



GlobalHealth

2017
Provider
Manual



GlobalHealth, Inc.
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Oklahoma City, OK 73104-5403
www.GlobalHealth.com

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Welcome to GlobalHealth

This Provider Manual is a reference tool which describes GlobalHealth Holdings, LLC (“GlobalHealth”) policies and procedures and is designed to assist you, the provider, as a participating Provider in the GlobalHealth Network. Please read this document carefully as it contains meaningful information that will help us work together more efficiently and effectively. It is important for you to know the GlobalHealth processes.

GlobalHealth will keep you informed of important changes in our policies, procedures, and benefits. The Provider Manual is available on the Provider Tab of the GlobalHealth site, www.GlobalHealth.com

This Provider Manual is intended for use by GlobalHealth Holdings participating Providers and Practitioners only and is incorporated by reference as a part of your contract with GlobalHealth. Therefore, your reimbursement may be affected by your compliance with the contents herein. The information contained in this Provider Manual is strictly confidential and proprietary to GlobalHealth and may not be copied in whole or part or distributed without the express written consent of GlobalHealth.

GlobalHealth does not discriminate on the basis of race, ethnicity, national origin, religion, gender or gender identity, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the Service Area. No oral statement shall add or take away any benefits, limitations, or exclusions, under this Plan.

See the Glossary for definitions of capitalized words and phrases.

Our Mission

- We are driven by our passion to deliver the best healthcare coverage in the industry
- We are committed to continuous innovation and comprehensive member engagement to earn the satisfaction and confidence of those we serve.
- We aspire to earn and retain our provider’s confidence and trust in us.
- We believe in developing and maintaining valued relationships with our partners.

GlobalHealth Products

GlobalHealth is fully licensed by the State of Oklahoma as a health maintenance organization (“HMO”).

Commercial

GlobalHealth provides affordable healthcare coverage for federal, state, education, and local government employees, and private companies in the large and small group markets. GlobalHealth commercial Plans are available in all 77 counties in Oklahoma.

Medicare Advantage

Medicare Advantage Plans combine the insurance benefits of Medicare parts A, B and D with the customer service and care of a consumer-focused health maintenance organization. Generations

Healthcare (HMO) was added to the GlobalHealth Medicare Advantage products on October 1, 2014. Generations Healthcare (HMO) received a 3.5 Overall Star Rating from Medicare for 2016. In January 2017, GlobalHealth combined the Medicare Advantage products under the Generations name. GlobalHealth Medicare Advantage products are available in 44 counties across Oklahoma.

These products require Members to select a Primary Care Physician ("PCP") and does not have Out-of-Network benefits, except in emergent, urgent or prior authorized circumstances.



Visit the GlobalHealth website at: www.GlobalHealth.com

Select the Provider Tab for various forms and reference materials.

Helpful Numbers and Information

Provider Services

Phone (405) 280-5300
Toll Free (866) 277-5300
Fax (405) 280-5251
Email provider.relations@globalhealth.com
Hours 8:00 AM – 4:00 PM
Closed 12 PM – 1:00 PM Daily

Contracting/Provider Relations

Phone (405) 280-5300
Toll Free (866) 277-5300
Fax (405) 280-5251
Email ghcontracting@globalhealth.com

Credentialing

Phone (918) 878-7319
Fax (918) 878-7350
Email ghcredentialing@globalhealth.com

Medical Management (UM)

Phone (405) 280-5300
After Hours (405) 819-7574
Toll Free (866) 277-5300
Fax (405) 280-5398
Email um@globalhealth.com

Quality Improvement

Phone (405) 280-5600
Fax: (405) 280-5641
Email quality@globalhealth.com

Claims Status

Use **GlobalLink™**
www.globalhealth.com/globalink.aspx

MHNet-Behavioral Health

Phone (866) 904-5234
TTY/ TDD/ Voice-1-866-200-3269

Claims Processing

Phone (405) 280-5300
(Closed 12:00 PM – 1:00 PM Daily)
Toll Free (866) 277-5300
Email ediclaims@globalhealth.com

Commercial Claims Submission

GlobalHealth, Inc.
Attn: Claims
P.O. Box 2328
Oklahoma City, OK 73101-2383

Medicare Advantage Claims Submission

GlobalHealth, Inc.
Attn: Claims
P.O. Box 1747
Oklahoma City, OK 73101-1747

Commercial Pharmacy

Phone (918) 878-7361
Fax (405) 280-5613
Email gh.pharmacy@globalhealth.com

Medicare Pharmacy: CVS Caremark

Phone: Toll Free: (866)-364-6331

Compliance

Phone (405) 280-5852
Toll Free Hotline (877) 280-5852
Email compliance@globalhealth.com

Privacy/HIPPA

Phone (405) 280-5524
Toll Free Hotline (877) 280-5852
Email privacy@globalhealth.com

Eligibility & Enrollment

Phone (405) 280-5300
Toll Free (866) 277-5300
Fax (405) 280-5881
Email edienrollment@globalhealth.com

Tulsa Office

6120 South Yale Ave, Suite 925
Tulsa, OK 74136-4216

Main Office

701 N.E. 10th Street, Suite 300
Oklahoma City, OK 73104-5403

GlobalLink™ Information

GlobalLink™ is an online tool available to all contracted Providers. GlobalLink™ is provided to allow Providers to:

- Verify eligibility
- Review Member Demographics
- View benefit information
- Create Referrals
- Check Preauthorization/ referral review status
- Check claim status
- Communicate with GlobalHealth

GlobalLink™ is available 24 hours a day, 7 days a week.

You may access information about GlobalLink™ on our website on the Providers tab or at:

www.globalhealth.com/globallink.aspx

Providers can submit an access request for access to GlobalLink™ on our website on the Provider Tab or at:

www.globalhealth.com/globallink_access_request.aspx

GlobalLink™ Support

For user access questions, please contact the GlobalHealth Provider Services department:

Phone (405) 280-5300

Toll Free (866) 277-5300

Fax (405) 280-5251

Email globallink.access@globalhealth.com

Hours 8:00 AM -- 4:00 PM

Closed 12 PM –1:00 PM Daily

For technical issues with GlobalLink™, such as forgotten passwords or error messages, please contact the GlobalHealth IT Help Desk:

- Local (OKC): 405-280-5647
- E-mail: helpdesk@globalhealth.com

Getting Care

As an HMO, GlobalHealth encourages its Members to take an active role in their healthcare by utilizing preventive services, collaborating with their Primary Care Provider in healthcare decisions and utilizing the PCP to coordinate care with specialists.

Member ID Cards

GlobalHealth will provide Member ID cards at the beginning of the Plan year. It should be presented each time the Member seeks care from a participating Provider. If a GlobalHealth Member fails to present an identification card, please contact us to verify the Member's eligibility. Eligibility can be verified by contacting Customer Care between the hours 8:00 AM and 5:00PM Central Time Monday through Friday. After regular business hours, Providers may call the UM afterhours number: (405) 819-7574.

It is essential to verify Member eligibility because:

- Employer groups may change benefit Plans
- Member benefits may change
- Copayments must be determined
- Fraudulent use may occur

Note: The Member ID card does not guarantee coverage or entitlement to benefits.

GlobalHealth Member ID Card:

Front of Card

1. Coverage ID number
2. Group ID number
3. Member ID number
4. The selected PCP
5. PCP phone number
6. PCP effective date
7. Relationship code to Subscriber
8. Copayment and benefit information


Back of Card

1. What to do in case of a life-threatening emergency
2. Routine and Urgent Care information
3. How to reach GlobalHealth's Customer Care Department including phone number, office hours, and claims address. *

* Commercial cards may have different contact information based on Plan.


Commercial Plan

Pre-authorization required. See back of card for instructions.



COVERAGE ID **123456**
 CVG EFFECTIVE DATE **42522**
 GROUP# **12345**

12345678900, DOB:
 PCP: () EFF:
12345678900 Johnathan Smith DOB: 03/12/1976
 PCP Name: Johnathan Smith
12345678900 Johnathan Smith DOB: 03/12/1976
 PCP Name: Johnathan Smith
12345678900 Johnathan Smith DOB: 03/12/1976
 PCP Name: Johnathan Smith
12345678900 Johnathan Smith DOB: 03/12/1976
 PCP Name: Johnathan Smith
12345678900 Johnathan Smith DOB: 03/12/1976
 PCP Name: Johnathan Smith
12345678900 Johnathan Smith DOB: 03/12/1976
 PCP Name: Johnathan Smith

(Health) (Prescription - Retail)  RxGRP JJ2A RxBIN 003858 RxCN A4
 PCP / SPEC / ER Gen / Brand / Non-Formulary \$50 / / \$50 /
 HPID: CARD ISSUANCE:



PHCS
Outside Year Service Area


EXPRESS SCRIPTS*

Customer Care:
 1-877-280-5600 (TOLL-FREE)
 1-405-280-5600 (LOCAL)
 711 (TTY)
 www.globalhealth.com
Send Claims or other inquires to:
 P.O. Box 2328
 Oklahoma City, OK 73101-2328

Customer Care:
 1-866-274-1612 (MEMBERS)
 1-800-824-0898 (PHARMACIES USE)
 1-800-899-2114 (TTY/DD)
Send pharmacy claims to:
 Express Scripts, Inc.
 P.O. Box 66583
 St. Louis, MO 63166

Healthcare Providers - This card is for member identification and does not guarantee eligibility. Other than emergency care and urgently needed care, non-PCP and non-plan providers must have specific advance authorization from GlobalHealth.

Medicare Advantage with Drug Plan



MedicareRx
Prescription Drug Coverage

Issuer: 47303
 PBP:
 Member ID:
 Member Name: ,
 PCP Name:
 PCP Phone:

Copayments
 PCP SPEC ER H3706-
 \$50 \$50 \$50 Effective: 42522



CVS caremark
Customer Care:


1-844-280-5555 (TOLL-FREE)
 1-405-280-5555 (LOCAL)
 711 (TTY)

Send Claims or other inquires to:
 P.O. Box 2328
 Oklahoma City, OK 73101-2328

Customer Care:
 866-494-3927 (MEMBERS USE)
 800-364-6331 (PHARMACIES USE)
Send Pharmacy Claims to:
 CVS Caremark
 P.O. Box 52066
 Phoenix, AZ 85072-2066

www.GlobalHealth.com/medicare

Medicare Advantage without Drug Plan



Issuer: 47303
 PBP:
 Member ID:
 Member Name: ,
 PCP Name:
 PCP Phone:

Copayments
 PCP SPEC ER H3706-
 \$50 \$50 \$50 Effective: 42522



Customer Care:
 1-844-280-5555 (TOLL-FREE)
 1-405-280-5555 (LOCAL)
 711 (TTY)

Send Claims or other inquires to:
 P.O. Box 2328
 Oklahoma City, OK 73101-2328

www.GlobalHealth.com/medicare

IMPORTANT!

The PCP shown on the card must approve in advance all non-Emergency Medical Services provided to the Member in order for the Member to be covered by GlobalHealth, except for the services the Member can obtain by self-referral. See section on Self-referral/Services Not Requiring Prior Authorization.

Physicians should not see Members for primary care services if they are not listed as the PCP on the Member's card, unless GlobalHealth has authorized the visit or service in advance or they are providing coverage for the listed PCP.

Primary Care Physician (PCP)

All GlobalHealth Members must choose a PCP. The PCP is the Member's first contact for all his or her healthcare needs. The PCP manages the Member's total healthcare program by providing a broad range of services and arranging and coordinating for specialty care when necessary.

A contracting PCP must practice in one of the following fields: Family practice, pediatrics, general practice or internal medicine. Internal medicine physicians must spend ninety percent (90%) of their time practicing family medicine to be eligible to contract with GlobalHealth as a PCP.

Responsibilities of the PCP

1. Manage the Member's total healthcare program. This includes health supervision, basic treatment, initial diagnosis, management of Chronic Conditions, and preventive health and wellness services.
2. Educate Members regarding their healthcare needs.
3. Communicate freely with patients about their treatment, regardless of benefit coverage limitations.
4. Coordinate healthcare with specialists or healthcare facilities when such care is needed, including obtaining authorization from GlobalHealth for Medically Necessary Referrals. (The PCP should always refer Members to GlobalHealth participating Providers and Facilities, unless the services are not available within the GlobalHealth Network.)
5. Provide Medically Necessary services in accordance with the GlobalHealth contract, the applicable benefit Plan, GlobalHealth policies and procedures, and requirements in the Provider Manual.
6. Discuss all treatment alternatives, risks, and benefits with Members, including the risks/benefits of receiving no treatment, recognizing that the Member makes the final decision concerning his or her preferred treatment option.
7. Provide complete information on authorized care or services to the referred specialist.
8. Provide medical care coverage for assigned patient panel 24-hours per day, seven days per week within GlobalHealth's established Network of Providers.
9. Participate in and cooperate with GlobalHealth's Utilization Management and Quality Improvement Programs and activities.
10. Allow GlobalHealth to use Practitioner performance data.
11. Maintain appropriate medical records to document all services provided to Members.
12. Complete the Provider Update Form found at www.GlobalHealth.com, Provider Tab within 30 days when any of the following information changes:
 - Tax ID number
 - NPI
 - Address
 - Telephone or fax number
 - Name change
 - New Location
 - Limitations/Restrictions to practice
13. Shall not discriminate in the delivery of healthcare services and shall accept for treatment any Member in need of the healthcare services they provide.
14. Submit accurate claims to GlobalHealth for services rendered to GlobalHealth Members in accordance with the specified contractual time frame.

PCP Panel Status

Notify GlobalHealth at provider.relations@globalhealth.com if there is a change in your panel status.

Open

Physician will accept any GlobalHealth Member, whether new or established.

Established Members Only

Physician may close his/her practice to new Members by notifying GlobalHealth. This option allows only patients currently seeing that physician to select him/her as a PCP. If a Member incorrectly selects an “established Members only” physician, the PCP must notify GlobalHealth as soon as possible. GlobalHealth will then assist the Member in selecting an available PCP.

Not Accepting Any Members (Closed)

Physicians who have a full practice may close their practice to all new GlobalHealth Members. Physicians who request to be listed as “not accepting any Members” will not be assigned new GlobalHealth Members.

Members Changing PCP

Members are allowed to change their PCP any time. The change will be effective right away.

We recommend against Members changing their PCP if the change could have an adverse effect on their quality of health care. For example:

- The Member is an organ transplant candidate.
- The Member has an unstable, acute medical condition for which they are receiving active medical care.
- The Member is in the third trimester of pregnancy.

Specialty Care Physician (“SCP”)

A physician specialist focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain types of symptoms and conditions. An SCP provides certain specialty medical care upon Referral from the Primary Care Physician and authorization by GlobalHealth.

SCP Responsibilities

1. Accept and treat GlobalHealth Members referred by their PCP and authorized by GlobalHealth.
2. Provide only those services authorized by the Member’s PCP and GlobalHealth. If additional Medically Necessary tests or treatments are needed beyond those initially authorized, specialist may seek additional authorization from GlobalHealth and notify the Member’s PCP.
3. Educate patients regarding their health needs and share findings of the Member’s physical exam and treatments with the PCP.
4. Communicate freely with patients about their treatment, regardless of benefit coverage limitations.

5. Provide Medically Necessary services in accordance with the GlobalHealth contract, the applicable benefit Plan, GlobalHealth policies and procedures, and requirements specified in the Provider Manual, Member Handbook, FEHB Brochure, or Evidence of Coverage.
6. Discuss all treatment alternatives, risks, and benefits with Members; including the risks/benefits of receiving no treatment, recognizing that the Member makes the final decision concerning his/her preferred treatment option.
7. Comply with all GlobalHealth pre-authorization requirements.
8. Use only GlobalHealth participating Providers and Facilities for services for the Member.
9. Submit accurate claims to GlobalHealth for services rendered to GlobalHealth Members in accordance with the specified contractual time frame.
10. Participate in and cooperate with GlobalHealth's Utilization Management and Quality Improvement Programs activities.
11. Allow GlobalHealth to use Practitioner performance data.
12. Provide a written report to the Member's PCP within ten (10) days of completing the consultation/treatment/procedure – or sooner if medically indicated.
13. Maintain adequate medical records to document all services provided to Members.
14. Assist GlobalHealth in determining Coordination of Benefits ("COB") issues with other carriers or payers.
15. Complete the Provider Update Form found at www.GlobalHealth.com, Provider Tab within 30 days when any of the following information changes:
 - Tax ID number
 - NPI
 - Address
 - Telephone or fax number
 - Name change
 - New Location
 - Limitations/Restrictions to practice
 - Adding or deleting a physician from a group practice
16. Shall not discriminate in the delivery of healthcare services and shall accept for treatment any Member in need of the healthcare services they provide.

