Things you should know about your health plan

2024

Geisinger

Introduction

Valuable member information

As a Geisinger Health Plan (GHP) member*, you deserve quality healthcare coverage and have a right to know how we work.

Most of the information in this book covers a variety of policies and procedures for Geisinger Health Plan HMO and PPO members. If you have any questions about the information in this or any other GHP publication, call the customer service team at the number on the back of your member ID card.

Contact us

Call the customer care team

Monday – Friday, 7 a.m. – 7 p.m.
Saturday, 8 a.m. – 2 p.m.

HMO, PPO with referral members:
800-447-4000 or 570-271-8760

PPO with no referral members:
800-504-0443 or 570-271-8770

Marketplace members:
866-379-4489

Visit us on the web: geisingerhealthplan.com

Contents

3 GHP information
Medical management
Quality improvement
Technology assessment
4 Primary care provider information
5 How to obtain services
Is it an emergency?
6 Coordinating care
7 Special communication services
Health and case management
8 Women's Health Act
Member rights
9 Member responsibilities
Prescription drug coverage
10 Specialty vendor drug program
Formulary
GHP privacy notice
Complaint and grievance procedure for HMO members
17 Appeal procedures for PPO members

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Planis part of Geisinger, an integrated health care delivery and coverage organization.his managed care plan may not cover all your healthcare expenses. Read your Subscription Certificate and riders carefully to determine which healthcare services are covered. For more information, call the customer care team.

**For Geisinger Health Plan members not enrolled through an employer, note that the term "member" is used in this document to describe you and your covered dependents. Your benefit documents use the term "covered persons."*

Geisinger Health Plan information

Medical management

GHP informs providers that medical management decisions are based upon appropriateness of care and that over- or under-utilization of care and services can have negative effects on quality.

Decision-making is based only on appropriateness of care, service and existence of coverage. GHP does not specifically reward practitioners or others conducting utilization review for issuing approvals or denials of coverage or services. GHP does not offer incentives for medical management decision makers that encourage decisions that might result in under-utilization.

Quality improvement

Our quality improvement (QI) program includes information on clinical guidelines, health management programs, certain cancer screenings and other initiatives intended to improve service to our members. As a member, you have the right to give us input on this program. Quality and accreditation staff work directly through personal and automated telephone calls and mailings to reinforce the importance of preventive measures and suggested screenings.

If you would like information or have a suggestion regarding our QI program, call the quality and accreditation department at 866-847-1216.

Technology assessment

To provide you with the best care, GHP makes every effort to stay up to date on the latest and most effective treatment options and preventive health measures.

This process, known as "technology assessment or evaluation," includes reviewing medical data; maintaining regulatory status; assessing published, peer-reviewed, controlled clinical trial outcomes and results; and evaluating scientific evidence to determine the status and effectiveness of equipment, procedures and treatments.

GHP's technology assessment committee is made up of physicians and members who volunteer their participation. After thorough evaluation, the technology assessment committee provides recommendations to GHP. GHP then determines if the technology or procedure should be a covered benefit.

Primary care provider information*

Your primary care provider (PCP) can be an important person in your life. They're usually the first person you see when you need medical attention and the person who coordinates all your medical care, from specialist referrals to medications. Your PCP should be your good-health partner, working with you to fulfill your healthcare needs. Develop a relationship with your PCP so you'll feel comfortable discussing any type of health problem you have.

How to choose your PCP

If your plan requires you to select a PCP, choose one for yourself and each covered family member in a town near you. To find a specific PCP, check the index in the back of the provider directory or online at geisingerhealthplan.com. For more information about a PCP, including their educational background, affiliations at participating hospitals, availability of weekend or evening office hours and languages spoken, log onto geisingerhealthplan.com and click on "Find a Doctor, Drug or Location" then "Search our network" in the blue box. To request a provider directory, call the number on the back of your ID card.

On your application form, list your chosen PCP's name, provider number and the town where the practice is located. (Include the complete address if the provider has multiple practice sites in the town you choose.)

Changing your PCP

There are three ways you can change your PCP: Visit geisingerhealthplan.com, contact the customer service team at the number on your member ID card or complete a Subscriber Application Change Form from your employer. We recommend you limit these changes to no more than twice a year to develop an ongoing relationship with your PCP. If they retire or decide to discontinue participation with GHP, we will notify you and help arrange care with another PCP. If you're seeing a specialist for an ongoing health condition, it may be possible to have them serve as your PCP.

Contacting your PCP

You can find information on your PCP at geisingerhealthplan.com. Remember, if you receive services from a primary care site other than the one we have designated for you, these will not be covered. Your PCP or a representative from your primary care site is required to be available 24/7. If you need non-emergency care during non-business hours, call your primary care site for further instruction.

**Geisinger Health Plan with No Referral members are not required to choose a PCP.*

Checking credentials

As a GHP member, you deserve quality care — and our standards help make sure participating providers are skilled and knowledgeable.

Physicians who want to join our network must first undergo a review to verify hospital affiliation, board certification, training, licensure and professional liability insurance coverage.

We recredential providers at least every three years. These reviews take many factors into account, including member satisfaction surveys, performance data and on-site visits.

Find information about participating providers in the provider search section of our website. Profiles include languages spoken, training information and board certification. For more details about providers or the credentialing process, call the customer service team.

How to obtain services

Behavioral health services

To use your behavioral health benefits, which include mental health and substance abuse services, call 888-839-7972. Our staff will help you locate a participating provider who's right for you. We have detailed information about participating providers and can help you find one who meets your specific needs. For your routine behavioral health services, you can go directly to a participating provider. However, for services such as inpatient treatment, partial hospitalization or intensive outpatient therapy, your mental health provider must contact Geisinger Health Plan first for pre-authorization. A referral from your PCP is not required, though we encourage you to involve your PCP in your treatment.

Is it an emergency?

In an emergency, call 911 or an emergency information center in your area, or go immediately to the nearest hospital emergency room. Fortunately, emergencies are rare. Far more common are situations which aren't emergencies, but require medical attention right away. As a GHP member, you have a variety of services available anytime, day or night, to help.

If your PCP or specialist determines that you require hospitalization, they will precertify your admission through the GHP utilization management department.

Contact your PCP

Medical direction is available 24/7. Simply call your PCP and do the following:

- Identify yourself as a GHP member.
- Provide relevant information: how urgent you think the problem is, specific information about health or condition and any treatment that has already been attempted.

Your PCP's office may recommend any of the following:

- Continued home care
- Visit the doctor's office
- Go to the emergency room

Notify your PCP or GHP of the emergency as soon as possible, preferably within 48 hours, so they can provide post-emergency care and coordinate follow-ups.

In the emergency room, you are required to pay any applicable emergency room copays. These copays are waived if you are directly admitted to the hospital or admitted within 72 hours for the same condition.

Urgent care

When it's not an emergency, but you need medical attention right away, visit urgent care.

During urgent situations:

- Your PCP should be your first contact when sick or in need of medical treatment. When you call:
  - Identify yourself as a GHP member.
  - Give relevant information, like how urgent you think the problem is, specific information about your health or condition and your phone number.
  - You may be connected to a doctor right away, or the doctor may have to call you back.
- **Your doctor may recommend any of the following:**
  - Steps you can take at home to avoid a trip to an emergency room or doctor's office.
  - That you come to the office for care.
  - That you go to the emergency room.
- All follow-up services after that visit must be provided, or authorized in advance, by a doctor or primary care site.
- If your PCP isn't readily available, medical direction is available 24/7 via Tel-A-Nurse.
- Convenient care and urgent care facilities can be cost-effective and convenient when you need immediate medical attention. No appointments are necessary. Check our provider list at geisingerhealthplan.com to find participating facilities near you.
- Note: Urgent care and convenient care facilities require PCP copays.

