifying event)

The subscriber application change form must be filled out completely with the appropriate information. The effective date of change must also be indicated in the upper right-hand corner. The form must be signed and dated within the timelines allowed by the qualifying event (e.g., date of birth, marriage) by the subscriber and the benefits administrator for your company.

If the subscriber has left your employment, you do not need their signature on the subscriber application change form to terminate their coverage.

When it's complete, forward it to the plan. Do this as soon as possible to allow time for the member ID cards and information to be sent to the subscriber. Your health plan representative can provide you with the mailing information for returning applications.

Adding dependents

When can dependents be added?

Open enrollment

A subscriber can add eligible dependents to their coverage during the annual open enrollment period. They must submit a subscriber application change form during open enrollment and their dependent's coverage will become effective on the renewal date.

Life changes

Dependents can be added at other times throughout the year as they become eligible for the following reasons:

- **Marriage:** The subscriber must submit a subscriber application change form within 60 days of the marriage to add the spouse and any stepchildren. Coverage will be effective on the date of marriage.
- **Birth:** When a baby is born to a plan subscriber, the newborn is automatically covered for only 31 days. Within the first 60 days, the subscriber must submit a subscriber application change form to permanently add the child. Coverage will be effective on the date of birth. The newborn child must be a child who is natural born, adopted or legally placed for adoption, or under the legal guardianship or legal custodianship of the subscriber or the subscriber's eligible dependent spouse.
- **Adoption:** When a child is adopted, the subscriber must submit a subscriber application change form within 60 days of the date of placement of the new dependent. Coverage will be effective the date of placement. An intent to adopt document, which has been time-stamped by the Prothonotary of the Court upon filing with the court, will allow the child's coverage to begin and must be replaced by official adoption papers when complete.

Change of status

A dependent can be added outside open enrollment and life changes only if a qualifying event occurs causing the dependent to lose coverage under another group health benefits plan or if they just became eligible (e.g., returning from active military duty). The subscriber must submit a subscriber application change form within 60 days of the change of status event. Documentary proof of loss of coverage must accompany the subscriber application change form.

Retroactive adjustments

Retroactive enrollment

Retroactive enrollment will be allowed if applications are received by the plan within 60 days of the date the employee first becomes eligible. Retroactive enrollment beyond 60 days is not allowed.

Retroactive terminations will be effective the date requested by the group if it is not more than 90 days before the plan receiving the termination notice.

Evidence of insurability

HIPAA regulations prohibit the use of evidence of insurability for employer groups. Therefore, employees and/or dependents may only enroll during open enrollment periods, new hire eligibility periods, or due to a life-change qualifying event.

Note: Geisinger Health Plan offers the ability to perform enrollment functions through our online employer portal. To learn more, visit section 1 of the employer admin handbook or contact your Geisinger Health Plan account executive.

Section 3: Using Geisinger Health Plan

Accessing services

All basic benefit limitations and exclusions are outlined in the group subscription certificate. Additional benefit riders (if applicable) that apply to your group coverage are attached.

Each employee who joins the plan may call to request a copy of the group subscription certificate and riders (if applicable) along with a schedule of benefits that outlines the dependent age limitations, copay, coinsurance, deductibles, coinsurance maximum and maximum out-of-pocket costs that apply when a member receives covered services. A member's benefit coverage begins on the effective date.

Primary care physician

The key to using the plan is a primary care physician (PCP). When an employee enrolls in the plan, they choose a PCP for themselves and each family dependent. The PCP coordinates medical care needed by the member. If a member ever needs medical direction, they should first contact their PCP. The telephone number for their PCP can be accessed 24 hours a day. Since the plan covers many types of preventive care, members don't need to wait until they get sick to make their first appointment with their PCP. They can see the doctor and get a physical checkup for just the cost of the office visit copay.

Copays are due at the time of the service. In fact, it's better for the member to make their first appointment when they are well. A "new patient" appointment takes longer since the doctor will need to fully examine the member and record information in their medical history. This establishes the physician/ patient relationship. It is important to remember that to be covered by the plan, all medical services (except for emergencies discussed in Section 3.7 of the group subscription certificate) must be provided by or authorized in advance by the member's PCP.

