GlobalHealth

PROVIDER MANUAL

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GlobalHealth Holdings, LLC
www.GlobalHealth.com

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Contents

Welcome to GlobalHealth

This Provider Manual is a reference tool that describes GlobalHealth policies and procedures and is designed to assist you as a Contracted 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 understand GlobalHealth's processes.

GlobalHealth will keep you informed of important changes in our policies, procedures, and benefits. The Provider Manual is accessed via the Providers menu on www.GlobalHealth.com.

This Provider Manual is intended for use by GlobalHealth Contracted Providers only and is incorporated for reference as a part of your Provider Participation Agreement, Independent Practice Association (IPA) Participation Agreement, or Facility Participation Agreement ("Agreement") with GlobalHealth. Therefore, your reimbursement may be affected by your compliance with the contents herein. The information contained in this Provider Manual is strictly proprietary to GlobalHealth and may not be copied in whole or part without the express, prior written consent of GlobalHealth.

Capitalized words and phrases have the same meaning as in Section 1 Definitions of your Agreement.

Our Mission

We are unique by providing high touch, high value, and a partnership to our members. We work hard to offer affordable health insurance coverage with the benefits people truly want and need. It is our hope to be more than just a health insurance company – we want to be a long-term partner with our members.

New information for 2023

Advanced Practice Registered Nurses (APRNs) Designated as Primary Care Providers (PCPs)

GlobalHealth now allows APRNs to be designated as PCPs and listed in the Provider Directory. APRNs wishing to operate as a PCP within the GlobalHealth network must follow all requirements set forth for PCPs and must practice in a primary care setting with an appropriately certified supervising physician who is a Contracted Provider with GlobalHealth. Contact GlobalHealth Provider Relations if you have questions about this change.

Dual Special Needs Plan (D-SNP)

GlobalHealth is offering a D-SNP in 2023 for Members who are eligible for both Medicare and Medicaid. The Centers for Medicare and Medicaid Services (CMS) requires all contracted medical providers and staff receive basic training annually about the D-SNP Model of Care (MOC). A MOC is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each Member enrolled in the D-SNP plan are identified and addressed. GlobalHealth's overall goals in the MOC are to improve access, improve coordination, and improve the health status of its Members. All GlobalHealth Providers participating in these Members' care are required to attend MOC training each calendar year and confirm completion of the training. Please coordinate your training by contacting Provider Relations using the contact information in the Helpful Numbers and Information section of the exhibit for your state.

GlobalHealth's Providers will be accessible to its D-SNP Members 24 hours a day, 7 days a week, collaborate with the Interdisciplinary Care Team (ICT), and contribute to the Member's Interdisciplinary Care Plan (ICP). The Provider will provide clinical consultation and assist with developing care plans as well as providing pharmacotherapy consultation and medication reconciliation.

GlobalHealth Providers will utilize evidence-based nationally approved clinical practice guidelines (CPGs). Please visit GlobalHealth's website to review the approved guidelines using the link in the exhibit for your state.

GlobalHealth will reimburse for D-SNP Covered Services provided to eligible members at the existing Medicare Advantage contracted rates. We will be responsible for Medicare-covered and supplemental services as a primary payor. Medicaid will reimburse as the secondary payor if there is any deductible, copayment, or coinsurance amount not covered by GlobalHealth's payment. Providers are required to register for a Medicaid ID number in order to submit and receive payment for those secondary claims. Your Medicaid ID number will be requested as part of the credentialing and re-credentialing process. Providers may not bill D-SNP members for costs that would be covered by Medicaid, regardless of Medicaid participation status. Any provider who does not enroll in Medicaid will not be able to pursue secondary payment.

GlobalHealth's Provider partners are an invaluable part of the ICT. Our Member, your patient, will benefit through enhancing communication, focusing on each individual Member's special needs, delivering care management programs to help with the Member's medical and non-medical needs, and supporting the Member's plan of care.

Provider Data Accuracy and Validation

Providers are encouraged to keep data current in the National Plan & Provider Enumeration System (NPPES). If NPPES is kept up to date by providers, GlobalHealth can download and rely on it as a primary data resource, instead of calling or faxing your office for this information. Visit NPPES help if you have questions: https://nppes.cms.hhs.gov/webhelp/index.html

GlobalHealth Products

GlobalHealth is fully licensed in the states we serve as a Health Maintenance Organization (HMO).