Tel-A-Nurse

Tel-A-Nurse is available 24/7 to offer support and healthcare advice. Just call toll-free at 877-543-5061 and choose from the voice menu.

Tel-A-Nurse also has a live chat service for medical information via geisingerhealthplan.com.

Submitting claims

Participating providers first bill GHP for your medical care, so with some exceptions, you will not receive a bill for covered services. You will receive bills for most out-of-area emergency and urgent care services. Specialists might also bill you.

If you have a deductible or coinsurance for certain services, your provider may ask you to pay an estimated amount at the time of service, or they may wait and bill you after we have processed the claim for services.

Providers will often bill you and GHP at the same time. If you get a second bill, submit it to us or call the customer service team. Provide your member ID number and a contact phone number with the bill. For an emergency care bill, you will also need to explain the situation that led to the services.

If you paid anything other than a copay, deductible, coinsurance or fees for non-covered services, request a claim form from the customer service team at the number on the back of your member ID card. Submit the claim form along with receipts and instructions to pay you, not the doctor. Claims must be received by GHP within 180 days of the date of treatment.

Coordinating care

Changes to your enrollment status

Listed below are a few of the life events that may affect your coverage.

- Additions to the family through birth, adoption or marriage
- Changes in employment
- Children leaving for college
- Financial independence when your child gets married, accepts a full-time job or graduates from a college or trade school
- PCP changes
- Relocation

For more information on how these changes will affect your coverage and what you should do, call the customer service team at the number on the back of your member ID card.

Continuity of care

New members who wish to continue an ongoing course of treatment with a non-participating provider must contact the customer service team prior to receiving treatment. We will confer with the provider to determine if they will accept our terms and conditions for payment. If the provider agrees, GHP will pay for covered services for the first 60 days of enrollment. (If you are in your second or third trimester of pregnancy, services will be covered through delivery and postpartum care.)

In certain cases, you may also be considered for coverage of ongoing treatment during a transitional period when a provider participation agreement is discontinued. If this occurs, GHP will notify you and outline the process you should follow to exercise your continuity of care option.

Coordination of benefits

Periodically, you may receive a letter of inquiry about insurance you have in addition to GHP. Complete the required information, even if you are not covered by another plan, and return it so we may update your insurance file. You can also complete this form online at geisingerhealthplan.com or by calling the customer service number on the back of your member ID card.

If you are covered by another type of insurance, we'll ask you to inform us about that coverage (e.g., name of plan, your ID number). We will cooperate with the other insurer to be sure you receive all benefits to which you are entitled.

We work with other insurers to avoid double payments for claims, which helps keep down the cost of health insurance for you and your dependents, while making sure you receive the maximum benefit allowed.

For a worker's compensation claim, you must use a doctor who participates with both your employer's worker's compensation insurance and GHP. If worker's compensation rejects your claims, they will be considered for coverage by GHP.

Even if you are covered by another insurance plan, you must follow GHP coverage guidelines for us to cover services.

Remember your copays

Before visiting your PCP or specialist, check to see if you have a copay due. Your copay amounts are listed on your member ID card and on your schedule page, or you can call the customer service team at the number on the back of your member ID card.

When a physician, nurse practitioner, physician assistant or nurse specialist provides office visit services, you pay one copay at the time of the visit. If you receive an injection or a diagnostic test in your physician's office, you pay a copay only if your provider bills you for an office visit service. If several departments provide medical services, you pay a copay for each office visit, even if those visits occur in the same day.

Note: If you are placed in an observation bed after an emergency room visit, it is not the same as an inpatient admission. If you are kept for observation and later released without being admitted, your emergency room copay does apply.

Benefit exclusion reminder

As a reminder, there may be exclusions to some of your coverage, which can affect what you pay for services. Services such as cosmetic surgery and the use of non-participating providers are exclusions, except as listed in your Subscription Certificate or benefit riders. If you have any questions call the customer service team at the phone number on the back of your member ID card.

Visiting non-participating providers

If you choose to see a non-participating provider, you may be billed for any charges over our allowed amount for the out-of-network service, in addition to your deductible and coinsurance. Seeing a non-participating provider could make your out-of-pocket costs significant and unpredictable. Before choosing a non-participating provider, call the customer service team at the number on the back of your member ID card for specific cost-sharing information.

Urgent and emergency care are covered no matter where you are

If you travel outside the GHP service area, certain services will still be covered. The health plan will pay for medical emergency care, urgently needed care, renal dialysis and any care that has been pre-approved by GHP.

Questions about coverage of treatment? Refer to your Subscription Certificate or contact the customer service team at the number on the back of your ID card.

Special communication services

GHP can accommodate you if you have special communication needs.

- Hearing impaired members can contact GHP via the TDD/TTY phone line at PA Relay 711, Monday to Friday, 8 a.m. to 6 p.m.
- GHP can provide visually and reading impaired members with audio cassettes of important member material upon request.
- For non-English-speaking GHP member phone calls, we use a third party phone line known as LanguageLine to communicate.
- Non-English printed materials can be produced upon request.

Health and case management

GHP's health and case management programs help you stay healthy and assist with chronic health conditions. Our case managers/health managers, who include specially trained nurses, social workers and community health workers, work with you in one-on-one sessions, by phone or via the web, to set personal goals and complete an action plan to better your health.

Programs offered include asthma, heart failure, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, osteoporosis, coronary artery disease (CAD), as well as lifestyle changes including weight management and tobacco cessation. A case manager can also help you transition back home after a hospital visit, including coordination of medications, follow-up appointments and home health services.

If you'd like to learn more, call 800-883-6355, Monday to Friday, 8 a.m. to 5 p.m.

Preventive health guidelines

You can find our Preventive Health Guidelines book online at geisingerhealthplan.com (member section). For a hard copy, call our customer service team at the number on the back of your member ID card.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998, or Women's Health Act, requires GHP to cover post-mastectomy and reconstructive services for members with breast cancer. GHP has always viewed the services outlined in the Women's Health Act as essential covered benefits and is in full compliance with this law.

If a member elects reconstructive surgery following a mastectomy, GHP will cover:

- All stages of reconstruction of the breast on which a mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas
- Your participating provider will work with GHP's medical director to determine how covered services will be provided.

Covered services are subject to copays as specified on your Schedule of Benefits.