If necessary, a member can change their PCP by completing a subscriber application change form or by contacting our customer care team to inform them of their new selection. The change of a PCP will become effective the first of the month after the plan receives the notification, subject to PCP availability.

Tel-A-Nurse

Tel-A-Nurse is a way to offer your employees immediate access to healthcare information, toll-free, 24 hours a day, 365 days a year from anywhere in the continental United States and Canada.

A staff of specially trained nurses is always available to provide information, education and support in urgent and routine situations. If members are not sure what to do in a situation and think they need medical care, they can call Tel-A-Nurse for advice at 877-543-5061 (this number is on the front of the member ID card).

Another service provided by Tel-A-Nurse is a free audio library, which provides members with information on more than 200 recorded health-related topics.

Pharmacy services

If your group has prescription drug coverage as part of your benefit plan, the following criteria must be followed:

- The prescription must be filled at a participating pharmacy. Find participating pharmacies.
- Using the retail participating pharmacy network, a member can receive up to a 34-day supply for one copay. They can receive a 35- to 68-day supply for two copays. They can also receive a discounted copay for a 69- to 102-day supply, which matches the mail-order benefit. Quantity limits and prior authorizations may apply in some instances. Certain medications may need to be obtained from a specialty pharmacy.
- Drug coverage revolves around the use of the formulary, which is a continually updated list of prescription medications covered by GHP. The formulary is available on the GHP website or by contacting the pharmacy customer care team at 800-988-4861. Providers may submit requests for exceptions to the formulary on a case-by-case basis to the pharmacy customer care team.
- We encourage members to refer to the formulary with their provider when a medication is about to be prescribed. Members are responsible for obtaining any necessary prior authorizations for restricted or non-formulary medications before purchase if they want the medication to be covered by GHP. If a non-formulary or restricted medication is purchased without this authorization, the member will be responsible for the full cost of the medication and will not be reimbursed. If the member is denied coverage via the prior authorization process, they may still choose to purchase the medication on their own.

Note: Concerns about a contracted pharmacy? Report them to 800-988-4861 or write to:

Geisinger Health Plan
Pharmacy Department
100 N. Academy Ave.
M.C. 24-10
Danville, PA 17822

Emergencies

Emergency services

Emergency services are services rendered for the immediate treatment of an emergency.

Emergency services do not require pre-certification or prior authorization and coverage provided during the period of an emergency shall include evaluation, testing and stabilization of the member's condition, if necessary. Use of emergency transport and related services provided by a licensed ambulance service will be covered as an emergency subject to limitations set forth in the subscription certificate.

Emergency service protocol

When an emergency happens, the member should:

- Call 911 or an emergency information center in the area, or safely proceed immediately to the nearest emergency services healthcare provider.
- If the emergency requires the member to be hospitalized, it is the emergency services healthcare provider's responsibility to notify the plan within 48 hours, or on the next business day, whichever is later, of services rendered.
- If the emergency does not require the member be admitted to the hospital, the claim for reimbursement for the services shall serve as notice to the plan of the emergency services provided.
- Medically necessary follow-up services obtained from a participating provider after the initial response to an emergency are not emergency services and must be authorized in advance by the PCP, obstetrical or gynecological participating healthcare provider (for services within their scope of care), or a designated health benefit program provider.

Non-participating provider

Emergency services provided by non-participating providers will be covered only until the plan determines the member's condition has stabilized and the member's care can be safely transferred to a participating provider.

Copays or coinsurance

Emergency services are subject to the emergency room copay or coinsurance amount specified on the schedule of benefits. The copay or coinsurance will be waived if emergency services rendered in the emergency department of an acute care hospital result in the immediate admission of the member to the hospital as an inpatient and the requirements for emergency services are satisfied.

The PCP copay or coinsurance shall apply in lieu of the emergency room copay or coinsurance when a member has been referred to an emergency department by their PCP if the covered services would have been provided in the PCP's office but the physician's office could not provide access during normal working hours. A specialist office visit copay or coinsurance shall apply in lieu of emergency room copay when a member receives covered services in a designated urgent care facility.

Section 4: Claims procedures

Medical bills

Bills for services

In certain circumstances, services from a non-participating provider or a clerical error on the part of a provider, members may be billed for covered services. In addition, providers may require members to make copays or coinsurance amounts for covered services after the maximum annual copay or coinsurance maximum has been reached. Members can request payment or seek reimbursement in such circumstances.