Provider Accessibility

GlobalHealth is required to notify all Network Physicians that under CFR 422.11(a)(7), they are required to:

Provide services, both clinical and nonclinical, that are readily available, accessible, and appropriate, when medically necessary (24 hours a day/7 days a week) to all enrollees, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. Services include access to specialty care such as women's health services.

Our providers are responsible for assuring access to services 24 hours a day, 365 days a year other than in emergency room for non-emergent conditions. This includes arrangements to assure patient awareness and access afterhours to another participating provider or if the Provider is unavailable beyond the accessibility standards. Referring a Member to the ER should not be used for routine services and non-emergency situations. An Urgent Care Facility or office visit might be an appropriate alternate option.

GlobalHealth recommends that Providers use one of these methods to assist Members after regular business hours:

- A professional answering service that contacts you or the provider covering for you.
- A high-quality voice mail system that tells Members:
 - How to reach you or your covering Provider in an emergency, including phone numbers
 - What to do in an emergency

GlobalHealth contracted Network Providers are required to provide services per the following standards:

Primary Care - Medical:

Type	Access Standard	Examples
Emergency	Immediate appointment or Member is directed to nearest emergency room or call 911	Major trauma, laceration, eye injury, musculoskeletal injury, chest pain. Prudent Layperson: absence of medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part.
Urgent Care	Within 24 hours	Minor trauma, sprain, high temperature, persistent diarrhea and vomiting. Prudent layperson, unexpected illness or injury that is not an emergency, but severe enough or painful enough to require treatment within 24 hours.
Post-acute (Inpatient or emergency room) Discharge	Within 7-30 <u>calendar</u> days of discharge	Update care plan, coordinate care with any specialist(s), obtain labs and reconcile medications
Symptomatic, Non-Urgent	Within 7 business days of request	Flu, cold, headaches, rashes, sore throat
Routine/Regular Care	Within 30 business days of request	Follow- up appointments for asthma, blood pressure checks, diabetes.
Annual Wellness/ Preventive care	Within 30 business days of request	Annual wellness or school activity exam, well-child exam, Preventive Care. Update care plan, coordinate care with any specialist(s), obtain labs and reconcile medications

Return Phone Calls (business hours)	Within 1 business day	
After-hours	Respond within 1 hour or messaging instructs Members on available services	Call for emergency RX refill, advise best course of action, which may include Urgent Care or emergent care

High Volume and High Impact Specialists

GlobalHealth identifies the following Providers as high volume and/or high impact specialists:

- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- General Surgery
- Neurology
- OB/GYN
- Oncology
- Ophthalmology
- Optometry
- Orthopedic Surgeons
- Pediatricians
- Psychiatry
- Pulmonology
- Radiology

GlobalHealth expects contracted Network High Volume Specialists and High Impact Specialists to provide services per the following standards:

Type	Access Standard
Initial referral	Within 14 business days
Urgent Care	Within 24 hours
Emergent care	Immediate
After-hours	Nurse triage or call coverage with Practitioner response within 1 hour

Specialties considered hospital based, such as anesthesiology and emergency medicine physicians will not be considered high volume or high impact specialties.

Appointment Wait Times

Members should not wait long after their scheduled appointment time to see a Practitioner. GlobalHealth expects all non-hospital contracted Providers to see the Member within 30 minutes of their appointment time, when the Member arrives on time. The office staff will notify Members as early as possible if the wait time is expected to exceed 30 minutes and allow the Member option of rescheduling the appointment or continuing to wait.

GlobalHealth encourages Providers to use technology such as texts, email, secure medical record systems or telephonic systems to remind Members of appointments, notify them of delays or address health related questions.

Termination of a Member

There may be an occasion where a Provider wishes to terminate a Member from his or her panel. Reasons for such termination may include non-compliance or threatening or disruptive behavior by

the Member. If a Provider plans to terminate a Member, the Provider must notify GlobalHealth prior to the termination, when possible. Additionally, the Provider must notify the Member in writing of the termination and continue to provide coverage for the Member for thirty (30) days or until the Member obtains a new PCP, whichever occurs first.

Exception: A Provider may not terminate a Member if such termination would be detrimental to the Member's health (e.g., a third trimester or complicated pregnancy, a hospitalized patient, a patient receiving treatment for a degenerative and disabling condition or disease, or Life-threatening Disease or Condition, or terminal illness, etc.) until the Member's condition is stabilized and another Provider has assumed care or through six weeks of post-delivery care.

Provider Termination

Termination can be initiated for several reasons either by the Provider or by GlobalHealth.

A Provider may choose to voluntarily discontinue participation in the GlobalHealth Network by providing a written notice of the disaffiliation. The GlobalHealth contract identifies the required termination notification time frame. However, the Provider can call the Provider Relations Department to discuss an optional time frame if situations warrant a sooner termination date. During the PCP termination notification period, GlobalHealth will notify affected Members and transfer their care to another Network Provider.

A Member might be eligible for ongoing treatment in special circumstances from the terminated Provider, see Continuity of Care.

GlobalHealth could initiate termination of a Provider for reasons that include, but are not limited to:

- Medicare or Medicaid sanctions imposed upon Provider
- Provider misrepresents credentialing or contracting information
- Provider is noncompliant with credentialing/re-credentialing requirements
- Provider's certifications or license being suspended or revoked

Continuity of Care

When a Provider voluntarily leaves GlobalHealth's Network, the Member that is currently in treatment might be eligible to continue an ongoing course of treatment during a transitional period. The Member may continue to see you for delivery and postpartum care if they were in the second or third trimester of pregnancy at the time the Provider notifies GlobalHealth.

A Member might be eligible for ongoing treatment in special circumstances from the terminated Provider. In these cases, the Provider would continue to coordinate care and submit claims as though he/she is a Network Provider. Member liability in these cases is limited to only what the Member would have paid if the Provider were part of the Network. The Provider will be paid their contracted rate. The Provider agrees to comply with all Utilization Management, claims, reconsideration requests and all other protocols affiliated with a Network Provider.

When a Provider's contract is terminated for reasons other than cause, the Provider may ask GlobalHealth for permission to continue treating a Member during the transition period, for up to ninety (90) days from the date of notice, if the Member:

- Has a degenerative, disabling, or Life-threatening Disease or Condition.
- Is in the second or third trimester of pregnancy at the time of Provider notice to GlobalHealth. Services are covered through at least six (6) weeks of postpartum evaluation.
- Is terminally ill.

GlobalHealth expects voluntarily terminating Providers to facilitate the Member’s transition to the new Provider(s).

Covering Physicians

A Network Provider must coordinate coverage by another GlobalHealth Network Provider when he/she is on vacation. The Network Provider is responsible for ensuring the covering Provider will:

- Follow the protocols, policies and rules as stated in this manual.
- Not bill any Members except for applicable Copayments/Coinsurance.
- Accept compensation from GlobalHealth as full payment for Covered Services except for applicable Member Copayments and Coinsurance.
- Obtain Referrals/Prior authorizations as stated in this manual.
- Any covering physician should use modifiers Q5 (substitute physician) or Q6 (locum tenens) to help ensure their claim is appropriately recognized.
- Be available 7 days a week, 24 hours a day.

Hospital/Facility Responsibilities

1. Provide covered health services to GlobalHealth Members twenty-four (24) hours a day, three-hundred and sixty-five (365) days a year.
2. Obtain necessary authorizations from GlobalHealth for Hospital admissions and continued Inpatient stays.
3. Assure Hospital/Facility and its personnel are duly licensed, certified, and authorized to provide covered healthcare services to GlobalHealth Members.
4. Provide advance written notice to GlobalHealth of any significant changes in the ability to provide covered healthcare services to GlobalHealth Members.
5. Assist GlobalHealth in proper Coordination of Benefits (“COB”) with other insurance carriers or third-party payers.
6. Remain in compliance with applicable state and federal requirements, Medicare Conditions of Participation, and The Joint Commission (“TJC”) accreditation standards or equivalent.
7. Participate in and cooperate with GlobalHealth’s Utilization Management and Quality Improvement Programs and activities.
8. Allow GlobalHealth to use Provider performance data.
9. Submit accurate claims to GlobalHealth for services rendered to GlobalHealth Members in accordance to the specified contractual time frame.
10. Complete the Provider Update Form found at www.GlobalHealth.com within 30 days when any of the following information changes:
 - Tax ID number
 - NPI
 - Address
 - Telephone number
 - Name change
 - Change in license status
 - New Location

Emergency Room (“ER”) Care

An emergency involves a medical condition manifesting itself by acute symptoms of severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that a Prudent Layperson, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual (or an unborn child) in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions and (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or (b) that the transfer may pose a threat to the health or safety of the woman or unborn child.

Referring a Member to the ER should not be used for routine services and non-emergency situations. An Urgent Care Facility or office visit might be an alternate option.

Urgent Care

Urgent Care is defined as care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require ER Care. An Urgent Care Facility offers an alternative when there is not an emergency.

During Normal Office Hours

- If a Member has an urgent medical illness or injury that cannot wait for a regular appointment, they will call your office. If possible, arrange to see the Member immediately or give them medical advice and direction, or set up an appointment for them.
- If you are not available, the Member can see another Provider in your office as long as they bill under the same tax identification number as the Primary Care Physician.
- You may direct the Member to an Urgent Care Facility if another physician is not available.

After Hours

When a Member needs to talk to or see you after the office has closed for the day, they have two options:

1. They should call the Provider’s contact number on their Member ID card. When a nurse or physician is on call, the Member’s call should be returned and the on-call provider should advise them how to proceed.
2. Otherwise, the Member should follow your after-hours voicemail instructions, which may include directing them to a Network Urgent Care Facility or Network emergency room. The Member may choose to self-refer to a Network Urgent Care Facility or, in a true emergency, call 911 or go to the emergency room.

Please Note:

- An Urgent Care Facility should not be used in place of the PCP for routine services and continuity of care.
- Use of Urgent Care Facilities is only for an unforeseen illness, injury, or condition that requires immediate, Medically Necessary care.

- All follow-up care must be provided or arranged by the PCP.
- Preauthorization may be necessary, depending on the care needed.
- If a Provider directs a Member to an Urgent Care Facility or emergency room, the Provider must notify GlobalHealth within 24 hours of services.

Utilization and Care Management Programs

GlobalHealth has a Utilization Management (“UM”) program to assist in determining:

1. The healthcare services that are covered and payable under the GlobalHealth Plans.
2. Healthcare services or supplies Medically Necessary needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms. Services must meet generally accepted standards of medicine.
3. The appropriate level of care.

GlobalHealth staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines® or CMS Medicare National Coverage Determinations, when conducting reviews. All medical necessity determinations are made by the GlobalHealth Medical Director. The Medical Director is a licensed physician in good standing.

All UM decisions are supported by current clinical information relevant to each case. Board-certified Practitioners or clinical peers from appropriate specialty areas may be used in determinations of medical appropriateness of care.

Decisions are made in a timely manner to accommodate the clinical urgency of the particular patient’s situation.

- Urgent Concurrent: determination made within 24 hours of receipt of request
- Urgent Preservice: Concurrent: determination made within 72 hours of receipt of request
- Nonurgent Preservice: determination made within 15 calendar days of receipt of request
- Post service: determination made within 30 calendar days of receipt of request

Our goal is to complete utilization review determinations for urgent requests within 24 hours and non-urgent requests within five (5) business days. Frequently, determinations are made the same day as requested.

GlobalHealth accepts requests by GlobalLink™ (electronic submission), which is the preferred method, and fax. Faxes are only monitored during regular business hours. Providers should check the status of referral in GlobalLink.

GlobalHealth’s UM Responsibilities

1. Clinical review decisions are based on published standard clinical review criteria and/or internal policies that are developed with input from actively participating physicians.
2. UM decision making is based only on appropriateness of care and service and existence of coverage.
3. GlobalHealth’s UM employees are properly trained, qualified, and supervised by a licensed physician Medical Director.

4. GlobalHealth does not reward Practitioners or other individuals for issuing denials of coverage. No financial incentives are provided to UM decision makers that would encourage determinations that result in underutilization or denial of Medically Necessary services.
5. Determinations not to authorize an admission, extension of a Hospital stay, medical treatment, diagnostic or therapeutic service, or other procedure based on medical necessity are made by the Medical Director.
6. GlobalHealth will maintain a process for Providers to Appeal UM denials in accordance with GlobalHealth policies and applicable regulatory requirements.
7. GlobalHealth reports Practitioner suspension or termination to the appropriate authorities.

Provider/Facility UM Responsibilities

1. Obtain prior written authorization from GlobalHealth for all non-emergent Hospital admissions, Outpatient surgeries performed in an ambulatory/Outpatient surgery center, and non-emergent services that cannot be provided within the physician's office (e.g., specialized scans, MRI, CT, nuclear medicine, etc.). GlobalHealth's preferred authorization method is through GlobalLink™.
2. In addition, to Preauthorization, GlobalHealth must be notified by the Hospital of all admissions on the day of admission or within 24 hours of unplanned admission.
3. Provide notification of any emergent Hospital admissions.
4. Provide notification of any observation admissions.
5. Obtain and verify Referral authorization for services.
6. Contact GlobalHealth to extend written authorizations for services, if necessary. Provide complete and detailed clinical information, including discharge planning.
7. Timely submission of medical records requested by us or our representatives for specific case reviews or as part of our Quality Improvement Program.
8. Refer Members to GlobalHealth's Case Management program if needed.
9. Cooperate with any investigations regarding Grievances, quality of care or other quality assurance measures.

Authorizations and Referrals

Healthcare services, such as Referrals for specialists, Hospitalization, and Outpatient surgery, require Preauthorization from GlobalHealth. If you do not obtain Preauthorization, services will not be paid.

In addition to the authorization, GlobalHealth must be notified by the Hospital of all admissions, including Observations, on the day of admission. Although authorization is not required for child birth, GlobalHealth still must be notified of the admission within 48 hours.

GlobalHealth's preferred authorization request method is through GlobalLink™. Providers can check on the status of authorization and referral requests in GlobalLink. PCPs can see all of the referrals for each individual Member of their panel.

GlobalHealth may redirect referrals to Low Cost Setting Providers when clinically appropriate. The modification may be made without prior notification to the requesting provider.

Medical Authorizations

The Provider should submit authorization requests for services. Services include any treatment, tests, or procedures. GlobalHealth will send you a letter once services are approved or denied. If the service is approved, this letter will provide you with the Member name information, the authorized doctor or Facility and the services that have been authorized. You must receive this letter before providing Covered Services. Any additional tests, services, or procedures beyond what is authorized require additional authorization from GlobalHealth. If you do not obtain authorization before providing tests, services, or procedures, services will not be payable. Although some services do not require Preauthorization, Members must use In-network Providers. See Self-Referral Services/Services Not Requiring a Referral. You may also review authorization determinations in GlobalLink™. The Member will also receive a letter of the approval .

If Globalhealth is unable to make a determination based on the submitted clinical information, UM staff will notify the provder and attempt to obtain the needed information. If the infomation is not provided in a timely manner, does not support the medical neesssity or is not a covered benefit, the requesting provider will be sent a denial letter with information about the reason, and appeals rights and processes. Please see “Provider Appeal of UM Denial or Adverse Determination” section below for additonal information.

The Member will also receive a letter regarding the denial, with inforamtion about the reason and appeals rights and processes.

Non-Urgent Decisions

Non-urgent pre-service decisions are made within 15 calendar days after receiving the request. This period may be extended one time by the Plan for up to 14 days if:

- It is necessary due to matters beyond the control of GlobalHealth;
- You are notified, prior to the expiration of the initial 14-day period, of why it is necessary; and,
- You are notified of the date by which GlobalHealth expects to render a decision.