Member rights

As a GHP member, you have the right to:

1. Timely and effective redress of complaints, appeals and grievances
2. Health maintenance literature and material about GHP and its services, practitioners and providers for your use, written in a manner that truthfully and accurately provides relevant information so it is easily understood by a person of average intelligence
3. Be treated with respect and recognition of your dignity and right to privacy
4. Obtain from your PCP, unless it is not medically advisable, current information concerning their diagnosis, treatment and prognosis in terms that they can reasonably be expected to understand
5. Be given the name, professional status and function of any personnel providing health services to you
6. Give your informed consent before the start of any procedure or treatment
7. A candid discussion of appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage
8. Participate with practitioners in decision-making about your healthcare
9. Be advised if a healthcare facility or any of the providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment (though a legally responsible party on your behalf may at any time refuse to participate in or to continue in any experimentation or research program for which you have previously given an informed consent)
10. Refuse any drugs, treatment or other procedure offered by GHP or its providers to the extent permitted by law and to be informed by a physician of the medical consequence of the subscriber's refusal of any drugs, treatment or procedure
11. Have all records pertaining to your medical care treated as confidential unless disclosure is necessary to interpret the application of your contract to your care or unless disclosure is otherwise provided for by law
12. All information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons
13. Obtain emergency services without unnecessary delay when services are required
14. Make recommendations regarding the member rights and responsibilities policies
15. Be informed of these rights and responsibilities

Member responsibilities

To get the most of your GHP coverage, you have the responsibility to:

1. Know your PCP and primary care site and your nearest participating hospital
2. Contact your PCP for all medical care except in the case of emergencies
3. Be prepared when talking with the doctor
4. Attempt to schedule appointments with the same primary care team each time
5. Contact GHP or your PCP to arrange for transport when your condition has stabilized, if admitted to a non-participating hospital
6. Identify yourself as a GHP member whenever you call or visit your doctor
7. Offer information your doctor or other healthcare providers need to care for you and to follow the instructions or guidelines you receive from your PCP, such as taking prescriptions as directed
8. Participate in understanding your health problems and developing mutually agreed upon treatment goals

Prescription drug coverage

Your benefits may include prescription drug coverage. We offer two prescription drug benefits: the traditional prescription benefit and the Triple Tier benefit. You are enrolled in only one plan.

A four-tier drug rider is an optional benefit. Restrictions related to this benefit can be found in the four-tier drug rider. Refer to this drug rider and your Schedule of Benefits as they contain important information about cost sharing, restrictions and limitations pertaining to the fourth tier list of medications. You can view both in the secured member section of the website or call customer service for copies.

Refer to your benefit documents, as formulary exclusions may differ based on the benefit. Check your policy's Schedule of Benefits for coverage and copay information, or call the customer service team. If you have this benefit, present your member ID card when you fill any prescription written by your physician.

Keep in mind:

- All prescriptions must be filled at a participating pharmacy.
- You will pay the applicable copay, coinsurance or deductible when you receive the prescription.
- Coverage is for generic drugs when they have equivalent rating in the drug products list (Orange Book–U.S. Department of Health and Human Services). Brand-name drugs that have a generic equivalent are covered only when medically necessary via the prior authorization process.
- Some medications on the formulary require prior authorization, which your provider may request through our pharmacy department.
- If you require drugs or medications not listed on the formulary, your provider may request an exception through our pharmacy department, except for those items listed as specific exclusions. Non-formulary medications which require prior authorization will be available at the highest copay level, if approved.
- Non-prescription (over-the-counter) medications are not covered.
- Some medications and diabetic supplies may be restricted to a specific manufacturer, vendor or supplier and may be subject to quantity limits.
- Quantity limits may apply to certain drugs. If you require drugs or medications not listed on the formulary, your provider may request an exception through our pharmacy department, except for those items listed as specific exclusions. Non-formulary medications which require prior authorization will be available at the highest copay level if approved.
- Non-prescription (over-the-counter) medications are not covered.
- Some medications and diabetic supplies may be restricted to a specific manufacturer, vendor or supplier and may be subject to quantity limits.
- Quantity limits may apply to certain drugs.

Specialty vendor drug program

Certain medications require the use of a contracted specialty pharmacy vendor for purchase. Contact the pharmacy customer service team or visit geisingerhealthplan.com for additional information on the program and a complete list of the medications included.

Formulary

The purpose of a drug formulary is to promote high-quality healthcare that is affordable for members like you. A drug formulary is a list of prescription medications currently covered by GHP. The formulary is constantly updated due to the high number of drugs on the market, as well as the introduction of new drugs. Therefore, the formulary is subject to change. Development of the formulary includes input from the pharmacy and therapeutics committee, a group of healthcare professionals, including physicians and pharmacists.

The pharmacy and therapeutics committee thoroughly reviews medical literature to first determine which drugs are likely to produce the best results for patients. Then, if two or more drugs produce the same clinical results, elements like cost and ease of use are considered.

A well-developed formulary enhances quality of patient care through coverage of medications that are safe, effective and likely to achieve the best possible outcome for the patient. When you use a formulary medication, it is considered a "covered" medication and the only cost to you is your applicable copay or coinsurance.

There are certain medications that GHP will not cover under any circumstance. These medications are called exclusions. Some examples of exclusions are over-the-counter medications, medications used for experimental, investigational or unproven drug therapies, medications used for weight loss, lifestyle medications and medications used for cosmetic purposes. The exclusion list is also updated continually. If you're unsure whether a medication is covered, ask before going to your pharmacy.

For more information or to review pharmaceutical lists on any limitations for prescribing or accessing pharmaceuticals, call the pharmacy customer service team.

You can view the formulary online at geisingerhealthplan.com. For a hard copy of the entire formulary, call 800-988-4861, Monday through Friday, 8 a.m. to 5 p.m. or go to geisingerhealthplan.com to view or print a copy.

Geisinger Health Plan privacy notice

We are required by law to maintain the privacy of protected health information (PHI) and to provide people with notice of our legal duties and privacy practices with respect to protected health information.

It's also important to us to uphold your trust, as our member, and the trust of others. We're committed to the confidentiality of your PHI.

PHI is any individually identifiable health information that is created or received by GHP that relates to your past, present or future physical or mental health or condition; the provision of healthcare to you; or the past, present or future payment for the provision of healthcare to you.

The Notice of Privacy Practices applies to all products offered by Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, Inc. (collectively referred to herein as "GHP") all referred to as GHP below.

Uses and disclosures of PHI

GHP uses and discloses PHI in connection with your treatment, to make payment for your healthcare and for GHP's healthcare operations. Except as stated below, GHP will not use or disclose your PHI unless you have signed a form that allows GHP to do so.

Treatment: GHP may disclose your PHI to doctors, dentists, pharmacies, hospitals and other caregivers who request it in connection with your treatment. GHP may also disclose your protected health information to healthcare providers in connection with preventive health, early detection and disease and case management programs.

Payment: GHP will use and disclose your PHI to administer your health benefits policy or contract. This may involve verifying eligibility, claims payment, subrogation, utilization review and management, medical necessity review, care coordination, and responding to complaints, appeals and external requests.

Healthcare operations: GHP will use and disclose your PHI as necessary, and as permitted by law, for its healthcare operations. These healthcare operations include, but are not limited to, credentialing healthcare providers, peer review, business management, accreditation and licensing, utilization review and management, quality improvement and assurance, enrollment, rating and underwriting, reinsurance, compliance, auditing and other functions related to your health benefits plan.

Business associates: Certain aspects and components of GHP's services are performed through contracts with outside persons or organizations, such as identification card printing, subrogation, accreditation, etc. At times it may be necessary for GHP to provide PHI to one or more of these outside persons or organizations who assist GHP with healthcare operations. GHP will give out as little information as possible to allow our business associates to complete these tasks and GHP requires these business associates to appropriately safeguard the privacy of your information.