Covered services

Bills received by a subscriber or member for covered services must be submitted to the plan as soon as possible. Payment of any such bills is the responsibility of the subscriber if it is not received by the plan within 180 days of the date of service, unless it is not reasonably possible. No bill will be considered for payment if it is received by the plan more than one year from the date of service, unless the delay was caused by absence of legal capacity on the part of the subscriber or member.

Reimbursement

If a member is required to make payment other than the required copay, deductible or coinsurance at the time the covered service is rendered, the plan will reimburse the member by check. The member must submit a completed claim form to the plan with a paid receipt as soon as possible but no later than 180 days from the date of service. Reimbursement will be made only for covered services received in accordance with the provisions of the certificate.

Click here to access our Pharmacy Reimbursement Claim Form.

Hospital statements

Pennsylvania Act 89 is a state law which requires hospitals to provide patients with a detailed summary of charges they incurred for services. Members will receive such statements, even when the plan covers the entire cost of the treatment. Members should review these hospital statements for accuracy and verify that they show no balance due. If a member has questions about hospital statements, they should contact the customer care team.

Refer your employees to the group subscription certificate or have them call the customer care team for more information on coordination of benefits.

Coordination of Benefits

How Coordination of Benefits works

The plan coordinates benefits with other types of insurance to make sure that members get the most from their benefits and prevent duplicate payments for services. Coordination of Benefits, or COB, occurs between the plan and other healthcare insurers and worker's compensation for adjudication.

When an employee completes the plan application, they should indicate any other health insurance they or their dependents are covered under. Periodically, the plan will survey members on other insurance coverage. This helps the plan control the cost of coverage by determining which insurance is the primary payer for claims. For employees covered by the plan through your group and by another insurance company through their spouse's employer, the plan is the primary insurance for that employee and the spouse's insurance is their secondary insurance. In cases where the plan is secondary, it is important to remember that the member must still use the provider network and have their care coordinated by their PCP in order for the plan to pay the balance on claims.

The birthday rule

When a dependent child is covered under more than one health insurance (one for each parent) the plan uses the "birthday rule" to determine which is primary. This rule applies only to dependent children covered under more than one health insurance program.

According to the birthday rule, the insurance carried by the parent whose birthday falls first in the year is primary. For example, if the mother's birthday is in February and the father's birthday is in July, the mother's insurance would be primary for the child since her birthday is earlier. The age of the parent is not an issue. If both parents have the same birthday, the plan that has been in effect longer is primary. In cases of separation or divorce, the birthday rule does not apply. The primary insurer may be determined by court order, custody or living arrangements. Keep in mind that services must be provided by the plan's established network for the plan to pay any claims.

Section 5: Ending coverage

Review of eligibility

As mentioned earlier in this handbook, the eligibility criteria established for your group is a key element of the group master policy between your company and the plan. When employees or their dependents no longer meet the eligibility criteria, their policies must be terminated from group coverage.

Termination may occur as the result of reduction in work hours, layoff, termination of employment, relocation outside the service area, divorce, death, change in dependent status (i.e., age), retirement or other reasons. It is the responsibility of the subscriber (the employee) to notify you — and for you to notify the plan in a timely manner — of changes in marital or dependent status that affect eligibility for coverage.

When a member's coverage must end with your group, they may be eligible for continuation of coverage under COBRA, which stands for the Consolidated Omnibus Budget Reconciliation Act. Members who are eligible to continue group coverage under the provisions of COBRA (for COBRA-eligible groups) are eligible for coverage on Geisinger Marketplace when their COBRA eligibility for group coverage expires. You must submit a subscriber application change form to terminate coverage for members who are no longer eligible. The effective date of termination will be the date coverage should end.

COBRA

COBRA is a federal law providing group coverage to members who cease to be eligible under the terms and conditions of a group plan due to a qualifying event, as defined by COBRA, and who have properly elected to receive COBRA coverage.

If members cease to be eligible for enrollment under this plan because of a qualifying event and have properly elected to receive COBRA coverage, they may continue group coverage for up to the maximum period of time set forth under COBRA. Upon timely notice, the plan will make continuation coverage available. However, the employer retains all responsibility for providing the member with required notices and information relating to COBRA coverage rights, as required by law. The plan has no obligation to notify members of continuation coverage rights under COBRA; the plan is not the COBRA administrator.