If such an extension is necessary because GlobalHealth does not have the information necessary to decide the claim:

- We will tell you specifically what information is needed; and,
- You will have 45 (Forty- five) days from receipt of the notice to provide the specified information.

Post Service Decisions:

Post services requests are considered non-urgent and will be made within 30 days of the receipt of the request.

Urgent Decisions

Urgent concurrent decisions are made within twenty-four (24) hours after receiving the request. Urgent pre-service decisions are made within seventy-two (72) hours after receiving the request. As the treating physician, you may act as the patient’s authorized representative.

How to Obtain a Preauthorization or Referral

Authorizations/Referrals can be requested two (2) ways from GlobalHealth's UM department:

- GlobalLink™ (www.GlobalHealth.com) *Preferred Method*
- Fax (405) 280-5398

For expedited authorization/Referrals, you may submit the request as specified above or call GlobalHealth's UM department at (405) 280-5300.

An authorization request can be sent via fax by downloading the appropriate request form from www.globalhealth.com, completing the form, and faxing it to GlobalHealth's UM Department.

How to Obtain a Behavioral Health Authorization

For Plan specified behavioral, mental health, and substance abuse services that require preauthorization, the provider will assess the Member for Medical Necessity Criteria, and then contact MHNNet for authorization at 1-866-904-5234 (toll-free) or 1-866-200-3269 (TTY/TDD/Voice). Members needing assistance finding a behavioral health provider, or obtaining care coordination, in their area can call GlobalHealth directly at the Customer Care Number provided in their Member Materials.

Provider Responsibilities for Referral/Authorizations

Primary Care Physician (PCP)

The PCP is responsible for submitting a Referral request when necessary and for supplying complete clinical information concerning the Referral to the receiving specialist or facility.

Specialist Physicians and Facilities

The Referral specialist or Facility may only perform the services specified on the authorization. The specialist or Facility providing the referred service should report the appropriate clinical information to the referring PCP. The PCP or specialist will need to authorize any additional services.

If the specialist decides the Member needs additional services, or services from another specialist, **it becomes the responsibility of the referring specialist to submit the the authorization for additional services.**

Notify GlobalHealth within 24 hours regarding any services that were Medically Necessary but were not specifically included on the authorization.

Office Visit Referrals

A specialist office visit is one that is not defined as urgent or emergent. GlobalHealth's preferred authorization method is through GlobalLink™.

1. We recommend the specialist's office verify eligibility the day prior to the office visit.
2. The Referral will state "Office Visit" along with the number of office visits that are approved.
3. The approved office visit(s) must occur within a 90-day time frame from the date of the Referral.
4. If the Referral covers more than one (1) office visit, the Provider must verify eligibility at the time of each visit. Payment will not be made for services rendered to an ineligible Member.

5. No ancillary testing is allowed, unless otherwise indicated on the Referral. Please see Prior Authorization, item 15, for more information.
6. Do not schedule appointments unless you have received an authorization letter at your office.
7. **Retroactive Referrals: GlobalHealth does not routinely approve Retroactive Referrals.** If a Provider renders services to a Member without prior authorization, that Provider may submit an Appeal for a retrospective review. At GlobalHealth's sole discretion, authorization will be retrospectively approved or denied. Such decision will take into consideration that Provider did not consciously circumvent the prior authorization requirement. Repeated violations of the Referral process may result in suspension from GlobalHealth's Network.
8. The receiving Referral Provider (Specialist) is required to send communication to the patient's PCP with his/her findings and recommendations within ten (10) days of seeing the Member.
9. Referrals are required whether GlobalHealth is the primary or secondary payer.

Services That Require Prior Authorization

NOTE: This list is not all-inclusive. Other infrequently requested or highly-specialized services not listed below may require prior authorization. By requesting prior authorization, the contracting Provider is representing that the proposed covered healthcare services are Medically Necessary.

1. Inpatient Care, except childbirth; Inpatient Rehabilitation, and Observation Stays:
All Inpatient care, Inpatient rehabilitation, and observation stays require prior authorization by the contracted Facility. GlobalHealth must be notified by the Hospital of all admissions on the day of admission. If a service does not require prior authorization this does not negate the Provider's responsibility to notify the Plan of admission.
2. Skilled Nursing and Long-Term Acute Care:
All skilled nursing and long-term acute care Facility ("LTAC") care requires prior authorization by the contracted Facility.
3. Emergency and Urgent Care:
Emergency Services do not require prior authorization if the services meet the definition of emergency care as provided in this Agreement, Member Handbook, FEHB Brochure, or Evidence of Coverage. Notification to GlobalHealth by the contracted Provider is required by the next business day following the date of service. Urgent Care does not require a prior authorization after hours or outside of the GlobalHealth Service Area.
4. Ambulance:
Scheduled ambulance transport from one Facility to another location requires prior authorization.
5. Hospital Transfers:
All scheduled Hospital transfers require prior authorization prior to transfer. All emergent Hospital transfers require notification to GlobalHealth the next business day following the date of service.
6. Outpatient Hospital / Ambulatory Surgery:
Procedures performed in an Outpatient Hospital (place of service 22) or ambulatory surgery center (place of service 24) requires prior authorization.
7. Audiology Services:
Audiology services, speech/language therapy, and hearing aids require prior authorization.

8. Home Healthcare and Hospice Care:

All Home Healthcare, including home infusion therapy, and hospice care services require prior authorization.

9. Durable Medical Equipment (DME), Prosthetics and Orthotics:

DME, prosthetic devices, and orthotic devices require prior authorization. DME, prosthetics and orthotics (Revenue Codes 274 through 278), including enhanced or specialty equipment or supplies, require prior authorization.

10. Therapies and Rehabilitation:

All occupational and speech therapy, cardiac rehabilitation and pulmonary Rehabilitation Services require prior authorization. Referrals for physical therapy follow the requirements outlined in the Physical Therapy Practice Act, 59 O.S. §§ 887.1 - 887.18.

11. Behavioral Health:

Outpatient Therapy has no PA requirement. Only the following Behavioral Health Services require Prior Authorization:

- Psychological Testing* (CPT codes 96101, 9612, 96103)
- Neuro-psychological Testing* (CPT codes 96118, 96119, 96120, U918)
- Applied Behavioral Analysis (ABA) autism Services** (CPT Codes contracted on the Autism Fee Schedule)
- Psychiatric Home Care Services (CPT Codes 99341-99345, 99347-99350)
- Medical Detoxification
- The following higher levels of care
 - Intensive Outpatient (IOP),
 - Partial Hospitalization (PHP),
 - Residential, Rehabilitation,
 - ECT, and
 - Inpatient Acute

- For Behavioral Health prior authorizations, contact MHNNet at 1-866-904-5234.

12. Diagnostic Services:

Other procedures and testing that require prior authorization include:

- Infertility testing and services.
- Organ transplant services; transplant evaluations, organ donor services, transplant procedures.
- Stereotactic radiosurgery (e.g. gamma-ray radiosurgery, gamma knife, etc.).
- Cardiac stress tests, nuclear cardiac testing, coronary computed tomography angiography, ECG, and other cardiographs.
- Neurology and neuromuscular diagnostic testing, including EEG, EMG, NCV, and sleep studies.
- Bone densitometry studies.
- Non-invasive diagnostic testing including vascular, pulmonary, and voiding cysto-urethrogram.
- CT scans, nuclear scans/tests, MRI, MRA, PET scan, and gamma camera.
- Dialysis, Epoetin alfa, and laboratory services rendered in conjunction with dialysis.
- Outpatient radiation therapy and chemotherapy.

- Maternity care, maternal support services, fetal monitoring, threatened and premature labor treatment. Members have direct access to OB/GYN Providers. OB/GYN Providers can request authorizations. Routine OB/ GYN services do not require PA.
- Elective Facility-based invasive diagnostic testing.
- Hyperbaric treatment.
- Blood transfusions and all infusion therapies/services.
- Preventive Care: Abdominal Aortic Aneurysm, colorectal cancer screening, diabetes self-management, and medical nutrition

13. Pharmacy

Certain injectable medications require prior authorization. Certain formulary drugs may be preferred agents or may require prior authorization. Specific prior authorization criteria are available by contacting the Pharmacy Department.

14. Specialty Care Services

- The Member's designated PCP must authorize or perform all Medically Necessary services. A Referral is needed for services not performed by the PCP. Exception: if the service is specifically listed in the Member's benefit Plan as not requiring a PCP Referral (e.g., Behavioral Health, mammogram, well-woman visit, etc.).
- If the specialist decides the Member needs additional services, or services from another specialist, **it becomes the responsibility of the referring specialist to submit the the authorization for additional services.**
- The Specialist is expected to continue to coordinate care with the PCP.

15. Tests. Some tests are included in the specialist visit authorization. You do not need separate Preauthorization for these tests performed in the doctor's office during the authorized visit:

- Routine lab work
- Ultrasound
- X-ray
- EKG

Physical Therapy Referrals

Except for worker's compensation claims, any person licensed under the Physical Therapy Practice Act as a physical therapist shall be able to evaluate human ailments by physical therapy on a patient without a Referral from a licensed health care Practitioner for a period not to exceed thirty (30) days. An authorization must be submitted for treatment. Treatment may be provided by a physical therapist assistant under the supervision of a physical therapist. Any treatment provided shall be only under the Referral of a person licensed as a physician or surgeon with unlimited license, or the physician assistant of the person so licensed, with those Referrals being limited to their respective areas of training and practice. All subsequent treatments, up to any Plan limitation, must follow normal Referral/Preauthorization processes.

Self-referral Services/Services Not Requiring a Referral

As explained elsewhere in this Manual, the PCP will coordinate the Covered Services a Member gets as a GlobalHealth Member. But there are a few exceptions. The Member may self-refer to an In-Network Provider for the following services. He/she does not need a Referral from the PCP before going to:

- OB/GYN: Any service from a Network health professional that specializes in obstetrics or gynecology. The healthcare professional is responsible for:
 - Obtaining Preauthorization for certain services.
 - Following the authorized treatment plan.
 - Following procedures for Referrals.
- MAMMOGRAM: Women may also self-refer to a Network imaging center for a routine screening mammogram once every twelve (12) months.
- BEHAVIORAL HEALTH: A Member may access Behavioral Health (mental health and/or substance abuse) services directly by calling GlobalHealth for a listing of contracted Providers.
- ER:
 - Services rendered in any emergency room or emergency ambulance.
 - Physician Services for unscheduled emergency admissions.
- Services rendered in Urgent Care Facility.
- PREVENTIVE SERVICES:
 - Any Medicare-covered preventive services such as diabetes and kidney disease education. (See exceptions in Services that Require Authorizations)
 - Routine annual preventive exams
- LABS: Laboratory services performed by an In-network laboratory.
- CONSULTING PHYSICIANS: Services from Inpatient consulting physicians.
- ANESTHESIA/PATHOLOGY: Services from a Hospital-based anesthesiologist or pathologist (excludes pain management or office based services).
- HEARING/SPEECH EXAM: A Member may self-refer to a Network audiologist only for a child's evaluation if the Member's Plan has this benefit. You will need Preauthorization for any additional treatment.
- DENTAL: (If the Member's Plan includes dental). A Member may self-refer to a Network dentist if this benefit is part of the Member's Plan.
- VISION:
 - A Member may self-refer to a Network optometrist for a routine eye exam if this benefit is part of the Member's Plan.
 - A Member may self- refer for eyewear.

Non-Approval of Referrals

The fact that a Referral is not approved should not be interpreted as a barrier to patient care or questioning of a physician's judgment. It may indicate the need for additional information from the Provider, or consideration of alternative treatment plan options, before authorizing the request. A peer-to-peer discussion is available for Adverse Determinations. The referring physician can call the UM department to coordinate the call.

When Services are Not Medically Necessary

Provider may not collect payment from a GlobalHealth Medicare Advantage Members for services that have been determined not Medically Necessary by the GlobalHealth Medical Director unless a proper Advanced Beneficiary Notice of Non-Coverage (1) was signed by the Member, (2) acknowledges the Member's financial responsibility, and (3) was obtained by the Provider prior to the service being rendered.

Non-Covered/Excluded Benefits

GlobalHealth details services that are not covered or excluded in Member Materials and will notify the Provider in its organization determination for the requested service(s). GlobalHealth will not reimburse Providers for services that are not-covered/excluded, even when provided by an In-Network Provider. Payments for services that are not covered/excluded are the responsibility of the Member. However, a signed Advanced Beneficiary Notice of Non-Coverage must be obtained for non-covered services prior to rendering the services in order for a Provider to collect from a Medicare Advantage Member.

If a service is found upon appeal to be a medical service that GlobalHealth should have paid for or covered due to the Member's specific situation, the member would not be responsible. The Provider will be sent a copy of the determination letter via fax.

Provider Appeal of UM Denial or Adverse Determination Standard Appeal

You may request a standard Appeal for denied services or claims where the patient is not currently receiving treatment or treatment is already scheduled and the patient's condition is not such that an expedited Appeal is warranted. You may download a GlobalHealth Reconsideration Request form at www.GlobalHealth.com.

Submit the Appeal in writing to:

GlobalHealth, Inc.
ATTN: Appeals
P.O. Box 2393
Oklahoma City, OK 73101-2393

Include all related information available concerning the denied services including:

- Patient name
- Member ID number
- Name of Facility where services are being rendered, if applicable
- Medical necessity, or basis of Appeal

Written Response to Appeal

A written response to a standard Appeal is sent no later than thirty (30) calendar days after receipt of the Appeal request and supporting documentation.

Provider Appeal of UM Denial or Adverse Determination Expedited Appeal

You may request an expedited Appeal if the Member is actually receiving services or is scheduled to receive services and the attending physician and/or the Member believes that the determination warrants immediate attention due to the patient's condition or health status.

1. Call GlobalHealth - please refer to the contact list for the appropriate contact information.
2. Have all related clinical information available regarding the denied services.

Expedited Appeal Decision

Decisions concerning expedited Appeals are made as expeditiously as the medical condition requires, but no later than 72-hours after the review request is received. Providers are notified by telephone followed by written determination.

Physician Review of Medical Necessity Denials

Only the Medical Director (or other physician designee) makes medical necessity denial determinations. The Medical Director is available to discuss denial decisions with a Provider.

Hospital Admissions

All Inpatient Hospital care **must** be provided at a GlobalHealth Network participating Hospital, except for emergency admissions or when preauthorized by GlobalHealth under special circumstances.

GlobalHealth reviews every Inpatient admission for appropriate level of care beginning on the day of admission through discharge.

Hospital admissions must be pre-certified. Additionally, GlobalHealth must be notified by the Hospital of all admissions on the day of admission.

Outpatient Observations

GlobalHealth reviews every Outpatient observation claim greater than twenty-four (24) hours to determine appropriate level of care and utilization of services.

Hospitals must notify Members of their status as an Outpatient Observation and how that affects what is covered and how their cost share may be affected.

How to Request Pre-authorization

Preauthorization can be requested three (3) ways from GlobalHealth's UM department:

- GlobalLink™ (www.GlobalHealth.com) *Preferred Method*
- Fax (405) 280-5398
- Telephone (405) 280-5300

Re-authorization

If a preauthorized admission is expected to extend beyond the initially assigned length of stay, the admission is subject to concurrent review and must be re-authorized. Re-authorization must be completed on or before the last day of the pre-approved Hospital stay. The re-authorization process is the same as pre-authorization.

Preauthorization Notification Does Not Guarantee Payment for Services Rendered

Preauthorization notification will only determine if a service is Medically Necessary. Preauthorization does **not** determine if the Member is enrolled or if the service is a covered benefit for the Member. We recommend that you call to verify the Member's enrollment and benefit coverage.

Emergency Admissions

GlobalHealth must be notified by the Hospital of all Emergency admissions on the day of admission. GlobalHealth will obtain clinical information from the Hospital on the first business day following admission. Subsequent reviews are performed as the Member's condition warrants or until the Member is discharged. GlobalHealth reviews all emergency admissions for appropriate level of care.

Concurrent Review

GlobalHealth performs concurrent review from the day of admission through discharge to assure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary discharge arrangements have been made. GlobalHealth's concurrent review process assesses:

- The necessity for continued treatment;
- Level of care; and
- Quality of care for Members receiving Inpatient services.