Family and friends involved in your care: With your approval, GHP may disclose your PHI to designated family, friends and others involved in your care. You may designate another person to act on your behalf in signing forms or making decisions when you are unable to do so. GHP recognizes the following documentation for member representation in certain circumstances:

- Applicable Durable Power of Attorney
- Legal guardian
- A GHP Authorized Representative Form

If you wish to designate an authorized representative, you must complete and sign an Authorized Representative Form. You can obtain one by calling the customer service team at the number on the back of your member identification card. If you are unavailable, incapacitated or facing an emergency medical situation and GHP determines that a limited disclosure may be in your best interest, GHP may share limited PHI with such individuals without your authorization. Certain state/federal laws limit our uses and disclosures even in the case of treatment, payment or healthcare operations of those medical records of a sensitive nature, including HIV-related records, records of alcohol or substance abuse treatment, mental health records, and records of sexual abuse/assault counseling. We will use and disclose your health information only in compliance of these more restrictive laws that provide greater protection for records in these categories of care.

Special authorizations are required by Pennsylvania laws to permit disclosures of certain highly sensitive personal information. In certain situations, consistent with applicable regulations or laws, GHP will ask for your written authorization before using or disclosing identifiable health information about you. If you sign an authorization to disclose specific information, you can later revoke that authorization to stop future uses and disclosures.

Unless authorized by you, GHP will not use or disclose genetic protected health information for underwriting purposes.

Additional uses and disclosures of health information

GHP may also contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services available to you. GHP may use or disclose your PHI without an authorization:

- For any purpose required by law
- For public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations
- As required by law if we suspect child abuse or neglect; we may also release your PHI as required by law if we believe you to be a victim of abuse, neglect, or domestic violence
- To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls
- To your plan sponsor (employer); however, your plan sponsor must certify that the information provided will be maintained in a confidential manner and not used for employment-related decisions or for other employee benefit determinations or in any other manner not permitted by law

- If required by law to a government oversight agency conducting audits, investigations or civil or criminal proceedings
- If required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release
- To law enforcement officials as required by law to report wounds and injuries and crimes
- To coroners and/or funeral directors consistent with law
- If necessary to arrange an organ or tissue donation from you or a transplant for you
- For certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy
- If you are a member of the military as required by armed forces services; we may also release your PHI if necessary for national security or intelligence activities
- To workers' compensation agencies if necessary for your workers' compensation benefit determination

Individual member rights regarding privacy

The Health Insurance Portability and Accountability Act (HIPAA) provides specific rights to all individuals about their PHI. You may request in writing that GHP not use or disclose your PHI for payment, health management or other healthcare operational purposes except when specifically authorized by you, when required by law, or in emergency circumstances. GHP will consider your request, but is not legally required to accept it. GHP will not sell your PHI or share it for marketing purposes unless you give us written permission.

To find out more about any of the following rights or request the necessary form(s), call the customer service team at the number on the back of your member identification card or contact the GHP Designated Privacy Specialist as noted in the Contacts section of this notice. Communications that you receive from GHP containing your health information will be conveyed in a confidential manner. You have the right to request in writing and GHP will process reasonable requests by you to receive communications about your PHI from us by alternative means or at alternative locations.

Unless GHP is given an alternative address, GHP will mail Explanation of Benefits forms and other mailings containing protected health information to the address that GHP has on record for the subscriber.

In most cases, you have the right to look at or get a copy of your PHI in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your healthcare benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set. If you request copies, GHP may charge reasonable copying and postage fees.

You may also request a copy of your protected health information in electronic format or direct us to transmit it to another entity or individual you choose. If you believe that information in your GHP records is incorrect or incomplete, you have the right to request in writing that GHP correct or add to the existing information.

GHP is not obligated to make all requested corrections, but will give careful consideration to each request. Requests for amendment(s) must be in writing, signed by you or your representative, and must state the reasons for the request. If GHP makes a correction that you request, GHP may also notify others who work with us and have copies of the uncorrected record if GHP believes that the notification is necessary.

You can ask for an accounting of disclosures — a list of the times we've shared your health information for six years before the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). If you request this accounting more than once in a 12-month period, GHP may charge you a reasonable fee.

We are required to notify you, should certain unpermitted uses and disclosures (a "breach") occurs that may cause you financial, reputational, or other significant harm. This will be done by mail and other means if necessary.

GHP’s duties

GHP is required by law to maintain the privacy of your PHI, provide this notice about its information practices and follow the information practices that are described in this notice. GHP may change its policies at any time.

If GHP makes a significant change in its policies, GHP will provide notice of the change to you via a letter, newsletter notice or a revised Subscription Certificate. You may request a copy of GHP’s privacy & confidentiality policy on uses and disclosures of health information at any time.

For more information on GHP’s privacy practices, contact the person listed below.

GHP has procedures in place to prevent unauthorized access to your PHI, which include employee training in the importance of maintaining member confidentiality and privacy.

Changes to this notice

We may change this notice at any time. We may make the revised or changed notice effective for PHI we already have as well as any PHI we receive in the future. On the first page of the notice, in the top right corner, you will find the effective date of that notice.

If we make a material change to uses and disclosures, your rights, our legal duties or other privacy practices stated in this notice, we will promptly revise and distribute our changed notice. Except when required by law, a material change to any term of this notice may not be implemented prior to the effective date of the revised notice.

CMS Blue Button Program

Notwithstanding the other provisions of this Privacy Policy, if you are participating in the Centers for Medicare & Medicaid Services (CMS) Blue Button Program through Geisinger, the following provisions apply to you:

(a) Geisinger will notify you of any material changes to this notice.

(b) We will notify you if Geisinger is sold or merged into another entity.

(c) The notice will be provided electronically through the Blue Button portal on Geisinger’s website.

(d) If you inform Geisinger that you are opting out of the Blue Button Program through the Blue Button portal, Geisinger will delete the Blue Button information that we received from CMS about you.

Complaints

If you are concerned that GHP has violated your privacy rights or you disagree with a decision GHP has made about access to your GHP records, follow the complaint procedures described in your plan documents. You can also call the customer service team or contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint with either GHP or the U.S. Department of Health and Human Services.

Contacts

If you have questions or need more information, contact our customer service team at the number on the back of your member identification card or the Privacy Office as follows:

Geisinger Privacy Office
Geisinger Health Plan
100 N. Academy Ave.
Danville, PA 17822-4038

Email: ghpprivacy@geisinger.edu

The address for the Department of Health and Human Services is:

The U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Effective date

This notice went into effect April 14, 2003, in accordance with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA). The notice was most recently revised Nov. 30, 2022.

Footnote to privacy notice

Organized health care arrangement designation

As covered entities, the bellow-listed separate GH corporate legal entities are participating in an organized health care arrangement (OHCA). These separate corporate legal entities may share PHI as necessary to carry out treatment, payment and healthcare operations related to the OHCA and for other purposes as permitted or required by law.

- Geisinger Affiliated Covered Entities
- Geisinger Indemnity Insurance Company
- Geisinger Quality Options, Inc.
- Geisinger Health Plan

Affiliated Covered Entity Designation

As of Oct. 1, 2019, the following Geisinger covered entities, under common control, designate themselves as a single covered entity known as the "Geisinger Affiliated Covered Entities" for purposes of the HIPAA privacy rule. The Geisinger Affiliated Covered Entities are:

- Geisinger Clinic (all sites)
- Geisinger Medical Center (including its Geisinger Shamokin Area Community Hospital Campus)
- Geisinger Wyoming Valley Medical Center (including Geisinger South Wilkes-Barre Campus)
- Geisinger Community Health Services
- Geisinger Bloomsburg Hospital
- Geisinger Health Plan (Added Jan. 23, 2020)
- Geisinger Jersey Shore Hospital
- Geisinger Lewistown Hospital
- GNJ Physicians Group PC
- Geisinger Pharmacy LLC
- Community Medical Center d/b/a Geisinger Community Medical Center
- Family Health Associates of Geisinger-Lewistown Hospital
- West Shore Advanced Life Support Services, Inc.
- Geisinger Medical Center Muncy (December 2021)

Contact us

If you have questions about the privacy of your health information, call us at 800-447-4000.