Premiums for COBRA coverage will be remitted to the plan by the group within the time frames required under this plan or as set forth in the group master policy on behalf of the member(s).

Mini-COBRA

Mini-COBRA is a state law enacted for 2009 which provides group coverage for groups of 2 to 19 employees to subscribers and eligible dependents (eligible dependent means spouse or dependent child of the Subscriber) who cease to be eligible under the terms and conditions of a group plan due to a qualifying event, as defined by mini-COBRA, and who have properly elected to receive mini-COBRA coverage. It provides COBRA continuation coverage for subscribers and eligible dependents.

Refer your employees to the group subscription certificate or have them call the customer care team for more information on COBRA or mini-COBRA.

COBRA or mini-COBRA election protocol

When an employee or dependent becomes ineligible for group coverage:

- If the employee or eligible dependent chooses continuation of coverage through COBRA or Mini- COBRA during the allotted time period, submit a group subscriber application indicating the effective date of COBRA or Mini-COBRA coverage, which should be the day after the termination date indicated above. Across the top of the application, print in large letters “COBRA” and the eligibility period (i.e., 18 months for COBRA and nine months for Mini-COBRA). This will allow COBRA or Mini-COBRA participants to be grouped separately on your monthly statement.
- When the member’s COBRA or Mini-COBRA period expires, submit a subscriber application change form indicating “Expiration of COBRA eligibility period,” and the effective date when COBRA or Mini- COBRA coverage will end.
- The plan will automatically terminate COBRA or Mini-COBRA coverage on the date eligibility expires unless otherwise notified of prior termination or extension of eligibility due to an additional qualifying event.

Medicare

Most people become eligible for Medicare at age 65 (in some situations, eligibility for Medicare occurs sooner). When people become eligible for Medicare, they enroll in Medicare Part A, which is hospital insurance. They will have the option of also enrolling in Medicare Part B, which is medical insurance. There is a premium required for Part B.

If a person is working beyond the age of 65, they may not have to take Part B until they retire (they should check with their employer benefits administrator to confirm). They should contact Social Security three months before their 65th birthday to get more information about Medicare. If an employee with the plan works beyond the age of 65 and continues to meet eligibility requirements for your group, the plan will be their primary insurance.

When they retire, the member may enroll in Geisinger Gold, a Medicare Advantage program for Medicare-eligible people. Enrollment may be as an individual, or as a member of a group should the employer offer group coverage to retirees. For a supply of Geisinger Gold information packets, contact your GHP representative. To be eligible for Geisinger Gold, the employee must be enrolled in Medicare Part A and Part B (original Medicare) and reside in our Geisinger Gold service area. Direct any questions to your GHP representative.

If you do not currently offer a program for pre-65 and post-65 retirees, but are considering adding this benefit, your GHP representative can give you rates and plan options.

Termination by Geisinger Health Plan

When a subscriber and a group enroll in the plan, they agree to abide by the provisions by the plan outlined in the group subscription certificate. The plan reserves the right to terminate coverage for failure to abide by those provisions. Refer to your group subscription certificate for complete details on termination by the plan.

Termination by group

If a large or small group decides to terminate their coverage, they must submit a request for termination no fewer than 15 days before the desired contract renewal date. However, if a large group employer wishes to terminate coverage any time during the contract term, a request must be submitted 90 days before the desired coverage termination effective date. For a small group employer, a termination request must be submitted no fewer than 30 days before the desired coverage termination effective date. Refer to your group subscription certificate for complete details on termination by a group.

Section 6: The premium statement

Payment of premiums

Premiums are due by the first of each calendar month (premium due date) for coverage during that month. Unless a termination notice is received from the group, a minimum of 30 days "grace period" will be given for payment of premiums. If notice of termination has been given, there is no grace period; the group will be in default for failure to pay premiums when due. If the group doesn't make payment during the grace period, a 15-day written notification will be sent to the group and all employees. If payment is not received in full, coverage will be canceled automatically without the need for any further action or notice from the plan. The group will be responsible for premiums due, including payments for coverage during and after the grace period, if applicable. Termination of coverage does not terminate or discharge the group's obligation to the plan up to the date of termination.