Inpatient services extending beyond the authorized period require concurrent review.

If GlobalHealth has approved a course of treatment (to be provided over a period or number of treatments):

- Any change before the end of the course of treatments is considered an Adverse Determination. A change may be either a reduction or termination of the course of treatment. GlobalHealth will notify you in advance of the change. The Member and you, on behalf of the Member will be given time to Appeal and obtain a review of that Adverse Determination before the benefit is changed. This does not apply when the Plan is amended or ended. GlobalHealth will provide continued coverage pending the outcome of an Appeal.
- You may request to extend the course of treatment beyond what is approved. GlobalHealth will notify you of the decision, whether adverse or not. The Member is not entitled to continued coverage pending the outcome of the request.
- Urgent concurrent review decisions are made within twenty-four (24) hours after receiving your request. GlobalHealth will notify you of the decision, whether adverse or not.

Contracted Providers should cooperate with GlobalHealth by:

- Providing concurrent review status reports by telephone.
- Allowing GlobalHealth's UM staff to conduct on-site concurrent reviews.
- Allowing access to medical records, for the Member, and Member's family.
- Providing admission and discharge notifications 24 hours/day, 7 days/week.

Daily Reporting

The following reports are required to be provided daily to GlobalHealth's UM Department:

- Census report for all GlobalHealth Members
- Discharge report
- Inpatient and Outpatient surgeries, observation stays and Skilled Nursing Facility admissions, if applicable

The following information must be included on the report:

- Member name

- Member ID number
- Date of birth
- Admitting and/or attending physician
- Facility
- Admit date
- Admit type
- Bed type
- Diagnosis (ICD-10)
- Procedures
- Extraordinary items and services requiring authorization
- Anticipated discharge date
- Actual discharge date
- Discharge disposition

Discharge Planning

Transition of care management / discharge planning starts at the time of Hospital admission or when the admission is authorized and continues throughout the discharge process and includes the coordination of a patient's continued care needs both in and out of the Inpatient setting. A comprehensive discharge plan includes assessment of needs, plan development, plan implementation, and evaluation of effectiveness.

The admitting physician should facilitate discharge planning by documenting the anticipated discharge date, disposition (e.g., home, SNF, rehabilitation, etc.), and any post-discharge services the Member may require. GlobalHealth's UM staff will coordinate with the Hospital case manager to arrange for any needed services. GlobalHealth's participation in the discharge planning process will vary based on the individual patient's circumstances and may occur by telephone or through on-site reviews.

Discharge planning activities include:

- Assessing patient's potential discharge requirements beginning on the day of admission, including behavioral health, psychosocial and economic needs.
- Completing evaluation of available support and assistance, including financial needs.
- Arranging multidisciplinary meetings to include patient and family members, as appropriate.
- Involving social services in discharge planning, as appropriate.
- Coordinating discharge needs such as DME, home health, Skilled Nursing Facility ("SNF"), transportation, medications, etc.
- Obtaining authorization from GlobalHealth for necessary post-discharge services.
- Coordinating Behavioral Health therapy and psychiatric medication management aftercare appointments within 7 days post discharge with MHNet at **(866) 904-5234**.
- Documenting and communicating the discharge plan.
- Ensuring patient understanding of discharge orders and follow-up care required.
- Making other Referrals as needed.
- Delivering a written notice of non-coverage, if applicable

Policy on Ensuring Appropriate Utilization

- GlobalHealth’s Utilization Management (“UM”) decision-making is based on appropriateness of care and service and existence of coverage.
- GlobalHealth does not specifically reward Practitioners or other individuals for issuing denials of coverage.
- GlobalHealth does not provide financial incentive for UM decision-makers which would encourage decisions that result in underutilization.
- GlobalHealth does not use incentives to encourage barriers to care and service.
- GlobalHealth does not make decisions regarding hiring, promoting or terminating its Practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

Technology Assessment Process

GlobalHealth has a technology assessment and guideline review process. It is designed to review requests for coverage of newly available devices, procedures, or treatments that are not considered established benefits.

A physician-directed committee reviews requests for approval of new technology. This includes both new technology and new application of existing technology.

The committee reviews medical and behavioral healthcare procedures, drugs, and devices using scientific medical evidence. An appropriate regulatory agency, such as the U.S. Food and Drug Administration (“FDA”), must have approved the new device, procedure, or treatment before it will be considered.

Before approving coverage, GlobalHealth requires documented evidence to ensure the efficacy and safety of the new technology. The new technology must:

- Improve the net health outcome of the Member;
- Be as beneficial as established alternatives;
- Be available outside the investigational setting;
- Significantly improve the quality of life of the Member; and,
- Clearly demonstrate safe medical care to the Member.

Case Management

GlobalHealth provides support to its Members who are transitioning between levels of care, have chronic health conditions or need additional resources. Case Management is the coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

The goal of Case Management is to help Members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the Member’s condition, determination of available benefits and resources, and development and implementation of a Case Management plan with performance goals, monitoring and follow-up.

Case Management is a collaborative process. A case manager works with the Provider and Member to assess, plan, and facilitate treatment options. He/she uses communication and available resources to promote quality, cost-effective outcomes.

As part of the Quality Improvement Program, GlobalHealth may target specific populations for additional outreach, such as promoting medication adherence in CVD or prenatal care and post-partum follow-up.

GlobalHealth considers Case and Disease Management to be opt-out programs; all eligible Members have the right to participate or decline to participate.

The patient may self-refer or you may refer your patient for Case Management or Disease Management.

Disease Management

A critical aspect of care is ongoing communication between the Member and physician. GlobalHealth actively works to improve the health status of its Members with Chronic Conditions, supporting the patient-doctor relationship.

Targeted diseases include:

- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Diabetes
- Depression
- Anxiety
- Substance Abuse (Illegal or Prescription Drugs not being used as prescribed)

GlobalHealth's care management uses a patient-centered approach. This includes establishing individualized care plans as well as sending the patient educational letters and educational information to help them learn better health habits. Members may self-refer or Providers may refer them into the program. Members are also selected to participate in the program based on their clinical risk factors.

GlobalHealth Generations Members taking multiple medications for Chronic Conditions can receive support from our medication therapy management program. The goal of this program is to help eliminate duplicate drug therapies, reduce potential for negative drug interactions and/or side effects, and optimize Member benefits by providing information on the lowest cost medication alternatives. Enrollment is automatic for qualified Generations Members. Benefits include personalized service from registered pharmacists and staff.

GlobalHealth Commercial Members can be referred for a similar pharmaceutical review at the request of the PCP.

Complex Case Management

Complex Case Management focuses on Members who have multiple or complicated health or psychosocial concerns.

GlobalHealth considers Complex Case Management to be an opt-out program; all eligible Members have the right to participate or decline to participate.

GlobalHealth offers a variety of programs to its Members and does not limit eligibility to one complex condition or to Members already enrolled in other GlobalHealth Disease Management programs.

The patient may self-refer or you may refer your patient for Complex Case Management.

Self-refer and enroll:

www.GlobalHealth.com

Click on Case Management under Wellness Resources

Contact the UM Department:

1-866-277-5300 (toll-free)

711 (TTY)

Cases that May Require Special Care

Conditions that may require Case Management intervention include, but are not limited to:

- AIDS, HIV, infection and related diagnoses
- Amputations
- Anxiety
- Asthma
- Burns (severe)
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coma (after three days' duration)
- Crohn's Disease
- Cystic Fibrosis
- Depression/Suicidality
- Diabetes
- Eating disorders
- Hospital admission greater than the expected length of stay ("LOS")
- Head injuries
- Hemophilia
- IV therapy (long-term)
- Muscular/neurological disorders (traumatic and degenerative such as ALS, MS, MD or paralysis)
- Neonates with high risk complications or congenital anomalies
- Pre-term labor
- Rehabilitation (long-term)

- Rheumatoid arthritis (severe)
- Severe Mental Illness
- Spinal cord injury
- Substance Misuse (Illegal Substances and/or Prescription Drugs not being used as prescribed.)
- Terminal illness – hospice candidates
- Transplant candidates
- Trauma (Major)
- Ulcerative Colitis
- Ventilator dependent

All Members are subject to evaluation for Case Management intervention.

Behavioral Health Benefits

Members can directly access mental health and/or substance abuse services by calling the GlobalHealth behavioral health unit at the Customer Care number listed in their Member materials.

For obtaining Pre-Authorization for PA required behavioral health services, or assistance with claims issues, call MHNet

1-866-904-5234 (toll-free)

1-866-200-3269 (TTY/TDD/Voice)

Additional services available through GlobalHealth include:

- Crisis intervention.
- Referrals to community resources and self-help groups.
- Help in locating a Provider.

Medical detoxification is covered for problems associated with acute alcohol, drug, or substance abuse.

A series of treatments is a structured, organized, and needed program which may include different Facilities. It is complete when the covered Member is discharged on medical advice from inpatient detoxification, inpatient rehabilitation, partial hospitalization, or intensive outpatient program

Treatment Setting	Benefit Description
Outpatient Therapy:	Non-emergent therapy that may include medication management, therapy, and/or psychiatric testing. Standard therapy session or medication management does not require Preauthorization from MHNet. Specified Outpatient services require Preauthorization from MHNet (see Member's Plan Schedule of Benefits).
Intensive Outpatient Program:	Treatment multiple times a week for a predetermined number of hours a day, depending on treatment plan. Requires Preauthorization from MHNet.
Partial Hospitalization (Day Treatment):	Treatment multiple times a week for a predetermined number of hours a day, depending on treatment plan.

	This treatment requires more days and/or hours per day than an intensive Outpatient program. Requires Preauthorization from MHNet.
Residential Treatment Center:	Non-acute Inpatient program. Requires Preauthorization from MHNet.
Acute Hospitalization:	24-hour Inpatient program. Requires Preauthorization from MHNet.

A chemical dependency treatment center is a Facility that provides a program for the treatment of chemical dependency using a treatment plan approved and monitored by a Network Provider

Prescription Drug Benefits

There are two Pharmacy Benefit Managers:

Express Scripts Inc. (ESI) for GlobalHealth commercial Members: 800-935-6103

CVS/Caremark for Generations Members: 866-494-3927

Home Delivery Pharmacy Service

ESI and CVS offer the convenience of home delivery. Maintenance medications are mailed to the Member's home in a 90-day supply when you prescribe a 90-day supply.

For Commercial members, Providers can submit the prescription and completed fax form to ESI at 877-207-0438. Forms are available at <https://www.GlobalHealth.com/prescriptions.aspx>

For Medicare Members, Providers can contact CVS at 866-494-3927 (toll free) or fax completed form and prescription to CVS at 800-378-0323. Forms are available at <https://www.GlobalHealth.com/2017/medicare/materials> under Pharmacy Documents, Links and Resources.

Extended Supply Retail Pharmacy Network

The Member may receive up to a 90-day supply of a maintenance drug at an extended supply retail Network pharmacy for the applicable home delivery Copayment or Coinsurance. Medications must be prescribed as a 90-day supply by a Network Provider. An extended supply retail Network pharmacy can be found on www.GlobalHealth.com

Commercial-Chickasaw Nation Refill Center Medications by Mail

Chickasaw Nation Refill Center is a Native American-owned retail pharmacy located in Oklahoma. It provides prescription medications to Native Americans. The Member must complete the Native American Prescription Benefit Program Patient Enrollment form available on www.GlobalHealth.com and submit to Chickasaw Nations Refill Center. Proof of Native American status in one of the federally recognized tribes is required. Once Native American heritage is established with Sovereign Medical Solutions, The Member may receive Cost-share discounts. Medications are mailed directly to the Member's home or designated location. Non- Native

American spouses are also covered. Prescriptions may be a 30 or 90-day supply. Online prescription services available at www.cnrefillcenter.net.

Specialty Pharmacies

Contracted specialty pharmacies may fill prescriptions for specialty medications and mail them to the Member's home. Specialty medications sent to and administered by a doctor are covered under the Member's office visit cost-sharing responsibility. Specialty medications sent to and administered by the Member are assessed the applicable Prescription Drug Copayment or Coinsurance. A specialty Network pharmacy can be found on in the Provider Directory or by Provider search at www.GlobalHealth.com

GlobalHealth's Preferred Formulary Drug List

Formularies are specific to the Plan benefits. Preferred drugs are listed in the *Drug Formulary*. Medications on the list are selected based on quality (effectiveness and safety) as well as cost-effectiveness. Doctors and pharmacists have worked together to develop the formulary. It includes generic and brand name medications that are approved by the FDA.

Drug Tiers

The cost share for each prescription drug is based on which Tier it is in. The number of tiers may vary based on the Plan Design. Generally, the lowest tier contains Generic or low cost medications. The next higher tiers contain preferred name brand medications or non-preferred brand name formulary medications and specified high cost generic drugs. Cost shares typically increase as the tier increases. Specialty medications are found in the highest tier and have the highest cost share. Specialty medications are limited to no more than a one month supply and must be pre-approved by either GlobalHealth Pharmacy (Commercials) or CVS Caremark (Medicare).

Please refer to the Member materials for Plan specific formularies, drug tiers and cost shares at www.GlobalHealth.com

Prior Authorization, Step Therapy, Quantity Limits, and Exceptions

Our Plans may include Utilization Management for Prescription Drugs. These programs are based on current medical findings, FDA-approved manufacturer labeling information, cost, and manufacturer rate agreements. The Medication Utilization Management Program identifies some medications that have requirements that must be met before they can be filled. The formulary indicates if the drug requires prior authorization ("PA") or other limitations.

The Prior Authorization process and point of contact is different for Medicare and Commercial Plans. GlobalHealth Pharmacy performs PA reviews for the Commercial Plans. CVS Caremark provides PA reviews for Medicare.

Type	Description
Prior Authorization ("PA"):	Physicians are required to obtain prior authorization for certain medications, including compound drugs. This promotes appropriate, cost-effective use. Any corresponding supplies or equipment also

	require prior authorization. GlobalHealth may not cover the drug, supply, or equipment without prior authorization.
Limited Access (“LA”)	Prescription may only be available at certain pharmacies. Physicians will need to consult the Provider/Pharmacy Directory or call GlobalHealth Customer Care at 1-866-494-3927 (toll-free) 24 hours a day, seven days a week
Step Therapy (“ST”):	Step therapy requires one or more prerequisite, clinically equivalent drugs to be tried before a step therapy drug will be covered.
Quantity Limits (“QL”):	There are limits to the amount of certain medications that you may receive. These drugs, if taken inappropriately for too long a time, could be unsafe and cause adverse effects.
Not Mail Order (“NM”)	Drugs that are not available by mail-order.
Medicare Formularies: (“B/D”)	Drugs that require coverage determination for Medicare Part B or Part D are designated with the abbreviation B/D;

Standard Exception Process

Commercial:

You can request GlobalHealth to waive coverage restrictions and limits. **Call (918)878-7361 to request an exception.** You may submit your request in writing, electronically, or telephonically.

This exception process also applies to new Members who are taking drugs that require coverage determination or taking non-formulary drugs. GlobalHealth could grant a temporary 30-day supply during the Member’s first 30 days of membership.

Expedited Exception

You may request an expedited exceptions process when:

- The Member is suffering from a health condition that may seriously jeopardize his/ her life, health, or ability to regain maximum function, or
- The Member is undergoing a current course of treatment using a non-formulary drug.

We will provide a decision to you within 24 hours after receiving the request and sufficient information to begin the review.

- If granted, the exception will be for the duration of the prescription, including refills.
- If GlobalHealth denies your exception request, you may request an External Review. You will receive the determination within twenty-four (24) hours of receiving your request for review.

The Member’ medication will be covered during the time GlobalHealth is reviewing, and if applicable, during the External Review.

Medicare:

You can request GlobalHealth to waive coverage restrictions and limits. **Call 866-494-3927 to request an exception.** You may submit your request in writing, electronically, or telephonically. Providers can contact CVS Caremark at 866-494-3927 (toll free) or fax completed forms to CVS at

855-633-7673. Forms for a Medicare Coverage Determination are available at <https://www.GlobalHealth.com/2017/medicare/materials> under Pharmacy Documents, Links and Resources.