GlobalHealth requires Members to select a Primary Care Provider (PCP) and does not offer out-of-network benefits, except in emergent, urgent, or prior authorized circumstances.

Products offered by GlobalHealth include Medicare Advantage (MA), Medicare Advantage with Prescription Drug coverage (MAPD), Chronic Special Needs Plans (C-SNP), and Dual Special Needs Plans (D-SNP), as well as products for active and retired State of Oklahoma employees.

MA plans combine the insurance benefits of Medicare Parts A and B with the customer service and care of a consumer-focused HMO. MA plans are sometimes called Part C. MAPD plans combine Medicare Parts A, B, and D. GlobalHealth's Oklahoma plan has received a 3.5 overall Star Rating out of 5 stars from Medicare since 2016, and 4.5 stars for 2023.

GlobalHealth's MA products for 2023 are Point of Service (POS) products. POS Members are able to access certain services from out-of-network providers with prior authorization. Such services include dialysis services (while still in our service area), eye exams (Medicare-covered), eyewear (Medicare-covered and supplemental), inpatient hospital care (acute and psychiatric), opioid dependence treatment services, skilled nursing facility (SNF) care, and certain specialist office visits. Additional information regarding the requirements of these products is included in the PCP Responsibilities, Services That Require Prior Authorization, and Referrals to Non-Contracted Providers sections.

C-SNP products are a type of MAPD product offered to Members with chronic conditions. Qualifying conditions for GlobalHealth C-SNP products include cardiovascular disorders (cardiac arrhythmias, chronic venous thromboembolic disorder, coronary artery disease, and peripheral vascular disease),

chronic heart failure, and diabetes. For additional information regarding C-SNP products and your role as a Provider, attend one of our SNP training sessions online. Training information can be found on the Provider Training page on www.GlobalHealth.com, accessed via the Providers menu.

D-SNP products are a type of MAPD product offered to Members who are eligible for both Medicare and Medicaid. No specific health conditions are required to qualify for D-SNP. For additional information regarding D-SNP products and your role as a provider, attend one of our SNP training sessions online. Training information can be found on the Provider Training page on www.GlobalHealth.com, accessed via the Providers menu.

C-SNP and D-SNP products require an evidence-based MOC, which is approved by the National Committee for Quality Assurance and subject to annual review. SNP products require an Interdisciplinary Care Team (ICT) and Interdisciplinary Care Plan (ICP). The ICT consists of qualified GlobalHealth clinical staff as well as providers participating in the Member's care. The ICP establishes the Member's health goals and recommended actions, based on the ICT's review of the Member's health risk assessment.

Helpful Numbers and Information

Please refer to the exhibit for your state for Helpful Numbers and Information.

Provider Portal

Please access the Portal for all MA/MAPD Members. The Portal will allow you to:

- Verify eligibility.
- Review Member demographics.
- View benefit information.
- Create Referrals.
- Check Prior Authorization/Referral review status.
- Check claim status.

The Portal is available 24 hours a day, 7 days a week. You may access information about the Portal on the Providers menu at www.GlobalHealth.com. The Portal is available here: https://ghprovider.prod.healthaxis.net/.

Online Provider Portal Training/New Provider Orientation/C-SNP & D-SNP Training

Training sessions are available online through Microsoft Teams. You may access training information on the Provider Training page on www.GlobalHealth.com, accessed via the Providers menu.

Provider Responsibilities

GlobalHealth expects all Contracted Providers to adhere to certain guidelines.

Participate in all required training including Provider Orientation, Provider Portal Training, and C-SNP/D-SNP MOC Training within 30 days of the Effective Date of your Agreement.

Educate Members regarding their healthcare and communicate freely with patients about their treatment, regardless of benefit coverage limitations.

Provide Medically Necessary healthcare services in accordance with your GlobalHealth Agreement, the applicable benefit plan materials, GlobalHealth policies and procedures, and requirements in the Provider Manual.

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 their preferred treatment option.

Participate in and cooperate with GlobalHealth's programs including Utilization Management (UM), Care Management (CM), Compliance, and Quality Improvement (QI).

Participate in the ICT and contribute to the ICP when caring for C-SNP/D-SNP Members.

When billing state Medicaid programs, obtain and maintain participation in good standing in the applicable state Medicaid program.

Maintain appropriate medical records to document all services provided to Members.

Do not discriminate in the delivery of healthcare services.