Premium adjustments

- Enrollment: If a member enrolls on or before the 15th day of a month, the group agrees to pay, on or before the next premium due date, the additional premium for the month in which the member enrolled. If a member enrolls after the 15th day of a month, no premium is due for this member for the month they enrolled.
- Termination: If a member terminates coverage on or before the 14th day of a month, to the extent the group has paid their premium for that month, the plan will extend credit to the group for that member's monthly premium. If the member's coverage terminates after the 14th day of a month, no premium adjustment is required.

- Enrollment reconciliation: The group is responsible for reconciling enrollment deficiencies against the monthly billing statement within 30 days from receipt of their bill using the billing reconciliation worksheet. If payment differs from the amount indicated on the billing statement due to reconciliation, the group must submit the billing reconciliation worksheet to justify the altered payment. The group must submit the worksheet via email or fax; do not include this worksheet with your payment. The plan is not required to credit or reimburse premiums paid or portions there of which is evidenced by the billing reconciliation worksheet received after the reconciliation period. If the group fails to reconcile enrollment deficiencies, premium payments on the billing statement will be expected and failure to make such payments may result in termination of the group contract.

Note: The reconciliation process for billing will not result in anyone being added, removed or changed. The group must still follow the appropriate enrollment process to submit these changes, as outlined in Section 2 of this document.

- Payment of premium reconciliation: The group is responsible to complete the reconciliation worksheet that is included with their premium statement to indicate any difference between the amount remitted and amount billed. This worksheet will be used by billing to identify any enrollment and billing discrepancies. The group must submit the worksheet via email or fax; do not include this worksheet with your payment. Be sure to include your group number on this worksheet. If you have an enrollment update to make, it cannot be made through the reconciliation worksheet. Enrollment updates should be made through the 834 file or through the employer portal. Alternatively, you could submit an application for new enrollment or a change form for a termination, addition or removal of dependent(s). The time frame to submit for a new enrollment is no more than 60 days and for a termination no more than 90 days.

Note: All adjustments are to be supported with the required application or change form. If form(s) have not yet been submitted, mail immediately to:

Geisinger Health Plan
ATTN: Enrollment
100 N. Academy Ave.
M.C. 25-80
Danville, PA 17822

Section 7: Appeal procedure

Appeal requests

Members may appeal an adverse benefit determination made by GHP. Requests for an appeal must be submitted in writing and received by the plan within 180 days following member's receipt of the notification of an adverse benefit determination. Written request for appeal should be mailed to:

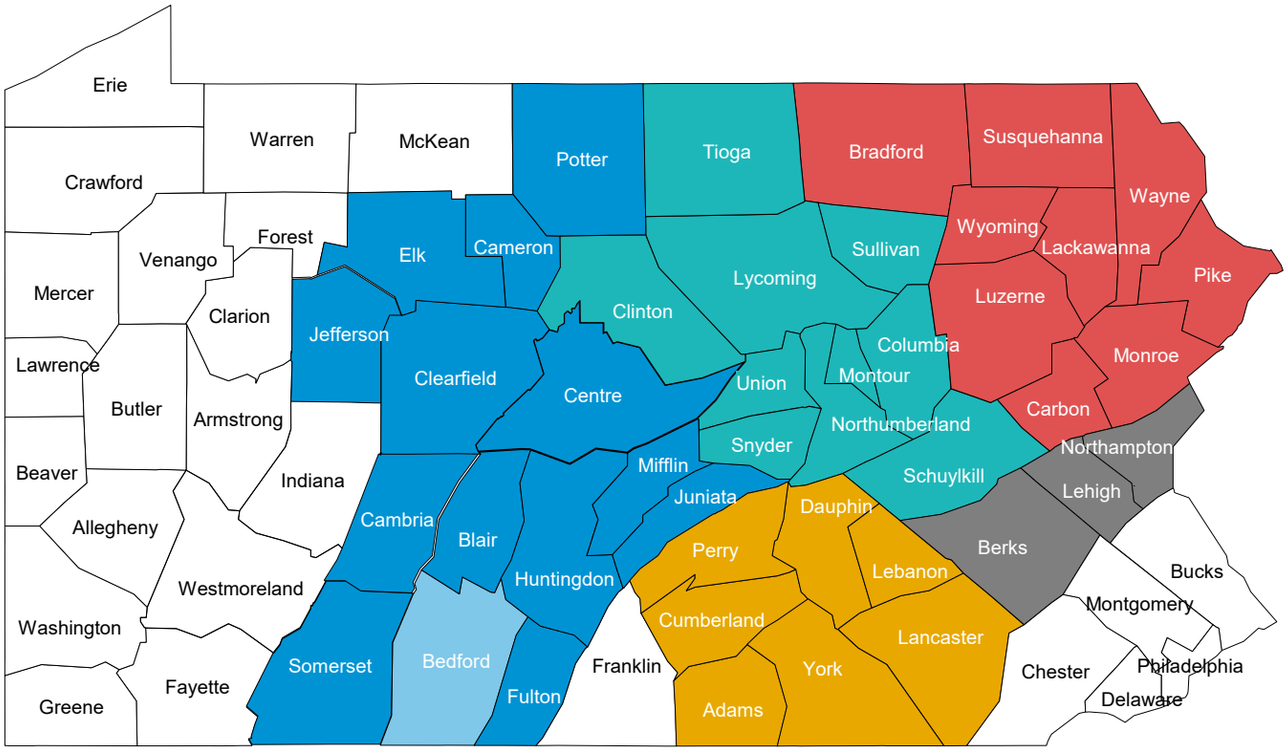
Geisinger Health Plan
Appeal Department
100 N. Academy Ave.
M.C. 32-20
Danville, PA 17822

