

Section 11: Glossary and Acronyms

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Glossary

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

Ambulatory Surgical Center: A facility or portion thereof not located upon the premises of a hospital which provides specialty or multi-specialty outpatient surgical treatment. This does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

Ambulatory Surgical Center Provider: An ambulatory surgical center licensed, certified or otherwise regulated under the laws of the state in which it operates, that has an agreement with the Health Plan to provide Covered Services to Members.

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

Benefit Document(s): The Subscription Certificate, Schedule of Benefits and any Rider(s) thereto and/or Summary Plan Document which sets forth the terms, conditions and benefits of coverage for Members enrolled in Geisinger Health Plan, Company, Geisinger Quality Options or an Employer-Sponsored Program, as applicable.

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

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

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

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

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

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

Company: Shall mean Geisinger Indemnity Insurance Company.

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

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

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

Covered Person: An individual eligible to receive Covered Services or other benefits under the terms of the applicable Benefit Documents as the Subscriber or an eligible enrolled family dependent. A Covered Person may also be referred to as a Member.

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

Customer Service Team (CST): The Health Plan representatives who can answer Member and Health Care Provider questions and provide information regarding the Health Plan and a Member's Coverage. The telephone number for the Customer Service Team is set forth on the back of the Member's Identification Card.

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

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

Durable Medical Equipment: Equipment designed to serve a medical purpose and which is not generally useful for a Member in the absence of illness or injury, is able to withstand repeated use, is appropriate for use in the home and is not a disposable supply.

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

Emergency Services: Any Health Care Service provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member, or, with respect to a pregnant women, the health of the Member or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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

Employer: An employer who has an agreement with Company for the provision of third party administrative services by Company, and access to Health Plan's Network for Employer's health benefits plan(s).

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

Formulary: A continually updated list of prescription medications that represents the current covered drugs by Health Plan based upon the clinical judgment of Geisinger Health Plan's Pharmacy and Therapeutics Committee. The Formulary contains both brand name drugs and generic drugs, all of which have been approved by the Federal Food and Drug Administration (FDA).

Formulary Committee: A committee comprised of physicians, pharmacists and administrative staff which makes recommendations regarding Formulary decisions.

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

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

Governmental Agency: Shall refer to the Pennsylvania Departments of Health, Insurance or Public Welfare, the Centers for Medicare and Medicaid Services or other government departments or their respective agents with direct responsibilities to access records for the purpose of quality assurance, investigation of Complaints or Grievances, enforcement or other activities related to compliance with applicable laws and regulations and shall specifically include the National Committee for Quality Assurance, as applicable.

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

Group: The employer, association, union or trust through which the Subscriber is enrolled.

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

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law, as may be amended from time-to-time, including, but not limited to, the following: a) limiting exclusions for pre-existing conditions (as defined under HIPAA); b) prohibiting discrimination against employees and dependents based on their health status; c) guaranteeing renewability and availability of health coverage to certain employers and individuals; d) protecting certain Members who lose Group health coverage by providing access to individual health insurance coverage; and e) regulating the use and disclosure of protected health information.

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

Health Plan: Shall refer to Geisinger Health Plan, Geisinger Indemnity Insurance Company and Geisinger Quality Options, Inc. collectively.

Home Health/Hospice Provider or Home Health Provider or Hospice Provider: A Medicare-certified agency under agreement with Health Plan which provides: (i) intermittent skilled nursing services and other therapeutic services in a Member's home when Medically Necessary; and when authorized by a Participating Provider unless otherwise permitted in accordance with the terms and conditions set forth in a Member's Benefit Document; and/or (ii) hospice services, as applicable. A Home Health/Hospice Provider or Home Health Provider or Hospice Provider must be Medicare-certified in order to render care to a Gold Member.