Submit accurate claims to GlobalHealth for services rendered to GlobalHealth Members in accordance with the time frame specified in the Agreement.

Assist GlobalHealth in resolving Coordination of Benefits (COB) issues with other payers.

Cooperate with any investigations regarding grievances, quality of care, or other quality assurance measures or fraud, waste, and abuse.

Have the capacity to accept GlobalHealth members.

Verify Member eligibility. Eligibility can be verified by accessing the Portal. The Member ID card does not guarantee coverage or entitlement to benefits. It is essential to verify Member eligibility because:

Member benefits may change.

Copayments must be determined.

Fraudulent use may occur.

Language Assistance

Contracted Providers must provide 24-hour access to interpreter services.

Contracted Providers may request interpreters for Members whose primary language is other than English by calling GlobalHealth's Provider Services using the contact information provided in the Helpful Numbers and Information section of the exhibit for your state. If the GlobalHealth representative is unable to interpret in the requested language, the representative will immediately connect the Provider and the Member to telephonic interpreter services. Contracted Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Contracted Providers may offer GlobalHealth Members interpreter services if the Members do

not request them on their own. It is never permissible to ask a family member, friend, or minor to interpret. If a Member requests someone be allowed to interpret, it must be documented that telephonic interpreter services were offered and declined by the Member.

As a Contracted Provider, you are responsible for documenting the Member's language services/needs in their medical record as follows:

- Record the Member's language preference in a prominent location in the medical record.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of GlobalHealth's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code, and vendor.

In addition, different types of Providers have specific responsibilities as outlined below.

Primary Care Provider Responsibilities

All GlobalHealth Members must choose a Primary Care Provider (PCP). The PCP is the Member's first contact for their healthcare needs. The PCP provides a broad range of services and coordinates other care when necessary.

- Manage the Member's total healthcare program, which includes health supervision, basic treatment, initial diagnosis, management of chronic conditions, and preventive health services.
- Provide medical care coverage for assigned patient panel 24 hours a day, 7 days a week within GlobalHealth's established network of Contracted Providers.
- Coordinate healthcare with Specialty Care Providers (SCPs) or healthcare facilities when such care is needed, including submitting Referrals. The PCP should always refer Members to GlobalHealth Contracted Providers and Contracted Facilities unless the services are not available. The most current list of Contracted Providers can be found using the online Provider Directory search tool. Members enrolled in a POS plan may access certain services from out-of-network Providers with prior authorization.
- Provide complete information on authorized care or services to the referred SCP.

Members will usually see their PCP first for most of their routine health care needs. MA/MAPD Members may see any network SCP without a referral, but when the PCP or SCP believes they need specialized diagnostic tests or treatment (such as therapy or outpatient surgery), a referral is required.

GlobalHealth requires its PCPs to practice in one of the following fields: Family Medicine, Pediatrics, General Medicine, Geriatrics, or Internal Medicine. Internal Medicine physicians must spend at least 90% of their time practicing primary care to be eligible to contract with GlobalHealth as a PCP. cs acting as PCPs must follow all requirements set forth for PCPs, practice in a primary care setting with an appropriately certified supervising physician, and provide care within the scope of their license.

PCP Panel Status

GlobalHealth ensures Members have access to Primary Care Services and routinely monitors PCP panel status.

Open

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

Closed

Providers who have a full practice may close their practice to new GlobalHealth Members. Providers who request to be listed as "not accepting any Members" will not be assigned new GlobalHealth Members.

A Provider may close their practice to new Members by notifying GlobalHealth. This option allows only patients currently seeing that Provider to select them as a PCP. If a Member incorrectly selects a closed Provider, the PCP must notify GlobalHealth as soon as possible. GlobalHealth will then assist the Member in selecting an available PCP.

Members Changing PCP

Members can change their PCP at any time; however, the effective date will be the first of the following month.

GlobalHealth recommends against Members changing their PCP if the change could have an adverse effect on the quality of their healthcare. For example:

The Member is an organ transplant candidate.

The Member has an unstable, acute medical condition for which they are actively receiving medical care.

The Member is pregnant.

Specialty Care Provider and Other Practitioner Responsibilities

A Specialty Care Provider (SCP) provides certain specialty medical care upon Referral from the PCP.

Accept and treat GlobalHealth Members referred by their PCP.

Comply with all GlobalHealth prior authorization requirements.