Refer your employees to the group subscription certificate or have them call the customer care team for direction on complaints and/or appeals.

In certain situations, the requesting provider can request review through the designated provider appeal process, which is managed through the medical management department.

Section 8: Plan service area

The following Pennsylvania counties are included in our service area for large groups (51+ employees):

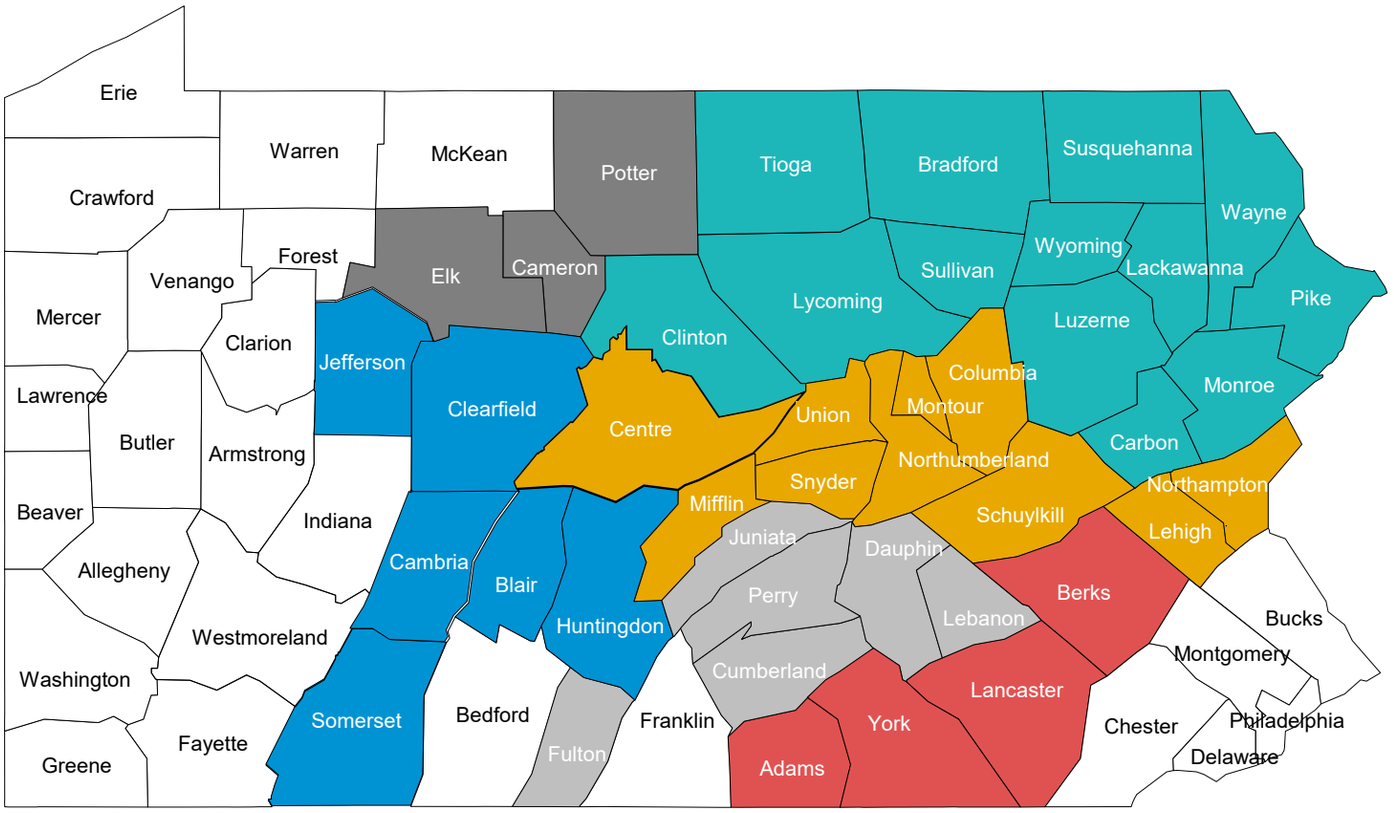


East region | North region | South region | Southeast region | West region

In Bedford county, only areas within the listed zip codes identified below are included:

15521	16633	16655	16664	16670	16678	16695
15554	16650	16659	16667	16672	16679	

The following Pennsylvania counties are included in our service area for ACA-compliant small group plans (1 to 50 employees):



Region 2	Region 3	Region 5	Region 6	Region 7	Region 9
Cameron	Bradford	Blair	Centre*†	Adams	Cumberland*
Elk	Carbon*†	Cambria	Columbia*†	Berks	Dauphin*
Potter	Clinton*	Clearfield	Lehigh*†	Lancaster	Fulton
	Lackawanna*†	Huntingdon	Mifflin*†	York	Juniata*
	Luzerne*†	Jefferson	Montour*†		Lebanon
	Lycoming*	Somerset	Northampton*†		Perry*
	Monroe*†		Northumberland*†		
	Pike		Schuylkill*†		
	Sullivan		Snyder*†		
	Susquehanna*		Union*†		
	Tioga				
	Wayne*†				
	Wyoming*				

* PPO Extra plans are only available in these specific counties within our service area.
† Premier HMO and Choices plans are available in these specific counties within our service area.

Section 9: First Health out-of-area employee/dependent class

The First Health Network provides out-of-area coverage to employees and/or dependents who live outside of the Geisinger Health Plan service area* and who do not have access to Geisinger Health Plan preferred providers.