Medicare members who are new to GlobalHealth Medicare can receive a “transition supply” of medication for the first 90 days of their enrollment if they are new to the Plan or during the first 90 days of the new plan year if they were enrolled in the plan the previous plan year. The temporary supply will be for a maximum of a 30-day supply. If the Member is in LTC, the supply is at a minimum 91, up to 98 days, for the first 90 days of enrollment.

Expedited Exception

You may request an expedited exceptions process when:

- The Member is suffering from a health condition that may seriously jeopardize his/ her life, health, or ability to regain maximum function, or
- The Member is undergoing a current course of treatment using a non-formulary drug.

CVS will provide a decision to you within 24 hours after receiving the request and sufficient information to begin the review.

- If granted, the exception will be for the duration of the prescription, including refills.
- If GlobalHealth denies your exception request, you may request an External Review. You will receive the determination within twenty-four (24) hours of receiving your request for review.

ATTENTION: PRESCRIPTION PAIN RELIEVERS CAN BE HIGHLY ADDICTIVE AND DANGEROUS!

Prescription Drugs, especially opioid analgesics—a class of Prescription Drugs used to treat both acute and chronic pain such as hydrocodone, oxycodone, codeine, morphine, and methadone, have increasingly been implicated in drug overdose deaths over the last decade.

Before you prescribe this type of medication for your patient, or if you have patients who’ve been taking this type of medication for a period of time, have a serious discussion regarding the potential for addiction and overdose, while considering titrating them off as soon as possible. GlobalHealth urges Prescribers to conduct at least annual medication reviews that include over-the-counter, prescription and supplements with their patients.

If you have a patient who has become addicted to any medication, then contact the Global Health Behavioral Health unit immediately for assistance in getting them to treatment and resources to support them through the recovery process. Your patient’s GlobalHealth benefits cover Outpatient Therapies, Medication Assisted Treatment Programs, Residential Substance Abuse Treatment as well as assisting Members with gaining community resources that will help in their recovery process.

Claims and Payment

Time Limits for Filing Claims

Providers must submit Clean Claims to GlobalHealth within the timely filing period specified in the Provider’s contract in order to receive payment. If the Provider fails to submit a Clean Claim within the required timeframes, GlobalHealth expressly reserves the right to deny payment for such claim(s). Claim(s) denied for untimely filing **cannot** be billed to a Member.

When GlobalHealth is a secondary payer, the filing period begins the date of the primary carrier's explanation of benefits showing their payment or denial.

Claims Submission

Claims must be submitted electronically or mailed to the following address:

Medicare: GlobalHealth, Inc.
ATTN: Claims
P.O. Box 1747
Oklahoma City, OK 73101-2328

Commercial: GlobalHealth, Inc.
ATTN: Claims
P.O. Box 2328
Oklahoma City, OK 73101-1747

GlobalHealth utilizes the following Clearing Houses for electronic claims submission:

- Emdeon
- OPTUM
- InfinEDI
- Zirmed
- SSI Group
- Gateway
- Claimlogic
- Relay Health

GlobalHealth's electronic data interchange (EDI) number is GHOKC.

The EDI Claims Submitter Request Form can be found at
http://www.GlobalHealth.com/providers_edi.aspx

Proof of Timely Filing

Your clearinghouse vendor can supply you with a report of accepted electronically filed claims. That report can be used for proof of timely filing for electronic claims. Your Certified Receipt or Return Receipt Signature is required for proof of timely filing for paper claims.

Claims Adjudication

GlobalHealth reviews and evaluates claims for:

- Correct coding (ICD-10, CPT-4[®], or other required coding as applicable).
- Correct billing (UB-04 or CMS-1500 format).
- Coverage criteria.
- Medical necessity.

Approved Forms:

- CMS 1500
- UB-04
- Electronic Filing

Copayments/Coinsurance

A Copayment or Coinsurance is an amount due from the Member at the time of service. Members are required to pay a Copayment or Coinsurance for certain benefits.

- Copayments should be collected when services are rendered. Copayment amounts are generally listed on the Member's GlobalHealth ID card.
- Coinsurance should not be collected at the time of service but billed to the Member after the Coinsurance amount due is indicated by GlobalHealth through the Remittance Advice sent to the Provider.
- No Copayment or Coinsurance should be collected from or billed to the Member for preventive care services.
- Some commercial plans have a deductible for some services. ER, hospital, and outpatient surgery all are subject to a deductible if a plan has one. Preventive services are not subject to any deductible.

Maximum Out-of-Pocket ("MOOP")

For GlobalHealth plans, member expenses are limited by a maximum out-of-pocket (MOOP) amount. If a Member has reached the MOOP, a Provider should not apply any Member cost-share for the covered services. Providers may obtain a Member's MOOP information via GlobalLink or by contacting GlobalHealth. If the Provider collected a cost-share from the Member, GlobalHealth will notify the Provider of the amount in excess of the MOOP and the provider shall promptly reimburse the Member.

If GlobalHealth determines that the Provider did not reimburse the Member the amount received in excess of the MOOP, GlobalHealth may reimburse the Member directly, and recoup the amount from the Provider. GlobalHealth will notify the Provider of any such recoupment thirty (30) days' prior to such recoupment.

GlobalHealth may audit the Provider's compliance with this section and may require the provider to submit documentation to GlobalHealth supporting that the Provider reimbursed Members for amounts in excess of the MOOP.

Situations That May Affect Hospital Reimbursement

Reimbursement for inpatient services may be affected in certain situations described below.

1. Hospital Acquired Conditions/ Not Present on Admission

GlobalHealth does not provide additional reimbursement for complications related to procedures and co-morbidities related to Hospital acquired conditions not present on admission as defined by the Centers of Medicare and Medicaid Services ("CMS").

2. Hospital Readmissions

GlobalHealth does not make additional, separate DRG payments for readmissions that are foreseeable and at the same Facility for same, similar or related conditions or the result of a premature discharge or inadequate discharge planning and that were avoidable. GlobalHealth applies standardized criteria such as the Centers for Medicare and Medicaid Services ("CMS") guidelines, Milliman Care Guidelines®, and other applicable industry guidance in determinations not to reimburse for a subsequent Hospitalization.

3. Never Events

GlobalHealth does not reimburse for charges that are related to “Never Events” or “Serious Reportable Events (“SRAE”) as defined by the CMS and National Quality Forum (“NQF”). “Never events” are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare Facility.

Responsibility for Payment

The Members Are Responsible for Payment of:

- Their Deductible, Copayments, or Coinsurance for approved Covered Services.
- The charges for services provided by a physician or medical Facility without an authorized Referral from your PCP.
- The cost of services not included in their GlobalHealth Plan benefits.
- Full billed charges when:
 - The services were non-Covered Services.
 - The services were received Out-of-network and were not authorized by GlobalHealth.
 - The services were obtained through Fraud.

The Members Are Not Responsible for:

- Any amounts owed by GlobalHealth to a Provider for approved Medically Necessary services that are covered by Plan benefits.
- Any amounts requested as Balance Billing (after GlobalHealth has paid the contracted Allowed Amount), provided that:
 - The services were preauthorized Covered Services;
 - The services were approved by GlobalHealth;
 - The services were provided by a Network Provider; and
 - The Member has paid the required Cost-share.

Claims Reimbursement

GlobalHealth will reimburse for Covered Services on timely filed claims in accordance with contractual agreements and applicable statutory requirements less any applicable Copayments, Coinsurance, and/or Deductibles owed by the Member. Unless otherwise specified, GlobalHealth follows Centers for Medicare and Medicaid Services (“CMS”) coding guidelines including; ICD-10, CPT-4®, and HCPCS. Should GlobalHealth fail to pay a claim within the required timeframe, GlobalHealth will pay interest in accordance with contractual and State regulatory requirements. Providers will receive a Remittance Advice (RA), also referred to as an Explanation of Benefits (EOB), detailing how each service was processed.

Reasons for Payment Delays

It is our goal to process your claims as expeditiously as possible. In order to do so, it is essential that you submit complete and accurate claims. Common mistakes that delay your payment include:

- No employer or group number
- No authorization number
- Failure to submit required additional documentation
- Inaccurate or questionable diagnosis or procedure coding

- Missing or wrong Tax ID Number
- Missing Provider name and/or NPI

Claims Status

Contracted providers must use Global Link to obtain claims status.

Balance Billing

A contracted or participating Provider accepts the GlobalHealth reimbursement as payment in full and may NOT “balance bill” a GlobalHealth Member. In other words, the Provider may not look to a GlobalHealth Member for payment for Covered Services beyond the Member’s applicable Deductible, Copayment and/or Coinsurance amounts. Balance Billing is a violation of the Provider Agreement with GlobalHealth and may result in termination of the Provider from the GlobalHealth Network.

Remittance Advice (“RA”)

GlobalHealth issues a Remittance Advice (“RA”). The RA summarizes the Provider’s claims and explains how benefits were applied. You can use the RA to determine how a claim was paid including non-allowed amounts and adjustments. The RA will note any appropriate non-covered services, Deductibles, and Coinsurance amounts that are the responsibility of the Member. The RA lists and explains all codes used in processing each claim. Claim details can also be obtained through GlobalLink™.

Claims Payment Recovery

If GlobalHealth overpays a claim for services or pays for service where the Member was not eligible for coverage at the time services were rendered, GlobalHealth may request a refund. This allows GlobalHealth to recoup overpayment amounts by subtracting such amounts from a Provider’s future payments. You will be notified of any offset amount, the name of the Member for whom an overpayment was made, and the relevant dates of service. This information will be noted on your RA.

Adverse Determinations

GlobalHealth will notify you of the Adverse Determination within thirty (30) calendar days after receipt of the claim. This period may be extended one time by GlobalHealth for up to fifteen (15) days, provided that GlobalHealth determines:

- An extension is necessary due to matters beyond its control;
- GlobalHealth notifies you, prior to the end of the initial 30-day period, of why the extension is needed; and,
- The date by which GlobalHealth expects to render a decision.

If an extension is necessary because GlobalHealth does not have the information to decide the claim, the notice will specifically describe the required information, and you will have forty-five (45) days from receipt of the notice to provide the specified information.

If your claim was denied due to missing or incomplete information, you may resubmit the claim to us with the necessary information to complete your claim.

Provider Payment Disputes/Claim Reviews

You may request a claim review if any part of a claim submitted for payment is either denied or you disagree with how the claim was paid. GlobalHealth will review the claim upon written request. The appropriate claim review form can be found at www.GlobalHealth.com, Provider tab. Claim reviews can usually be resolved by attaching any pertinent documents to support your claim (e.g. sending proof of timely filing, sending a copy of the authorizations for claims denied for no authorization).

Your request for claim review must be submitted in writing. The request should include the following:

- Member's name and address;
- GlobalHealth Member ID#;
- Date of service if appealing a denied claim;
- Description of the denied service and why the claim review is being requested; and
- Copies of documentation to support the claim review request (e.g., claims, medical records, physician statements, and any other relevant information).

The time frame for submitting claim review requests equals the claims timely filing limit stated in your contract. Example: if your timely filing is 60 days you have 60 days from the date of denial to submit a claim review request. This time frame applies only to: claims denied for notes, medical records or request for missing information and non-clean claims.

For review requests arising out of claims denied for no authorization, or if you do not agree with the payment amount, a request may be submitted within one (1) year from the date of payment or denial.

Preventive Care Guidelines

GlobalHealth refers to the US Preventative Services Task Force (USPSTF) list of preventative guidelines. The evidence based preventative health guidelines on care that we recommend for the following Member subgroups are posted on our website. Additional reference sources for preventative guidelines are the [American Academy of Pediatrics](#), [Centers for Disease Control and Prevention](#) and [Life Stages: Centers for Disease Control and Prevention](#). Disease Control and Prevention. Guidelines for preventative care are available for:

- Perinatal
- Children up to twenty-four (24) months old
- Children 2-19 years old
- Adults 20-64 years old
- Adults sixty-five (65) years and older

Clinical practice guidelines and preventative health guidelines can be found on the GlobalHealth website homepage, under Wellness. Go to www.GlobalHealth.com/wellness_maintain
Not everyone needs every preventative service. You should determine which services are right for each individual Member.

Commercial

If the primary purpose of the service is for treatment rather than preventive screening, the Member may be required to pay their normal Cost-share. Services are preventive when there are no prior symptoms. Services are for treatment purposes when the Member is having symptoms or they have been diagnosed with a particular condition. Please refer to Member Materials for additional information.

Medicare

CMS requires coverage at no cost share to Medicare Members for the following services. Some services require a prior authorization.

Alcohol Misuse Screening & Counseling	IBT for Cardiovascular Disease
Annual Wellness Visit	Hepatitis B Vaccine & Administration
Bone Mass Measurements	IBT for Obesity
Cardiovascular Disease Screening Tests	Lung Cancer Screening
Colorectal Cancer Screening	Medical Nutrition Therapy
Counseling to Prevent Tobacco Use	Pneumococcal Vaccine & Administration
Depression Screening	Prostate Cancer Screening
Diabetes Screening	Screening for Cervical Cancer
Diabetes Self-Management Training	Screening for STIs and HIBC to Prevent STIs
Glaucoma Screening	Screening Mammography
Hepatitis C Virus Screening	Screening Pap Tests
HIV Screening	Screening Pelvic Examinations
Influenza Virus Vaccine & Administration	Ultrasound Screening for AAA
Initial Preventive Physical Examination	

An interactive quick reference guide is available at

<https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html>

Laboratory Testing

If your practice has a CLIA-approved lab on site, you may provide and bill for those tests that you are approved and contracted to perform. All other test(s) must be performed at a laboratory Facility that is contracted with GlobalHealth. If your practice does not have a lab onsite, you may either refer the patient to a GlobalHealth contracted laboratory Facility or draw and send the lab specimen to a GlobalHealth contracted laboratory.

Drug Testing Limitations

- The test is limited to the detection of specific drugs.
- The frequency of the testing is limited to the lowest level to detect the presence of drugs.
- Drug confirmation is limited to:
 - When the result of the screen is positive, or
 - The result is negative and negative finding is inconsistent with the medical history.
- Confirmatory testing must be necessary for treatment planning.

Drug Testing Exclusions

- Testing ordered by third parties, such as school, courts, or employers or requested by a Provider for the sole purpose of meeting the requirements of a third party.
- Testing for residential monitoring.
- Routine urinalysis for confirmation of specimen integrity.

Compliance Program

GlobalHealth has a written Compliance Program that incorporates the following elements:

- A designated Chief Compliance Officer
- Written Code of Conduct
- Auditing and monitoring, including methods for detecting Fraud and abuse
- Education and training
- Hotline for reporting compliance concerns
- Policies and procedures
- Remediation / corrective action when problems are identified

All participating Providers are expected to adhere to the GlobalHealth Compliance Program, including the Code of Conduct. A current copy of the Code of Conduct is available on the GlobalHealth website. For any question concerning the Compliance Program, or to report a concern call our toll-free anonymous reporting line, (877) 280-5852, and leave a message. Or, email compliance@globalhealth.com.

All questions and concerns are thoroughly investigated by the Compliance Officer in a timely manner. GlobalHealth will not retaliate against anyone who, in good faith, reports an actual or potential violation of any federal or state law or regulation or GlobalHealth policy. You may also contact our Compliance Officer in writing at:

ATTN: Compliance Officer
GlobalHealth, Inc.
701 NE 10th
Suite 300
Oklahoma City, OK 73104-5403

Quality Improvement Program (“QIP”)

GlobalHealth is committed to supporting quality healthcare and the preservation of good health. The QIP helps GlobalHealth improve Health Plan functions and services from Network Providers.

The QIP provides the framework to assess and improve the quality of care and services. It is based on a model that stresses a systematic, integrated approach to quality. The QIP is designed to meet statutory requirements. It adheres to standards, guidelines, and contractual requirements for Health Plans, including those published by:

- The National Committee for Quality Assurance (“NCQA”).
- The Centers for Medicare and Medicaid Services (“CMS”).

The program identifies issues and opportunities for improvement. Multi-disciplinary work groups, comprised of GlobalHealth employees and participating Providers who:

- Monitor performance indicators.
- Analyze data.
- Implement changes to improve performance.