Ensure GlobalHealth has authorized services when required.

If additional Medically Necessary tests or treatments are needed beyond those initially authorized, the SCP may seek additional authorization from GlobalHealth and will notify the Member's PCP.

Actively participate in coordination of care activities which may include obtaining the Member's signed authorization to share Protected Health Information (PHI) with other providers involved in their care.

Use best efforts to utilize GlobalHealth Contracted Providers and Contracted Facilities for services for the Member.

Use best efforts to provide a written report to the Member's PCP within 5 working days.

Hospital/Facility Responsibilities

Provide Covered Health Care Services to GlobalHealth Members 24 hours a day, 365 days a year.

Obtain necessary authorizations from GlobalHealth for hospital admissions and continued inpatient stays. Notification is required within 24 hours of admission for all inpatient hospital stays including childbirth or emergencies.

In the event of a transfer, the receiving hospital is required to provide GlobalHealth notification within 24 hours of admission.

Verify hospital/facility and its personnel are duly licensed, certified, Contracted Providers and authorized to provide Covered Health Care Services to GlobalHealth Members.

Provide advance written notice to GlobalHealth of any significant changes in the ability to provide Covered Health Care Services to GlobalHealth Members.

Remain in compliance with applicable State and Federal requirements, Medicare Conditions of Participation, and The Joint Commission (TJC) accreditation standards or equivalent. Provide copies of CMS or State surveys and accreditation status to GlobalHealth when updated.

Medicare Outpatient Observation Notice (MOON)

Hospitals and critical access hospitals (CAH) are required to provide a MOON to Medicare beneficiaries (including MA/MAPD plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or CAH. For additional CMS guidance, visit https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.

Emergency Department Responsibilities

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.

A pregnant woman who is having contractions and (a) there is inadequate time to affect a safe transfer to another hospital before delivery or (b) the transfer may pose a threat to the health or safety of the woman or unborn child may receive care at the nearest Emergency Department (ED).

Referring a Member to the ED should not be used for routine services or non-emergency situations. An urgent care facility or office visit might be an alternate option.

Hospital/facility shall use best efforts to have contracted ED providers on staff.

Provider Accessibility

GlobalHealth is required to notify all Contracted Providers that, under 42 C.F.R. § 422.112, they are required to:

> Provide services, both clinical and nonclinical, that are readily available, accessible, and appropriate, when Medically Necessary 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.

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

> A professional answering service that contacts the Contracted Provider or the Covering Provider.
>
> A high-quality voice mail system that tells Members:
>
> > How to reach the Contracted Provider or the Covering Provider in an emergency, including phone numbers.
> >
> > What to do in an emergency or urgent situation.

GlobalHealth monitors Contracted Provider accessibility and appointment wait times. GlobalHealth may complete an annual access to care and availability survey for PCPs and high volume and high impact SCPs.

Provider Data Accuracy and Validation

It is important for Contracted Providers to ensure GlobalHealth has accurate practice and business information. Accurate information allows GlobalHealth to better support and serve our provider network and Members.

GlobalHealth Responsibilities

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement. Invalid information can negatively impact Member access to care. Additionally, current information is critical for timely and accurate claims reimbursement.

GlobalHealth is required to audit and validate the Provider Directory data quarterly at a minimum. As part of our validation efforts, GlobalHealth will reach out through various methods, such as phone campaigns, letters, fax verification, etc. Contracted Providers are required to respond to requests within 30 days of receipt to confirm accuracy of their provider data.

Contracted Provider Responsibilities

The Contracted Provider must validate their information for the Provider Directory at least quarterly for correctness and completeness. Contracted Providers must notify GlobalHealth in writing at least 30 days in advance, when possible, of changes such as:

> Change in office location(s), office hours, phone, fax, e-mail, or billing address.
>
> Addition or closure of office location(s).
>
> Addition or termination of provider(s).
>
> Opening or closing of practice to new GlobalHealth Members.
>
> Verification of specialty status.
>
> Any additional information that may impact Members’ access to care.

Failure to notify GlobalHealth within 30 days of changes may result in removal from the provider directory.

Also, a roster (either provider or facility as appropriate) must be submitted to GlobalHealth at least once per quarter.