Eligible employees and dependent(s) living outside the Geisinger Health Plan service area may use the First Health provider network for out-of-area services. First Health gives you a network of more than 5,000 hospitals, over 90,000 ancillary facilities and over 550,000 professional providers at more than 1 million healthcare service locations.

First Health is available to eligible members with PPO plans and dependents with HMO plans only. A First Health Network authorization form is required to enroll in a First Health out-of-area employee/dependent class.

Click here to access our First Health Network Authorization Form.

Here's how to find First Health providers online:

1. Go to myfirsthealth.com and click the "Start Now" button.
2. Pick a provider type.
3. Choose to search by zip code or state (to include more search options, click "Show more options." You can search by provider name, specialty or condition).
4. Click the "Search now" button.

Or you can call our customer care team at 800-447-4000 to verify provider participation.

Guidelines for eligible out-of-area employees:

- Employees residing within 20 miles or 30 minutes (as determined by GHP) of a primary care provider (PCP) that is within the service area will be considered eligible as in service area.
- Coverage is available for out-of-area dependents.
- Out-of-service-area coverage is available for groups with five or more enrolled subscribers. The number of out-of-area subscribers cannot exceed more than 40% of the total enrolled subscribers.
- Out-of-area classes requested off-cycle would require underwriting approval. Failure to meet these requirements and/or to provide proof may result in termination of the out-of-area division or the entire group.

**Your account executive will help set up a First Health Network class if you have employees and/or dependents who live outside our service area.*

Geisinger

Geisinger Health Plan may refer collectively to healthcare coverage offered by Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated healthcare delivery and coverage organization.

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