Complaint and grievance procedures For Geisinger

Health Plan HMO members

This section describes your rights if you believe you have not received the benefits or services to which you are entitled. Each complaint and grievance must go through the formal procedure. You have the opportunity to appeal the decision to an external review process.

At any time during the complaint or grievance process, you may choose to designate in writing a representative to participate in the complaint or grievance process on your behalf (your representative). In this section and in the grievance and complaint procedure section of your Subscription Certificate, the definition of "member" shall include your representative. You shall be responsible to notify GHP in writing of such designation; GHP has an authorization form available for your use.

GHP shall make a GHP employee available to assist you, at no charge, in the preparation of a complaint or grievance if you request help anytime during the complaint or grievance process. A GHP employee who has been made available to you may not have participated in a prior decision made by GHP regarding the complaint or grievance. You may call GHP toll free at the phone number on the back of your member ID card to obtain information about the filing and status of a complaint or grievance. You have the right to provide GHP with written comments, documents, records or other information about the complaint or grievance.

GHP will fully and fairly consider all available information relevant to the complaint or grievance, including any material submitted by you to GHP, when making a determination. In the event you disagree with classification of a complaint or grievance by GHP, you may contact the Department of Health or Department of Insurance for consideration and intervention with GHP in order to be redirected to the appropriate internal review process. The complaint or grievance will also be classified as either a pre-service appeal or post-service appeal. Pre-service appeals are appeals regarding services that have not yet occurred. Post-service appeals are appeals for services that have already been rendered.

You have the right to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) once all administrative remedies have been exhausted, if you are a member of an ERISA group.

GHP may not cancel or terminate your coverage for services provided under the Subscription Certificate on the basis that you have exercised rights under GHP's grievance and complaint procedure by registering a complaint against GHP.

Complaint procedure

Complaint means a dispute or objection by a member regarding a participating healthcare provider, or the coverage (including contract exclusions and non-covered services), operations or management policies of GHP, that has not been resolved by GHP.

First Level Complaint Review procedure

A member who has a complaint about their coverage, participating providers or the operations or management policies of GHP should contact the customer service team. A customer service team representative will attempt to satisfy the member's concern informally. If the customer service team representative is unable to resolve the member's concern to their satisfaction, the member may file a written or oral complaint that will be reviewed by the first level complaint review committee. This request must be filed within 180 calendar days following receipt of notification of an adverse benefit determination or the occurrence of the issue, which is the subject of the complaint.

GHP shall notify the member of its receipt in writing including a detailed explanation of the complaint process.

The first level complaint review committee shall include one or more employees of GHP who did not previously participate in a prior decision to deny the member's complaint and shall not be a subordinate of the person(s) who made the adverse benefit decision. Upon request from the member, GHP shall provide the member with access to the information available relating to the matter being complained of at no cost and shall permit the member to provide additional verbal or written data or other material in support of the complaint.

If the complaint involves services that have not yet been rendered (pre-service), the First Level Complaint Review shall be completed and a decision rendered with written notification of the committee's decision to the member no later than 30 calendar days from the receipt of the complaint and within five business days of the first level complaint review committee's decision.

If the complaint involves services that have already been rendered (post-service), the First Level Complaint Review shall be completed and a decision rendered with written notification of the committee's decision to the member no later than 30 calendar days from receipt of the complaint and within five business days of the first level complaint review committee's decision.

Notification to the member shall include the basis for the decision and the procedure to file a request for a voluntary second level complaint review of the decision of the first level complaint review committee including:

- A statement of the issue reviewed by the first level complaint review committee
- The outcome of the first level review
- The specific reason(s) for the decision in easily understandable language
- A reference to the specific GHP contract (i.e., Subscription Certificate, rider, amendment) provision on which the decision is based
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the decision either, the specific rule, guideline, protocol or criterion and notification that the member, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same
- A list of the titles and qualifications of the individuals participating in the review
- Notification that the member is entitled to receive upon request, reasonable access to, and copies of all documents relevant to the member's complaint/appeal at no cost and instructions as to how to obtain the same

- An explanation of how to request a voluntary second level complaint review of the decision of the first level complaint review committee and notification that the member has the right to provide additional material including but not limited to written comments, documents, records or other information to be considered as part of the voluntary second level review
- The time frames for requesting a second level complaint review, if any

Second level complaint review procedure

A member who is dissatisfied with the decision of the first level complaint review committee may request orally or in writing a voluntary Second Level Complaint Review. A written request should be addressed to: Geisinger Health Plan, Appeal Department, M.C. 3220, 100 N. Academy Ave., Danville, PA 17822. GHP shall notify the member of its receipt in writing, upon receipt of such request.

The member satisfaction review committee shall consist of a minimum of three or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the adverse benefit determination or of previous reviewers. Upon request from the member, GHP shall provide the member with access to the information available relating to the matter being complained of at no cost and shall permit the member to provide additional verbal or written data or other material in support of the complaint. At least one-third of the member satisfaction review committee shall not be employed by GHP or its related subsidiaries or affiliates. The member satisfaction review committee will fully and fairly consider all available information relevant to the member's complaint including any material submitted by the member to GHP. GHP shall provide at least 15 days advance written notification of the review procedures, date and time, and the member's right to attend the member satisfaction review committee meeting.

If the complaint involves services that have not yet been rendered (pre-service), the second level complaint review shall be completed and a decision rendered with written notification of the committee's decision to the member no later than 30 calendar days from the receipt of the complaint and within five business days of the member satisfaction review committee's decision.

If the complaint involves services that have already been rendered (post-service), the second level complaint review shall be completed and a decision rendered with written notification of the committee's decision to the member no later than 30 calendar days from receipt of the complaint and within five business days of the member satisfaction review committee's decision.

The written notice shall specify the reasons for the member satisfaction review committee's decision and shall include the specific reason and basis for the decision and the procedures to file an appeal to the Department of Health or the Department of Insurance including the address and phone numbers of both agencies and shall include the following information:

- A statement of the issue reviewed by the member satisfaction review committee
- The outcome of the second level review
- The specific reason(s) for the decision in easily understandable language
- A reference to the specific GHP contract (i.e., Subscription Certificate, rider, amendment) provision on which the decision is based
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the decision either, the specific rule, guideline, protocol or criterion and notification that the member, upon request, can obtain a copy of the actual benefit provision at no cost and instructions as to how to obtain the same
- A list of the titles and qualifications of the individuals participating in the review
- Notification that the member is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the member's complaint/appeal at no cost and instructions as to how to obtain the same
- An explanation of how to request an external complaint appeal review of the decision of the member satisfaction review committee by the Department of Health or the Department of Insurance, including the addresses and phone numbers for both agencies, a description of the External Complaint Appeal process including notification that the member has the right to provide additional material for inclusion in the external complaint appeal review and a statement that the member does not bear any costs for the external complaint appeal review

- The time frame for requesting an external complaint appeal review, if any

External complaint appeal procedure

If the member is not satisfied, the member may appeal the decision of the member satisfaction review committee within 15 calendar days from receipt of the notice of the second level complaint review decision to the:

Bureau of Managed Care
Pennsylvania Department of Health
Health & Welfare Building, Room 912
7th & Forster Streets
Harrisburg, PA 17120

Phone number: 717-787-5193 or 888-466-2787

AT&T relay service: 800-654-5984

Fax number: 717-705-0947

or

Pennsylvania Department of Insurance
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120

Phone number: 717-787-2317 or 877-881-6388

Fax number: 717-787-8585

GHP shall transmit to the appropriate Department all records from the first and second level complaint review processes within 30 calendar days of the Department's request. GHP and the member may submit to the appropriate Department additional materials related to the complaint. Each party shall provide to the other copies of the additional documents provided to the Department. GHP and the member have the right to be represented by an attorney or other individual before the appropriate Department. The appropriate Department shall have the final determination.