Home Health Services: Medically Necessary Health Care Services, which are: (i) rendered in the Member's place of residency by health care personnel; (ii) referred to a Home Health Provider by the Home Health/Hospice Management Department; (iii) provided in accordance with the Member's Benefit Document; (iv) rendered in accordance with a treatment plan established by a Home Health Provider and a Member's physician; or if so required by the terms and conditions of coverage set forth in a Member's Benefit Document, by a Member's physician Participating Provider; and (v) authorized by the Home Health/Hospice Network. Home Health Services may include the administration of Home Infusion, as applicable.

Hospice means a Covered Service rendered by a Preferred Provider who is licensed as a provider of Hospice services in the Commonwealth of Pennsylvania and is a certified provider of Hospice services under Medicare.

Hospice Services: Medically Necessary Health Care Services which are: (i) referred to a Hospice Provider by the Home Health/Hospice Management Department; (ii) provided in accordance with a Member's Benefit Document; (iii) rendered in accordance with a Plan of Care established by a Hospice Provider and a Member's physician; or if so required by the terms and conditions of coverage set forth in a Member's Benefit Document, by a Member's physician Participating Provider and authorized by the Home Health/Hospice Management Department; (iv) rendered for conditions related to the Terminal Illness; and (v) provided in accordance with the Member's executed advance directive.

Hospital: An institution which: (i) provides diagnostic, surgical and therapeutic services for the diagnosis, treatment and care of injured or ill persons by or under the supervision of physicians; and (ii) is licensed, certified or otherwise regulated to provide such services and to operate as a hospital under the laws of the state in which it operates and/or federal laws, as applicable. The term "Hospital" does NOT include a Skilled Nursing Facility, convalescent nursing home, custodial care home, health resort, spa or sanitarium. A Hospital must be Medicare-certified in order for a Gold Member to receive care at the Hospital.

Hospital Provider: A Hospital that has an agreement with Health Plan to provide Covered Services to Members.

Hospital Services: The Covered Services to be provided by Hospital Provider to Members as set forth in the Agreement.

Identification Card: The card issued by Health Plan to identify Members enrolled in Geisinger Health Plan, Company Geisinger Quality Options, Inc. or an Employer Sponsored Program. Possession of an Identification Card confers no right to Covered Services or other benefits under

Health Plan or an Employer-Sponsored Program. To be entitled to Covered Services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under the Benefit Documents have actually been paid; or with respect to an Employer-Sponsored Program, be an enrolled Member on whose behalf all amounts due to Company have been paid by an Employer.

Intermediate Care: A level of care that is less than the degree of care and treatment that Skilled Nursing Facility is designed to provide, but greater than the level of room and board.

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

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

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

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

Member: An individual eligible to receive Covered Services or other benefits under the terms of the applicable Benefit Documents as the Subscriber or an eligible enrolled family dependent. A Member may also be referred to as a Covered Person.

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

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

Non-Gatekeeper Product: A Health Plan product which does not require its Members to pre-select a Primary Care Physician.

Observation Services: Those certain outpatient services furnished by Participating Provider to Members that include the use of a bed and periodic monitoring by Participating Provider's nursing or other staff which are reasonable and necessary to monitor a Member's condition; or to determine the need for a Member's admission to Participating Provider as an inpatient. Observation Services may be extended beyond twenty-three (23) hours upon advance authorization by the Health Plan Medical Director.

Orthotic Device: A device which is a rigid appliance or apparatus used to support, align or correct bone and muscle deformities.

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

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

Policy: The certificate and/or agreement, as may be amended, which sets forth the terms, conditions and benefits of coverage, as awarded by the Health Plan to its Members, as applicable. A Policy may also be referred to as a Subscription Certificate.

Policy Holder: An individual who meets the requirements for eligibility, who has enrolled in the Health Plan, and for whom payment has actually been received by the Health Plan. A Subscriber is also a Member. A Policy Holder may also be referred to as a Subscriber.