With a focus on providing high-quality, cost-effective healthcare, the use of the QIP will positively impact the:

- Improvement in processes and outcomes of care.
- Satisfaction of Members and Providers.
- Cost of healthcare services.

Quality Improvement Work Plan

GlobalHealth develops and implements a Quality Improvement Work Plan each year. The Work Plan monitors and evaluates health care delivery systems and Health Plan management activities. Its purpose is to ensure quality care and service.

Quality Improvement activities are evaluated annually. We implement changes to address identified opportunities. We follow up in areas that need improvement.

Quality Program Goals:

- Improve Member health by increasing utilization of preventive health, Behavioral Health, and chronic care services as evidenced by improved HEDIS/CAHPS and HOS scores and reduced inpatient admissions
- Improve transitions in care for high risk Members with Chronic Conditions
- Improve Member education of chronic disease states and engage the Member in Case Management plans
- Reduce all-cause readmission rates across the Plan.
- Decrease the impact of cardiovascular disease, chronic obstructive pulmonary disease, congestive heart failure and diabetes through complex Case Management
- Improve Member adherence to medications for treatment of diabetes, cholesterol and blood pressure
- Maintain a high level of Member and Provider satisfaction, based on survey scores.
- 4-STAR rated Medicare Advantage Plan
- Meet or exceed external regulatory and accreditation standards (CMS, NCQA)
- Strive towards exceeding industry quality measure benchmarks: HEDIS® /CAHPS®/HOS

Medical and Behavioral Health Quality Reviews

GlobalHealth monitors several key quality indicators, including readmissions, hospital acquired conditions, surgical misadventures, “never events” and deaths. Cases are referred by UM, Claims, Members and Providers. Medical and behavioral health clinicians review medical records and other supporting documentation to determine if quality concerns are supported. The Provider will be notified of the Quality findings. Please contact quality@globalhealth.com for more information.

Risk Adjustment

As of January 2014, risk adjustment is required by the U.S. Department of Health and Human Services (“HHS”) by utilizing Hierarchical Conditional Categories (“HCC”) to calculate a patient risk score that annually represents the burden of each individual patient’s disease. In order to achieve

the calculation CMS and HHS require us to annually provide demographic and health status of our Members. All existing and Chronic Conditions must be evaluated and documented each calendar year as the patient diagnoses do not carry forward from year to year. The diagnosis codes and risk adjustment data you submit to use must be complete and accurate.

GlobalHealth conducts HCC reviews all year. In order to provide the required documentation, GlobalHealth requests records or attestation forms from Providers. HCC coding staff also arranges on-site reviews of medical records for the supporting documentation and help train clinic staff on what is needed to document the health conditions appropriately.

HEDIS®

The Healthcare Effectiveness Data and Information Set (¹“HEDIS”) is a tool used by more than 90 percent of America's Health Plans to measure performance on important dimensions of care and service. HEDIS® is part of a nationally recognized quality improvement initiative. Because so many Health Plans collect HEDIS® data, and because the measures are so specifically defined, HEDIS® makes it possible to compare the performance of Health Plans on an "apples-to-apples" basis. Health Plans also use HEDIS® results themselves to see where they need to focus their improvement efforts.

To ensure that HEDIS® stays current, NCQA has established a process to evolve the measurement set each year. NCQA's Committee on Performance Measurement, a broad-based group representing employers, consumers, Health Plans and others, debates and decides collectively on the content of HEDIS®. This group determines what HEDIS® measures are included and field tests determine how it gets measured.

HEDIS® is used by the Centers for Medicare & Medicaid Services (CMS) and the National Committee for Quality Assurance (“NCQA”) for monitoring the performance of managed care organizations. Data is collected for measures related to preventive care. NCQA has expanded the size and scope for HEDIS® 2017 and includes 91 measures across 7 domains of care. As a health plan, we are responsible for collecting data on these performance measures and one of the ways we do that is through medical record review. Each year, a sample of medical records are randomly selected for review to ensure quality care is being provided to our Members. Primary Care Physicians (“PCP”) and OB/GYNs are the primary participants. However, if the data is not found in these medical records, additional medical record reviews may be required.

GlobalHealth requests HEDIS® records all year and during a HEDIS® reporting drive each spring. Your assistance throughout year minimizes the number of records needed in the HEDIS® season. There are several ways you may receive record requests for HEDIS® purposes from GlobalHealth. For individual or very small amounts of records we will fax compliant requests to your office with detailed instructions on how to return the request. We also employ auditors in your area that may call to schedule an on-site visit to review appropriate medical records. They will provide a detailed list of information you need to prepare for the visit. We ask that Provider offices schedule these visits quickly on a day that is convenient. These visits are not a “pass or fail” situation, we are simply reviewing records to determine if they meet HEDIS® measure compliance. In some cases, the auditor may make recommendations on how your clinic can make positive changes to improve your overall compliance. On-site visits are designed to take the burden of complicated record review away

from your staff. If you ever have questions about HEDIS® record review, please use the contact information that is provided to you on the request.

GlobalHealth is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The HIPAA Privacy Rule, 45 CFR 164.506(c)(4), permits a Provider to disclose protected health information (“PHI”) to a health plan for the quality-related health care operations of the Health Plan, provided that the Health Plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. A Provider may disclose protected health information to a Health Plan for the Health Plan's Healthcare Effectiveness Data and Information Set (“HEDIS”) purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the Health Plan. You do not need a separate authorization from the patient to release the medical record information for purposes of these quality studies.

¹HEDIS® is a registered trademark of the National Committee for Quality Assurance (“NCQA”). HEDIS® is designed to provide purchasers and consumers with the information they need to reliably compare the performance of healthcare Plans. HEDIS® results are included in Quality Compass, an interactive, web-based comparison tool that allows users to view Plan results and benchmark information. Quality Compass users benefit from the largest database of comparative Health Plan performance information to conduct competitor analysis, examine quality improvement and benchmark Plan performance.

Consumer Assessment of Healthcare Providers and Systems (“CAHPS®”)

GlobalHealth also participates in the CAHPS® 5.0 survey, which asks Members about their experience with their care in areas such as Provider communication, access to care, getting care quickly, claims processing, and customer service. There are two versions of the CAHPS® survey that we participate in: Adult Commercial and the Medicare Advantage and Prescription Drug. These surveys are distributed annually to a random sample of GlobalHealth Members.

Survey questions include:

- Access to timely care
- Preventive care counseling
- Discussion of treatment options – including pros and cons
- Understandability of physician explanations
- Physician listened, showed respect, and spent enough time with Member
- Follow-up of test results with Member
- Medication review with Member
- Ease of access to specialists
- Smoking cessation discussion / counseling
- Annual flu vaccine

²CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (“AHRQ”).

Provider Satisfaction Survey

Member satisfaction is only part of the Quality Improvement picture. To continually improve upon Plan services, GlobalHealth will conduct regular Provider Satisfaction Surveys. The survey identifies the Providers level of satisfaction including, but not limited to:

- GlobalHealth overall
- Case Management/Referral Department
- Complex Case Management
- Provider Relations Department
- Claims Department

Member Complaints and Grievances

If a Member files a complaint against a Provider, GlobalHealth will contact the Provider for additional information, which may include an explanation or medical records so we can ensure all the facts are obtained before responding to the Grievance. Providers must respond to our requests for an explanation within fifteen (15) days so we can include your response in the investigation. GlobalHealth is subject to timeliness standards that require us to respond within a specific period. Your quick response to our inquiry will ensure we comply with state, federal and CMS regulations.

Access Quality Standards

Regulatory and accrediting agencies establish accessibility requirements. GlobalHealth follows those standards. Ensuring that Members have timely services that are accessible and available is the purpose of these standards. GlobalHealth routinely monitors our Network adequacy and Member access to confirm the standards are met. See the Provider Accessibility section for more information.

Medical Recordkeeping and Documentation Standards

Because complete and accurate documentation in medical records is an essential component of quality patient care, GlobalHealth conducts periodic Practitioner office reviews to assess medical recordkeeping practices and medical record clinical documentation.

Essential medical record components include:

1. An organized medical record filing system with patient medical records stored in a systematic, secure, and confidential manner.
2. Each page in the record contains the patient's name or identification number – both front and back sides.
3. Each record contains appropriate, updated biographical/personal data.
4. All entries are dated.
5. All entries are signed by the author. Transcribed notes are initialed or signed by the author. All signatures should include the credentials of the author. Note: an electronic signature is acceptable, provided authorization for its use is included in the signature line. Stamped signatures will not be accepted.
6. Physician Assistant's notes are co-signed by physician.
7. Personal/biographical data including date of birth, sex, marital status, address, employer, and home and work telephone numbers.
8. Family/social history is noted in the record.
9. Advance Directive documents or a notation that none exist.
10. The record is legible to the reviewer or someone other than the writer.

11. Medication allergies, adverse reactions, or “no known allergies” is prominently noted in the record. Location is consistent throughout patient charts.
12. A current medication list including drug name, dosage, frequency and duration, initial prescription and refill dates. Medication list is updated each visit.
13. Injections are documented and include drug name, dosage, route, and site as well as the NDC number.
14. Notation is made in record when sample drugs are provided.
15. A current problem list notes significant illnesses and medical conditions.
16. Immunization records are current, or a note indicates up-to-date immunizations.
17. Past medical and social history is present and identifies serious accidents, surgeries, illnesses and important family information. Personal health history includes complete medical and Behavioral Health history.
18. For Members twenty (20) years old or younger, past medical history includes prenatal care, birth, operations, and childhood illnesses.
19. For Members eleven (11) years and older (or younger if appropriate) who have been seen three (3) or more times, the use of cigarettes, alcohol, and any substance abuse is noted. Documentation of family/household tobacco history is also noted.
20. Pertinent history and physical exam is documented for visits, including reason for visit, history and description of presenting problems, including precipitating factors, mental status evaluation, physical status evaluation if appropriate, psychosocial history including an appropriate developmental history for children and adolescents, risk assessment of severity and possibility of potential harm to self or others accompanied by a Referral to a level of care which is appropriate to the level of risk, and appropriate diagnostic tests.
21. Notes indicate all services provided by Practitioner, all Referrals for diagnostic or therapeutic services, services and tests ordered, follow-up care plans including dates of subsequent appointments, and when applicable, a completed discharge plan.
22. Lab and other studies ordered as appropriate for diagnosis.
23. Preventive and screening services are offered consistent with national and GlobalHealth practice guidelines.
24. Diagnosis noted in the medical record is consistent with symptoms and physical exam or other diagnostic findings.
25. Evidence of patient teaching as appropriate.
26. Treatment plan is consistent with diagnoses and includes measurable objectives, estimated time frames, and prevention efforts, community resources utilization, and current caregivers contacted or involved in treatment (if no caregiver is involved, so stated in the record).
27. Follow-up plans and dates for return visits are clearly documented.
28. Unresolved problems are addressed in subsequent visits.
29. Consultations, ancillary services, lab, and imaging study reports are initialed by the Practitioner.
30. If hospitalized, the record includes an admit report, operative report (if applicable) and discharge summary.
31. Working diagnoses are consistent with findings and appropriate diagnoses are documented.
32. There is evidence of continuity and coordination of care between primary and specialty Practitioners including mental health Practitioners.

33. Phone calls to and from patient are documented, including phone calls notifying the patient of diagnostic test results or related to prescription refills.
34. Requests for prescription refills are documented to include the pharmacy name, medication name, dosage, administration directions, and number of refills allowed.

Credentialing/Re-Credentialing

Primary Care and Specialist Physician Credentialing Criteria

To be considered a Primary Care Physician (“PCP”), the applicant must specialize in internal medicine, general practice, family practice, or pediatrics. Internal medicine physicians must devote ninety percent (90%) of their time to family medicine to be credentialed as a PCP.

Credentialing Requirements:

1. Submit a complete standardized application or a completed Council for Affordable Quality Healthcare (“CAQH”) with original signature (no signature stamps).
2. Current unrestricted Oklahoma license.
3. Graduation from a school of medicine or osteopathy that is accredited by the Liaison Committee on Medical Education and completion of residency. Graduates of foreign medical schools must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG certificate). For other Practitioners, graduation from an appropriate accredited professional school and/or completion of a formal training program.
4. A current DEA certificate and Controlled Dangerous Substance certificate, if applicable.
5. Board certification or Board eligibility.
6. Evidence of Medicare certification.
7. Current and unrestricted admitting privileges in good standing at a GlobalHealth contracted Hospital. If the Practitioner does not have admitting privileges at a contracted Hospital with GlobalHealth, they must sign a “No Admit Form”.
8. Current professional liability insurance minimum: \$1,000,000 per occurrence and \$1,000,000 aggregate, unless otherwise agreed to.
9. Absence of history of involvement in malpractice suit, arbitration, or settlement; or in the case of an applicant with such history, evidence that the history does not demonstrate probable future substandard professional performance.
10. Absence of history of denial, suspension, restriction, or termination of Hospital privileges; or in the case of an applicant with such history, evidence that this history does not currently affect applicant’s ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future substandard performance.
11. Absence of a history of disciplinary actions affecting applicant’s professional license, DEA or other required certifications; or, for applicants with such history, evidence that this history does not currently affect applicant’s ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future substandard performance.
12. Absence of history of felony convictions; or for an applicant with such history, evidence that the nature of the conviction does not affect applicant’s current ability to perform the professional duties for which applicant contracted, or does not demonstrate probable future substandard care.
13. Absence of history of exclusions or sanctions by regulatory agencies, including Medicare/Medicaid sanctions; or for an applicant with such history, evidence that applicant is

not currently sanctioned or prevented by a regulatory agency from participating in any federal or state sponsored programs.

14. Absence of chemical dependency/substance abuse; or for those applicants who have such history, evidence that the applicant is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted.
15. Absence of physical or mental condition that would impair the ability to competently and safely perform the professional duties for which the applicant is seeking.
16. Evidence of the capability to provide twenty-four (24) hour, seven (7) days per week coverage.
17. Work history for at least the past five years.
18. Cooperation with office surveys, which includes a structured review of the office site and evaluation of the medical recordkeeping system and practices. Scores of 85% for the site evaluation and 80% for a detailed medical records review for re-credentialing are required.

Midlevel Credentialing Criteria

To be credentialed as a midlevel Provider, the applicant must be licensed as a Nurse Practitioner ("NP") or Physician's Assistant ("PA") in Oklahoma and provide the following:

1. A complete application with original signature (no signature stamps).
2. Current unrestricted Oklahoma license.
3. Graduation from an appropriate accredited professional school and/or completion of a formal training program.
4. Evidence of Medicare certification.
5. Current professional liability insurance minimum: \$1,000,000 per occurrence and \$1,000,000 aggregate.
6. Absence of history of involvement in malpractice suit, arbitration, or settlement; or in the case of an applicant with such history, evidence that the history does not demonstrate probable future substandard professional performance.
7. Absence of a history of disciplinary actions affecting applicant's professional license, or other required certifications; or, for applicants with such history, evidence that this history does not currently affect applicant's ability to perform professional duties for which the applicant contracted, or does not demonstrate probable future sub-standard performance.
8. Absence of history of felony convictions; or for an applicant with such history, evidence that the nature of the conviction does not affect applicant's current ability to perform the professional duties for which applicant contracted, or does not demonstrate probable future substandard care.
9. Absence of history of exclusions or sanctions by regulatory agencies, including Medicare/Medicaid sanctions; or for an applicant with such history, evidence that applicant is not currently sanctioned or prevented by a regulatory agency from participating in any federal or state sponsored programs.
10. Absence of chemical dependency/substance abuse; or for those applicants who have such history, evidence that the applicant is participating in, or has completed, a prescribed, monitored treatment program and that no current chemical dependency or substance abuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted.
11. Absence of physical or mental condition that would impair the ability to competently and safely perform the professional duties for which an applicant is seeking.

12. Evidence of the capability to provide twenty-four (24) hour, seven (7) days per week coverage, if applicable.
13. Work history for at least the past five years.

Hospitals and Facility Credentialing Criteria

To be credentialed as a Hospital or Facility within the GlobalHealth Network, the entity must be licensed in good standing with state and federal regulatory bodies. Additionally, the entity must be accredited by an approved accrediting body such as The Joint Commission (“TJC”) or equivalent. If the entity is not accredited, GlobalHealth will conduct an on-site review to ensure the entity meets quality standards established by TJC and GlobalHealth. GlobalHealth will confirm the entity continues to be licensed and in good standing with state and federal bodies at least once every three (3) years.