Complaint regarding increase to premium rates

A member who has an inquiry, complaint or question regarding GHP's increase to premium rates may contact the Pennsylvania Department of Insurance without the necessity of following GHP's First and Second Level Complaint procedures.

Grievance procedure

Medical necessity and appropriateness of care decisions

Grievance means a request by a member or a healthcare provider (with the written consent of the member) to have GHP reconsider a decision solely concerning the medical necessity and appropriateness of a healthcare service. A grievance may be filed regarding the decision that does any of the following:

- Disapproves full or partial payment for a requested health service
- Approves the provision of a requested healthcare service for a lesser scope or duration than requested
- Disapproves payment of the provision of a requested healthcare service but approves payment for the provision of an alternative healthcare service

First level grievance review procedure

A member or a healthcare provider with the member's written consent, may file a written request (or an oral request by a member who is unable to file a written grievance by reason of disability or language barrier) to have GHP review the denial of payment for a healthcare service based on medical necessity and appropriateness of care, including approval by GHP of an alternative covered service or approval of a covered service for a lesser scope or duration than requested. **This request must be filed within 180 calendar days following receipt of notification of an adverse benefit determination and should be addressed to:**

Geisinger Health Plan
Appeal Department, M.C. 3220
100 N. Academy Ave.
Danville, PA 17822

GHP shall notify the member and healthcare provider who filed the grievance with the member's written consent, of its receipt in writing including a detailed explanation of the grievance process.

The first level internal review committee shall include one or more individuals selected by GHP. The committee consists of a GHP medical director (licensed physician) who did not previously participate in any prior decision relating to the grievance and shall not be subordinates of the person(s) who made the adverse benefit determination. The first level internal review committee

shall include written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the healthcare service, or condition, performs the procedure or provides the treatment who was not previously involved in the matter under review. Upon request from the member or a healthcare provider with the member's written consent, GHP shall provide the member or the healthcare provider who filed the grievance with the member's written consent, with access to the information relating to the matter being grieved at no cost and shall permit the member and such healthcare provider to provide additional verbal or written data or other material in support of the grievance.

If the grievance involves services that have not been rendered (pre-service), the first level grievance review shall be completed and a decision rendered with written notification of the committee's decision to the member no later than 30 calendar days from receipt of the grievance and within five business days of the committee's decision.

If the grievance involves services that have already been rendered (post-service), the first level grievance review shall be completed and a decision rendered with written notification of the committee's decision to the member no later than thirty calendar days from receipt of the grievance and within five business days of the committee's decision.

Written notification to the member and the filing healthcare provider shall include the following:

- A statement of the issue reviewed by the first level internal review committee
- The outcome of the first level grievance review
- The specific reason(s) for the decision in easily understandable language
- A reference to the specific GHP contract (i.e., Subscription Certificate, rider, amendment) provision on which the decision is based
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the member or filing healthcare provider, upon request, can obtain a copy of the actual benefit provision at no cost and instructions how to obtain the same
- An explanation of the scientific or clinical judgment for the decision, applying the terms of GHP to the member's medical circumstances, if applicable
- A list of the titles and qualifications of the individuals participating in the review
- Notification that the member or filing healthcare provider is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the member's grievance/appeal at no cost and instructions as to how to obtain the same
- An explanation of how to request a voluntary second level grievance review of the decision of the first level internal review committee and notification that the member or filing healthcare provider, have the right to provide additional material including but not limited to written comments, documents, records or other information to be considered as part of the voluntary second level grievance review
- The time frames for requesting a second level grievance review, if any

Second level grievance review procedure

A member or a healthcare provider with the member's written consent, who is dissatisfied with the decision of the first level internal review committee may request in writing (or an oral request by a member who is unable to file a written grievance by reason of disability or language barrier) a voluntary second level grievance review. Upon receipt, GHP shall notify the member and healthcare provider who filed the grievance of its receipt in writing.

The Second Level Internal Review Committee is composed of three or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination or of the first level internal review committee reviewers. The Second Level Internal Review Committee shall include written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the healthcare service, or condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. Upon request from the member or a healthcare provider with the member's written consent, GHP shall provide the member or the healthcare provider who filed the grievance with the member's written consent, with access to the information relating to the matter being grieved at no cost and shall permit the member and such healthcare provider to provide additional verbal or written data or other material in support of the grievance. The member and the healthcare provider who filed a grievance have the right to appear before the Second Level Internal Review Committee. GHP and the member have the right to be represented by an attorney or other individual before the Second Level Internal Review Committee. GHP shall provide at least 15 days advance notification, in writing, of the hearing procedures, date and time, and of their right to attend the second level grievance review meeting to the member and the healthcare provider who filed the grievance with the member's written consent.

If the grievance involves services that have not been rendered (pre-service), the second level grievance review shall be completed and a decision rendered with written notification of the committee's decision to the member no later than 30 calendar days from receipt of the grievance and within five business days of the committee's decision.

- Written notification to the member and the filing healthcare provider shall include the following: A statement of the issue reviewed by the Second Level Internal Review Committee
- The outcome of the second level grievance review The specific reason(s) for the decision in easily understandable language
- A reference to the specific GHP contract (i.e., Subscription Certificate, Rider, Amendment) provisions on which the decision is based
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the decision, either the specific rule, guideline, protocol or criterion or notification that the member or filing healthcare provider, upon request, can obtain a copy of the actual benefit provision at no cost and instructions how to obtain the same
- An explanation of the scientific or clinical judgment for the decision, applying the terms of GHP to the member's medical circumstances, if applicable
- A list of the titles and qualifications of the individuals participating in the review
- Notification that the member or filing healthcare provider is entitled to receive, upon request, reasonable access to, and copies of all documents relevant to the member's grievance/appeal at no cost and instructions as to how to obtain the same
- An explanation of how to request an External Grievance Appeal Review by an Independent Review Organization (IRO) assigned by the Pennsylvania Insurance Department (PID) Bureau of Managed Care (BMC) and notification that the member or filing healthcare provider has the right to provide additional material including but not limited to written comments, documents, records or other information to be considered as part of the External Grievance Appeal Review, including a statement that the member and member representative do not bear the costs of the independent External Grievance Appeal Review
- The time frame of 15 days from receipt of the written notification of the decision of the second level grievance review for the member or the filing healthcare provider to file a request for an External Grievance Appeal Review

- The External Grievance Appeal Review, including a statement that the member and member representative do not bear the costs of the independent External Grievance Appeal Review