Providers are encouraged to keep data current in the National Plan & Provider Enumeration System (NPPES). If NPPES is kept up to date by providers, GlobalHealth can download and rely on it as a primary data resource, instead of calling or faxing your office for this information. Visit NPPES help if you have questions: https://nppes.cms.hhs.gov/webhelp/index.html

Access Timeliness Standards

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

PCP – Scheduling an Appointment

Type	Access Standard	Examples
Emergency	Immediate appointment or Member is directed to nearest emergency department or call 911	Major trauma, laceration, eye injury, musculoskeletal injury, chest pain. 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.
Urgently Needed Services	Within 24 hours	Minor trauma, sprain, high temperature, persistent diarrhea, or vomiting. 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 department) Discharge	Within 7 calendar days of discharge	Update care plan, coordinate care with any SCPs, obtain labs, and reconcile medications.
Symptomatic, Non-urgent	Within 7 calendar days of request	Flu, cold, headaches, rashes, sore throat.
Routine/Regular Care	Within 30 calendar days of request	Follow-up appointments for asthma, blood pressure checks, diabetes.
Annual Wellness/ Preventive Care	Within 30 calendar days of request	Annual wellness examinations.

High Volume and High Impact SCPs – Scheduling an Appointment

GlobalHealth identifies the following providers as high volume and/or high impact SCPs:

- Cardiologists
- Oncologists
- Ophthalmologists
- Psychiatrists

GlobalHealth expects contracted high volume and/or high impact SCPs to provide services per the following standards:

Type	Access Standard
Initial Referral	Within 30 days
Urgently Needed Services	Within 24 hours for sick visits and within 7 days for non-sick visits
Emergent care	Immediate
After-hours	Nurse triage or call coverage with response within 2 hours, or messaging on available services

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

PCPs and SCPs – Returning Telephone Calls

Contracted Providers are required to provide timely responses to inquiries.

Type	Access Standard	Examples
Return Phone Calls (business hours)	Within 1 calendar day	Schedule appointment and questions related to lab results, prescriptions, or treatment plan.
After-hours	Respond within 2 hours or messaging instructs Members on available services	Call for emergency prescription refill, advise best course of action, which may include Urgently Needed Services or emergent care.

Appointment Wait Times

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 make best efforts to notify Members as early as possible if the wait time is expected to exceed 30 minutes and allow the Member the options of rescheduling the appointment or continuing to wait.

GlobalHealth encourages Contracted 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.

Missed Appointments

If a GlobalHealth MA/MAPD Member is experiencing transportation issues that prevent them from making appointments, their benefits include non-emergency medical transport. All MA/MAPD Members have transportation benefits included in their plans, administered by RoundTrip. Additionally, some Members have home health support benefits administered by Papa Pals, which can be utilized for transportation. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for RoundTrip and Papa Pals. GlobalHealth Customer Care Representatives are also available to assist Members with utilizing these services.

Covering Providers

A Contracted Provider must coordinate coverage by another Contracted Provider when they are on vacation or leave of absence. The Contracted Provider is responsible for ensuring the Covering Provider will:

Follow the protocols, policies, and rules as stated in this Provider Manual.

Accept compensation from GlobalHealth as full payment for Covered Health Care Services except for applicable Member Copayments and Coinsurance.

Obtain Referrals/prior authorizations as stated in this Provider Manual.

Any Covering Provider should use modifiers Q5 (substitute physician) or Q6 (locum tenens) to help ensure the claim is appropriately recognized.

Be available 24 hours a day, 7 days a week.

Urgently Needed Services

Type	Access Standard	Examples
During Normal Office Hours	If possible, arrange to see the Member immediately, give them medical advice and direction, or set up an appointment for them. If the Member's assigned PCP is not available, the Member can see another Contracted Provider in the office if they bill under the same tax identification number as the PCP. When appropriate, direct the Member to an urgent care facility if another practitioner is not available.	If a Member has an urgent medical illness or injury that cannot wait for a regular appointment.
After-hours	The Member should call the PCP'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 Contracted Provider should advise them how to proceed. Otherwise, the Member should follow the after-hours voicemail instructions, which may include directing them to a network urgent care facility or network emergency department. The Member may choose to self-refer to a network urgent care facility or, in case of an emergency, call 911 or go to the emergency department.	Call for emergency prescription refill.

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. Prior authorization may be necessary, depending on the care needed.

If a Contracted Provider directs a Member to an urgent care facility or ED, the Contracted Provider must use best efforts to notify GlobalHealth within 24 hours of services.