Hospital and Facility Providers must provide the following:

1. Submit a completed GlobalHealth “Ancillary & Facility Application” along with the necessary attachments.
2. Evidence of Medicare certification.
3. Copy of accreditation approval letter (e.g., TJC).
4. If an organization is not accredited, the entity must provide current copies of its DEA certification, CLIA/CAP certification, and any other relevant certifications held by the organization.
5. If an organization is not accredited, GlobalHealth will conduct an on-site review. Any deficiencies identified during the on-site visit are communicated to the entity with a request for corrective action plan within fifteen (15) business days of the date received. Failure to timely correct deficiencies may result in a determination not to credential the organization. (Survey results provided by a regulatory agency may be accepted in place of a site visit at GlobalHealth’s sole discretion.)
6. Entities that are not accredited must also have an acceptable malpractice claims history as approved by GlobalHealth. The entity must provide the number and facts of each legal action brought against it in the three (3) years prior to the application and the resolution of such action (e.g. withdrawn, dismissed, judgment, or settlement), including the amounts of settlements and judgments.
7. The entity must submit a copy of its Quality Assurance/Quality Improvement (“QA/QI”) and Risk Management Plans and a copy of its medical staff roster.

Re-credentialing

To remain in the GlobalHealth Network, all Providers must be re-credentialed, at a minimum, every three (3) years.

GlobalHealth (including its delegated entity/entities, if applicable) does not discriminate in the selection of Providers based on race, religion, age, ethnicity, or gender factors.

Credentialing/Re-credentialing Appeal Process

GlobalHealth will:

- Provide written notification when a professional review action has been brought against a Practitioner, reasons for the action, and a summary of the Appeal rights and process.

- Allow Practitioners to request a hearing and provide the specific time period for submitting the request.
- Allow at least thirty (30) calendar days after the notification for Practitioners to request a hearing.
- Allow Practitioners to be represented by an attorney or another person of their choice.
- Appoint a hearing officer or a panel of individuals appointed by GlobalHealth to review the Appeal. This panel will include, at a minimum, the GlobalHealth Medical Director, or designated MD or equal Practitioners, and one Network Practitioner to participate in the Appeal.
- Provide written notification of the Appeal decision that contains the specific reason for the decision within 10 days.
- Follow all applicable state law requirements.

Member Rights and Responsibilities

As a partner with GlobalHealth, you should be aware of our Member Rights and Responsibilities.

Our Members have the right to:

1. Receive information about GlobalHealth, its services, Practitioners and Providers, and Member rights and responsibilities.
2. Be treated with respect and recognition of his/her dignity and right to privacy.
3. Ask questions about any medical advice or prescribed treatment in order to make an informed consent or refuse a course of treatment.
4. A candid discussion of all appropriate, Medically Necessary treatment options that are recommended, regardless of the cost or benefit coverage.
5. To participate in decisions regarding medical care, to completely understand his/her medical condition, health status, and the medications prescribed (including why the medication is being prescribed, how to take it properly, and possible side effects).
6. Voice complaints or Grievances about GlobalHealth or the care the Member received without discrimination, retaliation, or adverse effect.
7. Appeal any unfavorable medical or administrative decisions by following GlobalHealth's established Appeals and Grievances procedures. Members have the right to an external or expedited review of an Adverse Determination when applicable.
8. Timely access to his/her PCP and Referrals to specialists when Medically Necessary or urgent.
9. Use Emergency Services when the Member, acting as a Prudent Layperson, has a reasonable belief that an Emergency Medical Condition exists.
10. Confidential treatment of individual identifiable or protected health information as required by federal and state laws.
11. Receive explanations of benefits and claims processing determinations.
12. Expect problems to be fairly examined and appropriately addressed.
13. Exercise Member rights regardless of race, national origin, gender, sexual orientation, marital status, or cultural, economic, educational or religious background.

Our Members have the responsibility to:

1. Identify himself/herself as a GlobalHealth Member by presenting a Member ID card to the Provider of services.

2. Provide, to the extent possible, information and medical records needed by the Provider in order to render appropriate care.
3. Do their part to improve their own health condition by following treatment plans and instructions
4. Be on time for appointments and notify the Provider in advance as possible if the Member needs to cancel or reschedule an appointment.
5. Notify their PCP within forty-eight (48) hours, or as soon as possible, if hospitalized or if emergency or Out-of-network Urgent Care was received.
6. Pay all required Copayments.
7. Review their Member Handbook and Schedule of Benefits, FEHB Brochure, or Evidence of Coverage and ask questions if they do not understand health benefits or coverage information.

GlobalHealth Plan Ratings and Accreditation

As part of our commitment to Quality, GlobalHealth participates in nationally recognized Plan evaluation programs.

Medicare Advantage Plan Ratings (STAR Ratings)

CMS (The Centers for Medicare and Medicaid Services) created the 5-STAR Quality Rating System for Medicare Advantage (MA) beneficiaries and their families to be able to compare quality among MA Plans more easily.

STARS is a quality rating system that gives a rating between 1 and 5 stars for Part C and D Medicare Plans. The ratings are based on an average of 44 measures across Part C and D and are continually updated. Plans with 5 stars are considered to be above average in quality and Plans with a 1 star are considered to be below average in quality.

The **Overall Star Rating** combines scores for the types of services each Plan offers: For Plans covering health and drug services, the overall score for quality of those services covers many different topics that fall into the following categories:

- **Staying healthy:** screenings, tests, and vaccines. Includes whether Members got various screening tests, vaccines, and other check-ups that help them stay healthy.
- **Managing chronic (long-term) conditions:** Includes how often Members with different conditions got certain tests and treatments that help them manage their condition.
- **Member experience with the Health Plan:** Includes ratings of Member satisfaction with the Plan.
- **Member complaints and changes in the Health Plan's performance:** Includes how often Medicare found problems with the Plan and how often Members had problems with the Plan. Includes how much the Plan's performance has improved (if at all) over time.
- **Health Plan customer service:** Includes how well the Plan handles Member Appeals.
- **Drug Plan customer service:** Includes how well the Plan handles Member Appeals.
- **Member complaints and changes in the drug Plan's performance:** Includes how often Medicare found problems with the Plan and how often Members had problems with the Plan. Includes how much the Plan's performance has improved (if at all) over time.
- **Member experience with Plan's drug services:** Includes ratings of Member satisfaction with the Plan.

- **Drug safety and accuracy of drug pricing:** Includes how accurate the Plan’s pricing information is and how often Members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

Commercial Plans Accreditation

GlobalHealth demonstrates its commitment to high quality value based services by undergoing a standardized, comprehensive evaluation of clinical measures and consumer experience conducted by the National Committee for Quality Assurance (NCQA) every three years. GlobalHealth was last accredited in 2015. The accreditation covers all non – Medicare Plans, including State and Federal Employees. The assessment measures five areas of performance:

- **Staying healthy:** Health Plan activities that help Members maintain good health and avoid illness; provider Doctors with guidelines about appropriate preventive services and if Members receive appropriate tests and screenings
- **Getting Better:** Health plan activities that help people recover from illness: How does the plan evaluate new medical procedures, drugs and devices to ensure that patients have access to the most up-to-date care? Do doctors in the plan’s network advise patients to quit smoking?
- **Living With Illness:** Health plan activities that help people manage chronic illness: Does the plan have programs in place to help patients manage chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?
- **Qualified Providers:** Health plan efforts to ensure that each doctor is licensed and trained to practice medicine and that plan members are happy with their doctors: Does the plan check whether physicians have had sanctions or lawsuits against them? How do plan members rate their personal doctors or nurses?

The accreditation standards look at the Health Plan’s

- **Quality and Improvement Management**
 - A health plan’s systems for continuous improvement of quality of care and service.
 - How the plan makes sure that members have access to the care they need.
 - Specific plan programs that help members with chronic illnesses (e.g., disease management and complex illness or trauma; case management).
- **Utilization management**
 - How fair, consistent and prompt is the plan when it makes decisions about medical necessity for medical, behavioral health and pharmacy services?
 - Does the plan use evidence-based clinical guidelines and clinical staff—including physicians—to make decisions?
 - Does the plan have a process for members to appeal its medical necessity and coverage decisions?
- **Credentialing**
 - How thoroughly the plan investigates qualifications and practice history before allowing a physician to join its network.
 - The plan’s process for ongoing evaluation of the physicians in its network.
- **Member’s rights and responsibilities**
 - Does the plan clearly inform its members about how to get care and use its services?
 - Does the plan have a process to respond to member concerns and complaints?
 - How the plan protects members’ personal information.

- Member Connections
 - How the plan distributes important information to members, such as their health status, plan resources, member care options and the cost of different services and prescription drugs.
 - How the plan promotes wellness and prevention to its members.
- HEDIS and CAHSPS survey results.

Federal Employees Health Benefit (“FEHB”) Plan Performance Assessment

In addition to the NCQA accreditation, the Federal Office of Personal Management performs an annual assessment of the FEHB Plan, which evaluates the following areas:

- Clinical Quality
 - Members’ use of preventive care and behavioral health services (HEDIS),
 - Members’ adherence to medications (HEDIS),
 - Chronic Disease Management services
- Customer Services
 - Communication with Members (materials, etc.)
 - Access to services
 - Members’ experience and engagement (CAHPS Surveys)
- Resource use
 - How well we manage utilization of services (over and underutilization, medical necessity)
- Contract Oversight
 - Compliance with Contract
 - Responsiveness to OPM
 - Technology Management and Data Security

Regulations

GlobalHealth takes all reasonable steps and uses best efforts to comply with applicable laws and regulations. The regulations include, but are not limited to:

- The Health Information Technology for Economic and Clinical Health (“HITECH”)
- The False Claims Act and Fraud Enforcement Recovery Act
- Fraud, Waste and Abuse
- The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)
- The Physician Self-Referral Law (Stark Law)
- The Medicare Improvements for Patients and Providers Act (“MIPPA”)
- Anti-Kickback Statute

As a contracted Provider in the GlobalHealth Network, you are also expected to comply with these laws and regulations.

Women’s Health and Cancer Rights Act

Women who have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). Coverage will be provided in a manner professionally determined for:

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles, Copayments, and Coinsurance applicable to other medical and surgical benefits provided under this Plan.

The Health Information Technology for Economic and Clinical Health (“HITECH”)

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law to promote the adoption and meaningful use of health information technology.

The False Claims Act and Fraud Enforcement Recovery Act

The Federal False Claims Act was enacted by Congress as an effective tool in combating Fraud against the federal government. It allows a private individual or ‘whistleblower’, who has knowledge of Fraud of the federal government, to file a lawsuit on behalf of the government resulting in stiff penalties and damages.

Fraud, Waste and Abuse

GlobalHealth is committed to an effective Fraud, Waste, and Abuse (“FWA”) Program to detect, correct, and prevent FWA.

Fraud is knowingly and willfully carrying out, or attempting to carry out, a plan or scheme to defraud a healthcare benefit program, or to obtain, by means of a lie or false pretenses, a benefit for which the individual is not entitled.

Abuse includes requesting payment for items and services when there is no entitlement for payment of those items or services. Unlike Fraud, the individual or entity has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of potential FWA include, but are not limited to:

- Submission of false or fraudulent claims by a Provider.
- Submission of claims for services that are not Medically Necessary.
- Submission of claims for services that are not properly documented.
- Failure to provide Medically Necessary services to a Member which adversely affects the Member.
- Payments made for excluded drugs or drugs that were not for medically accepted indications.
- Multiple billings for the same services.
- Altered or forged documentation
- Billing or charging for services that GlobalHealth covers (other than Copayments).
- Offering gifts or money to for treatment or services that are not needed.
- Offering free services, equipment, or supplies in exchange for using a GlobalHealth Member ID number.
- Member selling or lending their Member ID card to someone else.
- Members lying to a Healthcare Provider to receive goods or services that are not medically necessary.

GlobalHealth will promptly investigate any reported potential violations of federal or state laws, regulations or other policies. Reports of actual or potential FWA should be reported to the GlobalHealth Compliance Officer at the toll-free reporting line at 1-877-280-5852.

Education on FWA is available on the GlobalHealth website. Additionally, the GlobalHealth Compliance Officer will provide FWA and other compliance-related training to Providers upon request.

GlobalHealth reserves the right to audit paid claims in order to determine payment accuracy and as part of its program to detect FWA. Such audits may be conducted at random or selected based on data analysis. Certain claims present higher risk for payment errors and may be subject to pre- or post-payment audits.

Such claims include, but are not limited to:

- Inpatient short stays
- Outpatient observation greater than twenty-four (24) hours
- Inpatient high-severity DRG
- Readmissions within thirty (30) days
- High dollar claims
- Multiple units billed
- Targeted areas identified by the Office of the Inspector General (“OIG”), the Centers for Medicare and Medicaid Services (“CMS”) or other entity as being high risk for error.

Reporting Fraud and Abuse

GlobalHealth is committed to detecting and preventing healthcare Fraud and abuse. You can help in this effort by reporting suspected Fraud and/or abuse by calling our 24-hour hotline toll-free at 1-877-280-5852. If you call this number, please provide as much detailed information as possible. You may remain anonymous if you choose.

GlobalHealth’s Fraud, Waste, and Abuse, Compliance, and Privacy Hotline:

Call and leave message twenty-four (24) hours.

405-280-5852 (local)

1-877-280-5852 (toll-free)

compliance@globalhealth.com

HIPAA/Protected Health Information (“PHI”)

The HIPAA Privacy Rule provides protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. The Privacy Rule is balanced as it permits the disclosure of health information needed for patient care and other important purposes.

Members identifiable health information is protected by federal and state laws. Members have the right to access or restrict the release of their PHI in accordance with federal and state laws. They may also request an accounting of disclosures of your PHI.

Medical records and/or information may be collected and used for:

- Clinical review.
- Satisfaction and quality studies.
- Complaint and/or Appeal investigation.
- Fraud detection.
- State, federal, or accreditation reviews.
- Other matters as required by law.

To report a possible privacy violation or breach, please contact the GlobalHealth Compliance and Privacy Officer at (405) 280-5524 (direct phone) or 1-877-280-5852 (recorded hotline), email privacy@globalhealth.com, or write to:

ATTN: Privacy Officer
GlobalHealth, Inc.
701 NE 10th
Suite 300
Oklahoma City, OK 73104-5403

Personally Identifiable Information (“PII”)

PII is information that can be used to distinguish or trace an individual’s identity. It may be information used alone. It may be combined with other information that may be linked to a specific individual. It is protected by federal and state laws.

As a GlobalHealth Provider, anyone who receives information that you are required to provide may use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Member’s health coverage. GlobalHealth may receive the information directly, from another person, or from a federal agency. GlobalHealth will not share PII with anyone else except to carry out the functions of providing a Member’s health coverage and for which the Member has provided consent for the information to be used or disclosed.

Notice of Privacy Practices (“NPP”)

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (“PHI”) MAY BE USED AND/OR DISCLOSED. PLEASE REVIEW IT CAREFULLY.

GlobalHealth, Inc. (“GlobalHealth”) is committed to protecting the privacy and confidentiality of our Members’ Protected Health Information (“PHI”) in compliance with applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health (“HITECH”) Act.

How GlobalHealth May Use or Disclose Your Health Information:

For Treatment. We may use and/or disclose your PHI to a healthcare provider, hospital, or other healthcare facility in order to arrange for or facilitate treatment for you.

For Payment. We may use and/or disclose your PHI for purposes of paying claims from physicians, hospitals, and other healthcare providers for services delivered to you that are covered by your health plan; to determine your eligibility for benefits; to coordinate benefits; to review for medical

necessity; to obtain premiums; to issue explanations of benefits to the individual who subscribes to the health plan in which you participate; and other payment related functions.

For Health Care Operations. We may use and/or disclose PHI about you for health plan operational purposes. Some examples include: risk management, patient safety, quality improvement, internal auditing, utilization review, medical or peer review, certification, regulatory compliance, internal training, accreditation, licensing, credentialing, investigation of complaints, performance improvement, etc.