External grievance appeal procedure

The member or the healthcare provider with the member's written consent, who is dissatisfied with the decision of the Second Level Internal Review Committee, may request an external review. If an external review is warranted, the BMC will assign an independent review organization (IRO) as required by and in accordance with all applicable state and federal regulations. The plan will notify the member of acceptance for external review and will inform the member that they may submit in writing, within 15 business days, any additional information the member would like the IRO to consider in the review. The IRO will perform an independent claim review and will not be bound by decisions or conclusions reached during the plan's internal claims and appeals process. **In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:**

a) The member's medical records

b) The attending healthcare professional's recommendation

c) Reports from appropriate healthcare professionals and other documents submitted by the plan, member, or the member's treating provider

d) The terms of the member's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law

e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations

f) Any applicable clinical review criteria developed and used by the plan unless the criteria are inconsistent with the terms of the plan or with applicable law

g) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this section 5.4.1.2 to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate

Time frame for decision:

The IRO will provide written notice of the final external review decision to the member and the plan within 45 days after the IRO receives the request for external review. The decision will be in writing and will include the following:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the reason for the previous denial)

b) The date the IRO received the assignment to conduct the external review and the date of the IRO's decision

c) References to the evidence or documentation including the specific coverage provisions and evidence-based standards, considered in reaching its decision

d) A discussion of the principal reason for its decision, including the rationale for its decision and evidence-based standards that were relied on in making its decision

e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either Geisinger Health Plan or the member

f) A statement that judicial review may be available to the member

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

Binding decision:

The member and Geisinger Health Plan will be bound by the final decision of the IRO except to the extent that other remedies are available under state or federal law. The requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require payment or benefits. The plan must provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external decision and unless or until there is a judicial decision.

Expedited grievance appeal review procedure

Should the member's life, health or ability to regain maximum function be in jeopardy by delay caused by GHP review procedure, the member or a healthcare provider with the member's written consent, may request an Expedited Grievance Review (orally or in writing). **GHP will perform an expedited grievance appeal review when:**

1. Upon review by GHP, the member's request meets medical criteria to initiate the expedited grievance appeal review process
2. It is the healthcare provider's opinion that the member is subject to severe pain that cannot be managed without the care or treatment being requested
3. The member provides GHP with a certification, in writing, from the member's physician stating that the member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the pre-service grievance process of 30 days. The certification must include a clinical rationale and facts to support the physician's opinion
4. Requests concerning admissions, continued stay or other healthcare service for a member who has received emergency services but has not been discharged from a facility

GHP shall accept the above, perform an Expedited Grievance Review and render a decision within 48 hours of receipt of the member's request for an Expedited Grievance Review. The member shall be responsible to provide information to GHP in an expedited manner to allow GHP to conform to the Expedited Grievance Review requirements.

The Expedited Internal Review Committee shall be comprised of three or more individuals, one of whom is a licensed physician, did not previously participate in the decision to deny coverage or payment for the service and who are not subordinates of the person(s) who made the adverse benefit determination. Upon request from the member or a healthcare provider with the member's written consent, GHP shall provide the member or the healthcare provider who filed the expedited grievance with the member's written consent, with access to the information relating to the matter being grieved at no cost and shall permit the member and such healthcare provider to provide additional verbal or written data or other material in support of the expedited grievance. The Expedited Grievance Review shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the healthcare service, condition, performs the procedure or provides the treatment not previously involved in the matter under review.

Expedited External Grievance Appeal Review procedure

The member or the healthcare provider who filed the Expedited External Grievance Review with the member's written consent, who is dissatisfied with the decision of GHP's Expedited Grievance Review may appeal orally or in writing to the plan within two business days of receipt of the expedited grievance review decision.

Note: Under certain circumstances, which will be outlined to the member in the plan's appeal correspondence, an expedited external review may be requested at the same time the member requests an expedited appeal.

Preliminary review:

If GHP determines the expedited external review request meets the expedited external grievance requirements, notice will be sent to the member within one business day after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information. If the request is not complete, the notification will describe the information or materials needed to make the request complete.

External review procedure:

If an external review is warranted, the BMC will assign an IRO as required by and in accordance with all applicable state and federal regulations. The plan will notify the member of acceptance for external review and will inform the member that they may submit in writing, within 15 business days, any additional information the member would like the IRO to consider in the review. The IRO will perform an independent claim review and will not be bound by decisions or conclusions reached during the plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision.

This managed care plan may not cover all your healthcare expenses. Read your Subscription Certificate carefully to determine which healthcare services are covered. For more information, contact the customer service team at the phone number on the back of your member ID card.

Appeal procedures

For Geisinger Health Plan PPO members

This section describes your rights if you believe you have not received the benefits or services to which you are entitled. Each complaint and grievance must go through the formal procedure. The member may have the opportunity to appeal the decision to an external review process.

Pre-service appeal review for denials not based on medical judgement (complaint):

A pre-service appeal of an adverse benefit determination that is not based in whole or in part on a medical judgment will be reviewed by the member satisfaction review committee. The member satisfaction review committee shall consist of a minimum of three or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the adverse benefit determination or of previous reviewers. At least one-third of the member satisfaction review committee shall not be employed by GHP or its related subsidiaries or affiliates. The member satisfaction review committee will fully and fairly consider all available information relevant to the member's appeal including any material submitted by the member to GHP. GHP shall provide at least 15 days advance written notification of the review procedures, date and the member's right to attend the member satisfaction review committee meeting.

Pre-service appeal review for denial based on medical judgment (grievance):

A pre-service appeal of an adverse benefit determination that is based in whole or in part on a medical judgment will be reviewed by the internal review committee. The internal review committee is comprised of three or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination. The internal review committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the healthcare service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the member or a healthcare provider with the member's written consent, GHP shall provide the member or the healthcare provider with access to the information relating to the matter being grieved at no cost and shall permit the member and such healthcare provider to provide additional verbal or written data or other material to support the appeal. The member and/or the healthcare provider who filed the appeal have the right to appear before the internal review committee. GHP and the member have the right to be represented by an attorney or other individual before the internal review committee. GHP shall provide the member and/or healthcare provider at least 15 days' advance notification, in writing, of the hearing procedures, date, and of their right to attend the internal review meeting.

Pre-service appeal time frame for decision:

A pre-service appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than 30 days after receipt of the member's written request. GHP shall provide the member with a written notification of GHP's decision no later than 30 days from receipt.

The written notification from GHP will include:

a) The basis for the decision in easily understandable language
b) Reference to the specific GHP provisions on which the decision is based
c) Notification of the fact that the member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable
d) Notification that the member may request assistance with their appeal from the applicable state Office of Health Insurance Consumer Assistance
e) The member may have the right to request an external appeal review conducted by an independent review organization

Post-service appeal review for denials not based on medical judgment:

A post-service appeal of an adverse benefit determination that is not based in whole or in part on a medical judgment will be reviewed by the member satisfaction review committee. The member satisfaction review committee shall consist of a minimum of three or more individuals who did not previously participate in the matter under review and shall not be subordinates of the person(s) who made the adverse benefit determination or of previous reviewers. At least one-third of the member satisfaction review committee shall not be employed by GHP or its related subsidiaries or affiliates. The member satisfaction review committee will fully and fairly consider all available information relevant to the member's appeal including any material submitted by the member to GHP. GHP shall provide at least 15 days advance written notification of the review procedures, date and the member's right to attend the member satisfaction review committee meeting.