Controlled Substance Restrictions

GlobalHealth may, in rare cases, limit Member access to opioid or benzodiazepine medications such as:

Requiring a Member to get all prescriptions for opioids or benzodiazepines from one pharmacy.

Requiring a Member to get all prescriptions for opioids or benzodiazepines from one doctor.

Limiting the amount of opioids or benzodiazepines that will be covered.

Termination of a Member from Panel

There may be an occasion where a Contracted Provider wishes to terminate a Member from their panel. Reasons for such termination may include non-compliance or threatening or disruptive behavior by the Member. If a Contracted Provider plans to terminate a Member, the Contracted Provider must notify GlobalHealth prior to the termination, when possible. Additionally, the Contracted Provider must notify the Member in writing of the termination and continue to provide coverage for the Member for 30 days or until the Member obtains a new PCP, whichever occurs first.

Exception: A Contracted 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 Contracted Provider has assumed care or through six weeks of post-delivery care.

Provider Termination from Network

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

A Contracted Provider may choose to voluntarily discontinue participation in the GlobalHealth network by providing a written notice of the disaffiliation. Providers are expected to notify GlobalHealth in writing as outlined in their Agreement when terminating a contract. When terminating an individual provider, at least 30 calendar days' notice is required. During the termination notification period, GlobalHealth will notify affected Members and transfer their care to another Contracted Provider.

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

Sanctions imposed upon provider by State and Federal regulatory entities.

Provider misrepresents credentialing or contracting information.

Provider is noncompliant with credentialing/re-credentialing requirements.

Provider's certification or license being suspended or revoked.

Safety issues.

GlobalHealth reports practitioner suspension or termination to the appropriate authorities.

Continuity of Care

When a Contracted Provider voluntarily leaves GlobalHealth's network, a Member that is currently in active treatment might be eligible to continue an ongoing course of treatment during the transitional period, up to 90 days or through six weeks of postpartum care. For example, the Member may continue to see a terminating provider for delivery and postpartum care if she is in the second or third trimester of pregnancy at the time the provider notifies GlobalHealth.

When the Agreement is terminated for reasons other than cause, the terminated provider may ask GlobalHealth for permission to continue treating a Member during the transition period 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.

Is terminally ill.

The terminating provider would continue to coordinate care and submit claims. Member liability in these cases is limited to only what the Member would have paid if the provider were remaining in the network. The terminating provider will be paid their contracted rate. The terminating provider agrees to comply with utilization management, claims, reconsideration requests, and all other protocols affiliated with a Contracted Provider.

GlobalHealth expects all terminating providers to actively facilitate the Member's transition to the new Contracted Provider(s).

Leave of Absence

GlobalHealth requires a Contracted Provider to notify GlobalHealth when they are going on a leave of absence (LOA) for longer than 60 calendar days. At a minimum, this notification must include the dates and the general reason for the LOA (sabbatical, medical reason, etc.). Contracted Providers must notify GlobalHealth of a pending LOA as soon as possible.

Contracted Providers taking a LOA must arrange for coverage by another Contracted Provider in the GlobalHealth network. All covering arrangements must be acceptable to GlobalHealth.

Arrangements for coverage by a nonparticipating practitioner may be considered. These arrangements must make best efforts to have GlobalHealth's prior authorization and must be consistent with established policies and procedures.

If the LOA is scheduled for six months or less, GlobalHealth will confirm the conclusion of the LOA. If the LOA is concluded within six months, the Contracted Provider's LOA status will be removed and will reflect his or her prior status.

If the LOA is scheduled for longer than six months, GlobalHealth reserves the right to terminate the Contracted Provider from the network based upon continuity of care issues. In addition, if a Contracted Provider's recredentialing is due during the LOA and the Contracted Provider does not complete his/her recredentialing materials, GlobalHealth reserves the right to terminate the provider from the network based on contractual noncompliance. GlobalHealth will process the application upon return to the practice.

Medical Records

Medical Recordkeeping and Documentation Standards

Complete and accurate documentation in medical records is an essential component of quality patient care. GlobalHealth conducts periodic Provider office reviews to assess medical recordkeeping practices and medical record documentation.

Essential medical record components include:

An organized medical record filing system with patient medical records stored in a systematic, secure, and confidential manner.

Each page in the record contains the patient's name or identification number – both front and back sides.

Each record contains appropriate, updated biographical/personal data including language preference.