Health-Related Business and Services. We may use and disclose your PHI to tell you of health-related products, benefits, or services related to your treatment, care management, or alternate treatments, therapies, providers, or care settings.

Where Permitted or Required by Law. We may use and/or disclose information about you as permitted or required by law. For example, we may disclose information:

- To a regulatory agency for activities including, but not limited to, licensure, certification, accreditation, audits, investigations, inspections, and medical device reporting;
- To law enforcement upon receipt of a court order, warrant, summons, or other similar process;
- In response to a valid court order, subpoena, discovery request, or administrative order related to a lawsuit, dispute or other lawful process;
- To public health agencies or legal authorities charged with preventing or controlling disease, injury or disability;
- For health oversight activities conducted by agencies such as the Centers for Medicare and Medicaid Services (“CMS”), State Department of Health, Insurance Department, etc.;
- For national security purposes, such as protecting the President of the United States or the conducting of intelligence operations;
- In order to comply with laws and regulations related to Workers’ Compensation;
- For coordination of insurance or Medicare benefits, if applicable;
- When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat); and
- In the course of any administrative or judicial proceeding, where required by law.

Business Associates. We may use and/or disclose your PHI to business associates that we contract with to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, health information organizations, data storage and electronic health record vendors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI.

Personal/Authorized Representative. We may use and/or disclose PHI to your authorized representative.

Family, Friends, Caregivers. We may disclose your PHI to a family member, caregiver, or friend who accompanies you or is involved in your medical care or treatment, or who helps pay for your medical care or treatment. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Emergencies. We may use and/or disclose your PHI if necessary in an emergency if the use or disclosure is necessary for your emergency treatment.

Military / Veterans. If you are a member or veteran of the armed forces, we may disclose your PHI as required by military command authorities.

Inmates. If you are an inmate of a correctional institute or under the custody of law enforcement officer, we may disclose your PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through direct mail, email, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Medication and Refill Reminders. We may use and/or disclose your PHI to remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications.

Limited Data Set. If we use your PHI to make a “limited data set,” we may give that information to others for purposes of research, public health action, or health care operations. The individuals/entities that receive the limited data set are required to take reasonable steps to protect the privacy of your information.

Any Other Uses. We will disclose your PHI for purposes not described in this notice only with your written authorization. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale of PHI require your written authorization.

NOTE: The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to State law.

Your Health Information Rights

Right to Inspect and Copy

You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by State and Federal law for such copies. We may deny your request to inspect and copy your records in certain circumstances. If you are denied access, you may appeal to our Privacy Officer.

Right to Confidential Communication

You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with.

Right to Accounting of Disclosures

You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or health care or health plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost and you may withdraw your request before any costs are incurred.

Right to Request Restrictions on Uses or Disclosures

You have the right to request restrictions or limitations on certain uses and disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If do we agree, we will make all reasonable efforts to comply with your request unless the information is needed to provide emergency treatment to you or the disclosure has already occurred or the disclosure is required by law. Any agreement to restrictions must be signed by a person authorized to make such an agreement on our behalf.

Right to Request Amendment of PHI

You have the right to request an amendment of your PHI if you believe the record is incorrect or incomplete. You must submit your request in writing and state the reason(s) for the amendment. We will deny your request if: (1) it is not in writing or does not include a reason to support the request; (2) the information was not created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and copy, or (4) the information in the record is accurate and complete. If we deny your amendment request, you have a right to file a statement of disagreement with our Privacy Officer.

Right to Be Notified of a Breach

You have the right to receive notification of any breaches of your unsecured PHI.

Right to Revoke Authorization

You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required.

Right to Receive a Copy of this Notice

You have the right to receive a paper copy of this Notice upon request.

Changes to this Notice

GlobalHealth reserves the right to change this notice and make the new provisions effective for all PHI that we maintain.

To Report a Privacy Violation

If you have a question concerning your privacy rights or believe your rights have been violated, you may contact our Privacy Officer at:

ATTN: Privacy Officer
GlobalHealth, Inc.
701 NE 10th
Suite 300
Oklahoma City, OK 73104-5403
Toll-free: 1-877-280-5852
Email: privacy@globalhealth.com

You may also report a violation to the Region VI U.S. Department of Health and Human Services Office for Civil Rights, 1301 Young ST, Suite 1169, Dallas, TX 75202. You will not be penalized or retaliated against for filing a complaint.

Physician Self-Referral Law (Stark Law)

Physician self-referral is the practice of a physician referring a patient to a medical Facility in which he has a financial interest either directly or indirectly. CMS published the self-referral disclosure protocol ("SRDP") that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral statute.

The Medicare Improvements for Patients and Providers Act ("MIPPA")

Legislation enacted to expand access to care, enhance the quality of healthcare and provide coverage for certain preventive services.

Anti-Kickback Statute

The Federal Anti-Kickback Statute prohibits the willful and knowing acceptance or solicitation, offer, of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind regarding influencing the Referrals of the federal healthcare program business. Violators may face charges and/or penalties including being debarred from participation in federal programs.

American with Disabilities Act

Provider's offices are required to adhere to the American with Disabilities Acts ("ADA") guidelines and any other applicable federal or state laws.

Special Needs

Limited English Proficiency, Vision, Hearing, or Physically Challenged

Contact Customer Care if you have a Member who requires the services of an interpreter or who has special language needs (e.g., is visually and hearing impaired or who is physically disabled). GlobalHealth offers over 150 languages from professionally certified medical interpreters. Please have Members call the Customer Care Number on the back of their ID card. The contact information is also listed on page 7 of this Manual.

Advance Directives

An Advance Directive is a written document that allows the Member to inform physicians and others of a Member's wishes to receive, decline, or withdraw life-sustaining medical care. It may include a living will, appointment of a health proxy, or both.

Who can have an Advance Directive?

Any individual of sound mind and eighteen (18) years of age or older can have an Advance Directive for healthcare. Publications may be ordered from DHS by calling 1-877-283-4113 or 962-1721 in the Oklahoma City area.

Non-Discrimination Notice

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If you believe that GlobalHealth has discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **ATTN: Director, Compliance & Legal Services, 701 NE 10th Street, Suite 300, Oklahoma City, OK 73104-5403, Fax: (405) 280-5894, or Email: Compliance@globalhealth.com.** You can file a grievance in person or by mail, fax or email. 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, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Glossary

Adverse Determination – A determination that an admission, availability of care, continued stay or other healthcare service that is a covered benefit has been reviewed, and based upon the information provided, does not meet the Plan’s requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness, and the requested services or payment for the service is therefore denied, reduced, or terminated.

Allowed Amount – Maximum amount on which payment is based for covered health services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.”

Appeal – A request for GlobalHealth to review a decision or a Grievance again.

Balance Billing – When a Provider bills for the difference between the Provider’s charge and the GlobalHealth Allowed Amount. For example, if the Provider’s charge is \$100 and the GlobalHealth Allowed Amount is \$70, an out of Network Provider could bill for the remaining \$30. An In-network Provider may *not* balance bill.

Behavioral Health - The scientific study of the emotions, behaviors and biology relating to a person's mental well-being, their ability to function in everyday life, their concept of self, and their possible misuse of and/or addiction to substances (illegal drugs or Prescription Drugs not being used as prescribed).

Case Management – A process to assess, plan, implement, coordinate, monitor, and evaluate options to meet a Member’s healthcare needs based on the benefits and resources needed in order to promote a quality outcome for you.

Chronic Condition – A continuous or persistent condition over an extended amount of time which requires ongoing treatment.

Clean Claim – A claim for Medically Necessary, covered healthcare services that is timely submitted and includes all the information necessary to adjudicate the claim for payment. A Clean Claim has no defect or impropriety, includes all substantiating documents, and requires no special treatment or development prior to adjudication.

Coinsurance – A Member’s share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the Allowed Amount for the service. A Member pays the Coinsurance *plus* any Deductibles they owe. For example, if GlobalHealth’s Allowed Amount for an office visit is \$100

and the Member met their Deductible, their Coinsurance payment of 20% would be \$20. GlobalHealth pays the rest of the Allowed Amount.

Copayment – A fixed amount (for example, \$15) paid for a covered healthcare service, usually when a Member receives service. The amount can vary by the type of covered healthcare service.

Cost-share – The portion of the cost for services, treatment, and supplies that a Member pays. This includes Deductibles, Copayments, and Coinsurance.

Covered Services – Medically Necessary services or supplies provided under the terms of the applicable Member Handbook, Schedule of Benefit, FEHB Brochure, or Evidence of Coverage materials.

Deductible – The amount a Member owed for covered healthcare services that GlobalHealth covers before GlobalHealth begins to pay. For example, if the Deductible is \$1,000, GlobalHealth won't pay anything until the Member pays \$1,000 Deductible for covered healthcare services subject to the Deductible. The Deductible may not apply to all services. Not all GlobalHealth Plans have a Deductible.

Dependent – Any spouse or child up to the age of twenty-six (26) (including stepchildren, foster children, and adopted children from the date placed in the home) of the Subscriber. GlobalHealth covers Dependents when they meet eligibility and Premium requirements.

Durable Medical Equipment (DME) – Equipment and supplies ordered by a healthcare Provider for everyday or extended use. Coverage for DME may include: Oxygen equipment, wheelchairs, or crutches.

Emergency Medical Condition – The sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Emergency Room Care – Emergency Services received in an emergency room.

Emergency Services – Evaluation of an Emergency Medical Condition and provision of necessary treatment to stabilize or keep the condition from getting worse.

External Review – An Appeal process through which you may have a denied claim reviewed by an external, independent reviewer.

Facility – Any building in which healthcare services are delivered.

Fraud – The intentional deception by a Member or a Provider to provide false information to GlobalHealth, or the intentional misuse of a Member ID Card.

Grievance – A complaint that is communicated to GlobalHealth in writing.

Health Plan – A health insurance company that provides a benefits Plan.

High Impact Specialists- Specialists who treat special, specific conditions that have serious consequences for the Member and require significant resources.

High Volume Specialists – Specialists who treat a significant portion of the organization's membership.

High Volume Behavioral Health Specialists- Behavioral Health Practitioners who treated at least 50% of the members receiving behavioral health services of the following defined specialties:

Psychiatrists/ APNPs/ PAs (those who prescribe and monitor medications or provide outpatient opioid treatment), Behavioral Health Clinicians (Psychologists and Masters-prepared, licensed) therapists who provide mental health assessments and counseling) and AODA counselors (those who specialize in treating substance abuse)

Home Healthcare – Medically Necessary healthcare services a person receives in his or her home, including Skilled Nursing Care and/or Skilled Rehabilitation Services.

Hospital – A medical Facility primarily and continuously engaged in providing and operating for the medical care and treatment of sick or injured persons on an Inpatient basis for which a charge is made. GlobalHealth contracts with Hospitals licensed by the State of Oklahoma. Each Contracting Medical Group designates a Hospital for delivery of Hospital Services to Members.

Hospitalization – Care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay.

Hospital Outpatient Care – Care in a Hospital that usually doesn't require an overnight stay. In certain situations, a patient may require overnight observation as an Outpatient.

Hospital Services – Medically Necessary services provided by a Hospital. The services may be provided on an Inpatient or Outpatient basis. They are prescribed, directed, or authorized by the Member's physician.

Independent Review Organization (IRO) – An entity that conducts independent External Reviews of Adverse Determinations and final Adverse Determinations, for out-of-network Providers or if the Provider has appealed on behalf of the Member.

Infertility – The inability to conceive a pregnancy or to carry a pregnancy to live birth after a year or more of regular sexual relations without contraception and the presence of a demonstrated condition recognized by a licensed physician, who is a Network Provider, as a cause of Infertility.

In-network – A healthcare Provider or Facility that has a Contract with GlobalHealth to provide services at a discounted rate for Members. In-network Providers can be found in the *Physician and Health Providers Directory* or on our website Provider Search. Also see Network.

Inpatient – Patient who is admitted to and is assigned a bed in a healthcare Facility while undergoing diagnosis and receiving treatment and care.

Life-threatening Disease or Condition – Any disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.

Medical Group – Any group of licensed doctors of medicine or osteopathy. A Contracting Medical Group is a Medical Group that has entered into a written agreement with GlobalHealth to provide Medical Services to GlobalHealth Members.

Medical Services – The Medically Necessary professional services delivered by a physician, surgeon, or paramedical personnel. Medical Services must be directed by the PCP or specialty physician and authorized by your PCP unless specified otherwise.

Medically Necessary – Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms and that meet generally accepted standards of medicine.

Member – Any eligible Subscriber or Dependent of Subscriber.

Network – The Facilities and Providers that GlobalHealth has contracted with to provide healthcare services to its Members. These Facilities and Providers are referred to as In-network.

Out-of-network – A healthcare Provider does not have a Contract with GlobalHealth to provide services to Members.

Out-of-network Coinsurance – The percent (for example, 40%) a Member pays of the Allowed Amount for covered healthcare services to Providers who do *not* contract with GlobalHealth. GlobalHealth does not have different Cost-share based on Network. A Member only has coverage for services in our Network, except for urgent or emergent care.

Out-of-network Copayment – A fixed amount (for example, \$30) a Member pays for covered healthcare services from Providers who do *not* contract with GlobalHealth. GlobalHealth does not have different Cost-share based on Network. A Member only has coverage for services in our Network, except for urgent or emergent care.

Out-of-pocket Maximum – The most a Member pays during a Plan period (usually a year) before GlobalHealth begins to pay 100% of the Allowed Amount. This limit never includes the Premium, balance-billed charges, or healthcare costs that GlobalHealth doesn't cover.

Outpatient – Patient who is undergoing diagnosis and receiving treatment and care, but is not admitted to or assigned a bed in a healthcare Facility.

Physician Services – Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan – A policy, Contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services

Practitioner – A professional who provides healthcare services. Practitioners are licensed as required by law.

Preauthorization – A decision by GlobalHealth that a healthcare service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. This is sometimes called prior authorization, prior approval, or precertification. GlobalHealth may require Preauthorization for certain services before a Member receives them, except in an emergency. Preauthorization isn't a promise that GlobalHealth will cover the cost.

Prescription Drugs – Drugs and medications that by law require a prescription.

Prevailing Rates – See Usual and Customary.

Primary Care Physician (PCP) – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Provider - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional, or healthcare Facility licensed, certified, or accredited as required by state law. It may also refer to an institution or organization that provides services for Health Plan Members (such as Hospitals and home health agencies).

Prudent Layperson – A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed. A person, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

Quality Improvement Programs – Programs and services aimed at improving your health through education, focusing on primary and secondary prevention, as well as disease management.

Referral - An electronic or written communication submitted to us by a Member's PCP or specialist who directs a Member to a specialist, Hospital, or other ancillary Provider for Covered Services. GlobalHealth reviews each Referral and sends the Member a letter authorizing the service, if approved.

Rehabilitation Services – Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric Rehabilitation Services in a variety of Inpatient and/or Outpatient settings.

Service Area – A geographical area, as determined by the Oklahoma Insurance Department, within which GlobalHealth arranges for basic medical, Hospital, and supplemental healthcare services.

Skilled Nursing Care – Services provided in the home by or under the direction of a registered nurse.

Skilled Rehabilitation Services – Services provided in the home by licensed therapists (e.g., physical, occupational, speech).

Skilled Nursing Facility – A Facility or Hospital unit primarily engaged in providing, in addition to room and board accommodations, twenty-four (24) hour Skilled Nursing Care under the supervision of a licensed physician. GlobalHealth contracts with Skilled Facilities that are certified under Title XVIII of the Social Security Act (Medicare certified).

Specialty Care Physician ("SCP") – A physician Specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a Provider who has more expertise in a specific area of healthcare.

Subscriber – A person meeting the eligibility requirements of the *Group Agreement* based on employment or association rules of the group, and for whom the appropriate Health Plan Premium has been received by GlobalHealth. When an employer pays the Premium, the Subscriber is the employee. Applies to Commercial groups only.

Urgent Care – Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

Usual and Customary – The amount paid for a Medical Service in a geographic area based on what Providers in the area usually charge for the same or similar Medical Service. The UCR amount may be used to determine the Allowed Amount.

Utilization Management ("UM") – A process for monitoring the use, delivery, and cost-effectiveness of services.



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