Post-service appeal for denials based on medical judgment:

A post-service Appeal of an adverse benefit determination that is based in whole or in part on a medical judgment will be reviewed by the internal review committee. The internal review committee is comprised of three or more individuals, one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and shall not be subordinates of the person(s) who made the adverse benefit determination. The internal review committee shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the healthcare service, condition, performs the procedure or provides the treatment and who was not previously involved in the matter under review. The committee will consider the full record including any aspects of clinical care involved and make an independent and fair decision regarding the appeal. Upon request from the member or a healthcare provider with the member's written consent, GHP shall provide the member or the healthcare provider with access to the information relating to the matter being grieved at no cost and shall permit the member and such healthcare provider to provide additional verbal or written data or other material to support the appeal.

The member and the healthcare provider who filed the appeal have the right to appear before the internal review committee. GHP and the member have the right to be represented by an attorney or other individual before the internal review committee. GHP shall provide the member and/or healthcare provider at least 15 days' advance notification, in writing, of the hearing procedures, date, and of their right to attend the internal review committee meeting.

Post-service appeal time frame for decision:

A post-service appeal, whether denied in whole or in part based on a medical judgment, will be reviewed and a decision made no later than 30 days after receipt of the member's written request. GHP shall provide the member with a written notification of GHP's decision no later than 30 days from receipt.

The written notification from GHP will include:

a) The basis for the decision in easily understandable language

b) Reference to the specific GHP provisions on which the decision is based

c) Notification of the fact that the member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable

d) Notification that the member may request assistance with their appeal from the applicable state Office of Health Insurance Consumer Assistance

e) The member may have the right to request an external appeal review conducted by an independent review organization

Request of an urgent care appeal:

A member or a member's healthcare provider may request an urgent care appeal either orally or in writing. The member or the member's healthcare provider requesting the urgent care appeal may contact GHP by telephone, fax or other methods that will expedite receipt of the information by GHP. GHP will contact the requestor by telephone, fax or other prompt method to resolve the member's appeal. GHP will provide a full and fair review of the appeal.

Review of an urgent care appeal:

GHP shall perform an urgent care appeal review and render a decision within 72 hours of receipt of the member's request. The member shall be responsible to provide information to GHP in an expedited manner to allow GHP to conform to the urgent care appeal requirements. The Urgent Care internal review committee shall be comprised of three or more individuals one of which is a licensed physician, who did not previously participate in the decision to deny coverage or payment for the service and who are not subordinates of the person(s) who made the adverse benefit determination. The urgent care appeal review shall include the written input and/or presence of a licensed physician or approved licensed psychologist in the same or similar specialty that typically manages or consults on the healthcare service, condition, performs the procedure, or provides the treatment and who was not previously involved in the matter under review. **GHP shall provide the member with written notification of GHP's decision that shall include:**

a) The basis for the decision in easily understandable language

b) Reference to the specific GHP provisions on which the decision is based

c) Notification of the fact that the member is entitled to receive, upon verbal or written request and free of charge, copies of all documents, records and other information relevant to the appeal including instructions for requesting a written statement of clinical rationale including clinical review criteria used, if applicable

d) Notification that the member may request assistance with their appeal from the applicable state's Office of Health Insurance Consumer Assistance

e) The member may have the right to request an external appeal review conducted by an independent review organization

External review procedure:

If an external review is warranted, BMC will assign an IRO as required by and in accordance with all applicable state and federal regulations. The plan will provide all the necessary documents and information considered in making the final adverse benefit determination to the external IRO by any available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents as set forth in Section 5.4.1.2. In reaching a decision, the IRO will review the claim de novo and shall not be bound by any decisions or conclusions reached during GHP's internal appeal procedures.

Notice of the final external review decision:

The IRO will provide notice of the final external review decision as expeditiously as the member's medical condition requires, but in no event later than 72 hours after the IRO receives a request for an expedited external review.

a) The member's medical records
b) The attending healthcare professional's recommendation
c) Reports from appropriate healthcare professionals and other documents submitted by the plan, member, or the member's treating provider
d) The terms of the member's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law
e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
f) Any applicable clinical review criteria developed and used by the plan unless the criteria are inconsistent with the terms of the plan or with applicable law
g) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this section 5.4.1.2 to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate

Time frame for decision:

The IRO will provide written notice of the final external review decision to the member and the plan within 45 days after the IRO receives the request for external review. The decision will be in writing and will include the following:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates claim amount (if applicable), the diagnosis code and its corresponding meaning, and the reason for the previous denial)
b) The date the IRO received the assignment to conduct the external review and the date of the IRO's decision
c) References to the evidence or documentation including the specific coverage provisions and evidence-based standards, considered in reaching its decision
d) A discussion of the principal reason for its decision, including the rationale for its decision and evidence-based standards that were relied on in making its decision
e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either GHP or the member
f) A statement that judicial review may be available to the member
g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

Binding decision:

The member and GHP will be bound by the final decision of the IRO except to the extent that other remedies are available under State or Federal law. The requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require payment or benefits. The plan must provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external decision and unless or until there is a judicial decision.

Expedited external grievance/adverse benefit determination review procedure:

The member or the healthcare provider with the member's written consent, who is dissatisfied with the decision of the plan's expedited grievance review may appeal orally or in writing to the plan within two business days of receipt of the expedited grievance review decision.

Note: Under certain circumstances, which will be outlined to the member in the plan's appeal correspondence, an expedited external review may be requested at the same time the member requests an expedited appeal.

Preliminary review:

If GHP determines the expedited external review request meets the expedited external grievance requirements, notice will be sent to the member within one business day after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information. If the request is not complete, the notification will describe the information or materials needed to make the request complete.

External review procedure:

If an external review is warranted, BMC will assign an IRO as required by and in accordance with all applicable state and federal regulations. The plan will provide all the necessary documents and information considered in making the final adverse benefit determination to the external IRO by any available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents as set forth in Section 5.4.1.2. In reaching a decision, the IRO will review the claim de novo and shall not be bound by any decisions or conclusions reached during GHP's internal appeal procedures.

Notice of the final external review decision:

The IRO will provide notice of the final external review decision as expeditiously as the member's medical condition requires, but in no event later than 72 hours after the IRO receives a request for an expedited external review.

Notice of the final external review decision:

The IRO will provide notice of the final external review decision as expeditiously as the member's medical condition requires, but in no event later than 72 hours after the IRO receives a request for an expedited external review.

If the notice from the IRO to the member is not in writing, within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the member and GHP.

1293084 lew 11/23

Discrimination is against the law

Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company (the "Health Plan") comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the Health Plan at 800-447-4000 or TTY: 711.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Grievance Coordinator
Geisinger Health Plan Appeals Department
100 North Academy Avenue, Danville, PA 17822-3220
Phone: 866-577-7733, TTY: 711
Fax: 570-271-7225
GHPCivilRights@thehealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-447-4000 or TTY: 711.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-447-4000 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-447-4000（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-447-4000 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-447-4000 (телетайп: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-447-4000 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-447-4000 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-447-4000 (رقم هاتف الصم والبكم:711.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-447-4000 (ATS : 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-447-4000 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800-447-4000 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-447-4000 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-447-4000 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-447-4000 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-447-4000 (TTY: 711).

Geisinger

100 N. Academy Ave.
Danville, PA 17822-3220

HPM50 njp
GHP HMO PPO TYSK 2023
dev. 11-21

1293525 lew 12/23