Preferred Health Care Provider or Preferred Provider: A Health Care Provider that has an agreement with PPO to provide Covered Services to Members. PPO contracts with a national provider network of professionals and facilities. Preferred Providers within such national preferred provider organization shall not be Preferred Health Care Providers or Preferred Providers unless otherwise provided by the PPO. Please refer to the Provider List or contact the Customer Service Team at the number set forth on the back of the Member's Identification Card for a listing of Preferred Providers.

Protected Health Information ("PHI"): Individually Identifiable Health information (as defined by HIPAA), whether oral or transmitted by electronic media, maintained by electronic media or transmitted or maintained in any form or medium, including demographic information collected from an individual, and a.) created or received by a Health Care Provider, the Health Plan, employer or health care clearinghouse; and b.) relates to the past, present or future physical or mental condition of an individual, as well as the provision of health care to an individual or the past, present or future payment for the provision of healthcare to an individual and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

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

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

Primary Care Site: The medical office, health center, or other facility, or a designated department of a medical facility, staffed by one or more Primary Care Physicians, and designated a Primary Care Site by Health Plan.

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

Prosthetic Device: A device, which is an externally worn appliance or apparatus, which replaces a missing body part.

Provider List: A published listing (as amended from time to time) provided to Members by the Health Plan which sets forth the names, addresses and telephone numbers of current Providers who have contracted with the Health Plan to provide Covered Services. The current Provider List can be found on the Health Plan's website (www.thehealthplan.com) or obtained by calling the Customer Service Team at the number on the back of the Member's Identification Card.

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

Rider: A document that sets forth the terms and conditions for coverage of certain Supplemental Health Services in effect for the Subscriber and all family dependents enrolled under the Subscription Certificate.

Schedule of Benefits: A summary of coverage for a Member that identifies the Subscriber, applicable Copayment, Deductible and Coinsurance amounts for Covered Services and any Riders in force of the Benefit Documents.

Self-Referred Service: A Covered Service which is received from a: (i) Participating Provider that have not been delivered, prescribed or authorized in advance by the Member's Primary Care

Physician or Medical Director; or (ii) non-Participating Provider without prior authorization by the Health Plan.

Service Area: The counties where Health Plan is licensed to operate by the Pennsylvania Department of Health, as may be amended from time to time.

Skilled Nursing Facility (SNF): A facility which: (i) provides inpatient skilled nursing care, rehabilitation services or other related health services; (ii) is licensed, certified or otherwise regulated to provide such services under the laws of the Commonwealth of Pennsylvania; and (iii) is certified by Medicare. The term Skilled Nursing Facility does NOT include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in activities of daily living.

Skilled Nursing Facility (SNF) Provider: A Skilled Nursing Facility that has an agreement with Health Plan to provide Covered Services to Members.

Skilled Nursing Facility (SNF) Services– Skilled Nursing Facility (SNF) Services are certain Medically Necessary skilled health care services which: (i) consist of comprehensive, inpatient care designed for the medically stable Member who requires skilled nursing or skilled rehabilitation services as identified by the then current industry-standard medical review criterion in use by Health Plan including, but not limited to, Interqual and Medicare guidelines; (ii) are covered under the terms of a Member’s applicable Benefit Document; and (iii) are for Gatekeeper Product Members, when authorized by a Primary care Physician of such Member’s Primary Care Site or the Medical Director unless otherwise permitted in accordance with the terms and conditions of coverage set forth in the Member’s Benefit Document. SNF Services do not include custodial, convalescent or domiciliary care.

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

Specialist: A Health Care Provider whose practice is not limited to primary health care services and who has additional postgraduate or specialized training, board certification or practices in a licensed specialized area of health care.

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

Subscriber: An individual who meets the requirements for eligibility, who has enrolled in the Health Plan, and for whom payment has actually been received by the Health Plan. A Subscriber is also a Member. A Subscriber may also be referred to as a Policy Holder.

Subscription Certificate: The certificate and/or agreement, as may be amended, which sets forth the terms, conditions and benefits of coverage, as awarded by the Health Plan to its Members, as applicable. A Subscription Certificate may also be referred to as a Policy.

Summary Plan Document (SPD): An Employer document which sets forth the terms, conditions and benefits of coverage for Members enrolled through an Employer-Sponsored Program.

Supplemental Health Services: Benefits of coverage provided under the Riders listed on the Schedule of Benefits.

Technology Assessment Committee: A committee of clinicians and/or other individuals, which review new or presently non-covered medical equipment, procedures and treatments in order to, among other things, advise the Health Plan on the experimental or non-experimental nature of any equipment, procedure or treatment and/or appropriate coverage status of any equipment, procedure treatment.

Tel-A-Nurse (TANS): A twenty-four (24) hour per day, toll free telephone number for Members to access nurse advice. The toll free telephone number is set forth on Member's Identification Card. Tel-A-Nurse is not an authorized agent for purposes of coverage determination or appointment scheduling.

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

Urgent Care: Any Covered Health Care Service provided to a Member in a situation, which requires care within twenty-four (24) hours. Urgent Care does not rise to the level of an Emergency as it allows the Member and provider to consider alternative settings of care.

Acronyms

ALJ: Administrative Law Judge
ASC: Ambulatory Surgical Center
ATOD: Alcohol, Tobacco and/or Drugs
CCM: Catastrophic Case Management
CHAP: Community Health Accreditation Program
CHDR: Center for Health Dispute Resolution
CHF: Congestive Heart Failure
CME: Continuing Medical Education
CMN: Certificate of Medical Necessity
CMS: Center for Medicare and Medicaid Services
COB: Coordination of Benefits
COPD: Chronic Obstructive Pulmonary Disease
CPC: Clinical Practice Committee
CPT®: Physician's Current Procedural Terminology
CRDQ: Chronic Respiratory Disease Questionnaire
CRMS: Care Enhance Resource Management System
CST: Customer Service Team
DAB: Department Appeals Board
DEC: Diagnostic Equivalent Category
DME: Durable Medical Equipment
DOH: Pennsylvania Department of Health
DOI: Pennsylvania Department of Insurance
DRG: Diagnostic Related Groups
EDI: Electronic Data Interchange
EOP: Explanation of Payment
ERISA: Employee Retirement Security Income Act of 1974
HAC: Hospital Acquired Condition
HAP: Hospital and Health System Association of Pennsylvania
HEDIS®: Health Plan Employer Data and Information Set
HHS: Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act of 1996
HIPPS: Health Insurance Prospective Payment System
HMO: Health Maintenance Organization
ICD-9-CM: International Classification of Disease, 9th Edition
INR: International Normalized Ratio
JCAHO: Joint Commission on Accreditation of Health Care Organizations
LCM: Large Case Management
LOB: Line of Business
LOS: Length of Stay
MCE: Medical Care Evaluations
MDS: Minimum Data Set
MHAC: Modified Health Assessment Questionnaire

MI: Myocardial Infarction
MMT: Manual Muscle Tone
NCQA: National Committee for Quality Assurance
NOMNC: Notice of Medicare Non-Coverage
OPM: Office of Personnel Management
PCF: Personal Care Facility
PCP: Participating Primary Care Physician
PDCA: Plan, Do, Check, Act
PNM: Provider Network Management
POA: Present on Admission
POS: Point of Service
PPO: Preferred Provider Organization
PRA: Predictive Resource Assessment
PRO: Peer Review Organization
QI: Quality Improvement
QIO: Quality Improvement Organization
QIC: Quality Improvement Committee
RUG: Resource Utilization Group
SCP: Participating Specialty Care Provider
SNF: Participating Skilled Nursing Facility
SPD: Summary Plan Document
TPA: Third Party Administrator
TSI: Transition Systems Inc.
UCR: Usual, Customary, Reasonable Fee
UM: Utilization Management
USPHTF: United States Preventive Health Task Force