All entries are signed by the author and dated. 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.

Physician Assistant's notes are co-signed and dated by physician.

Personal/biographical data including date of birth, sex, marital status, address, employer, and home and work telephone numbers.

Family/social history is noted in the record and updated at least annually, initialed and dated.

Advance Directive documents or a notation that none exist.

The record is legible to the reviewer or someone other than the writer.

Medication allergies, adverse reactions, or "no known allergies" is prominently noted in the record. Location is consistent throughout patient charts.

A current medication list including drug name, dosage, frequency and duration, and initial prescription and refill dates. Medication list is updated each visit.

Injections are documented and include drug name, dosage, route, and site as well as the NDC number.

Notation is made in record when sample drugs are provided.

A current problem list notes significant illnesses and medical conditions, updated at least annually, initialed and dated.

Immunization records are current, or a note indicates up-to-date immunizations.

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.

For Members 20 years old or younger, past medical history includes prenatal care, birth, operations, and childhood illnesses.

For Members 11 years and older (or younger if appropriate) the use of cigarettes, alcohol, and any substance use is noted. Documentation of family/household history is also noted.

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.

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.

Lab and other studies ordered as appropriate for diagnosis.

Preventive and screening services are offered consistent with national and GlobalHealth practice guidelines.

Diagnosis noted in the medical record is consistent with symptoms and physical exam or other diagnostic findings.

Evidence of patient teaching as appropriate.

Treatment plan is consistent with diagnoses and includes measurable objectives, estimated time frames, prevention efforts, community resource utilization, and current caregivers contacted or involved in treatment (if no caregiver is involved, so stated in the record).

Follow-up plans and dates for return visits are clearly documented.

Unresolved problems are addressed in subsequent visits.

Consultations, ancillary services, lab, and imaging study reports are initialed by the practitioner.

If hospitalized, the record includes an admit report, operative report (if applicable), and discharge summary.

Working diagnoses are consistent with findings and appropriate diagnoses are documented.

There is evidence of continuity and coordination of care between primary and specialty practitioners including behavioral health practitioners.

Phone calls to and from patient are documented, including phone calls notifying the patient of diagnostic test results or related to prescription refills.

Requests for prescription refills are documented to include the pharmacy name, medication name, dosage, administration directions, and number of refills allowed. Encourage use of technology, like telehealth, as determined appropriate.

Advance Directives

GlobalHealth expects Contracted Providers to give Members the option to complete an Advance Directive if one is not on file. The statutory form of your state's Advance Directive, also called a Living Will, can be found on GlobalHealth's website on the "All Member Materials & Resources" page.

GlobalHealth MA/MAPD Members also have Advance Care Planning Services as a supplemental benefit, administered by Vital Decisions. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for Vital Decisions.

Retention

Medical records shall be retained for 10 years following treatment, 10 years following the patient's age of majority, or 10 years from the final date of GlobalHealth's CMS contract or completion of any audit, whichever time period is longer.

Confidentiality

GlobalHealth expects Contracted Providers to maintain medical records according to HIPAA and other State and Federal privacy laws.

Record Release

Contracted Providers must make medical records available for utilization management, risk management, performance improvement, peer review studies, medical review, fraud, waste, and abuse (FWA), Claims Payment Accuracy, Customer Care inquiries, grievance processing, pre- and post-claim inquiries and disputes, and other GlobalHealth initiatives.

To comply with accreditation and regulatory requirements, GlobalHealth may periodically perform documentation audits.

GlobalHealth may request records be mailed or faxed, accessed via Electronic Medical Records (EMR), or schedule an on-site visit. If GlobalHealth requests duplicate records, the administrative fee specified in the Agreement will be paid.

GlobalHealth is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA Privacy Rule permits a provider to disclose PHI to a health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the PHI requested pertains to the relationship. You do not need a separate authorization from the patient to release the medical record information for the purposes listed above. See the Notice of Privacy Practices in the Regulations section in this Provider Manual.

Utilization Management Program

Program Overview

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

The healthcare services that are covered and payable under the GlobalHealth plan.

Healthcare services or supplies are Medically Necessary to prevent, diagnose, or treat an illness, injury, disease, or its symptoms. Services must meet generally accepted standards of medicine.

The appropriate level of care based on evidence-based guidelines.

Prior authorization decisions are made in a timely manner to accommodate the clinical urgency of the Member's situation.

Urgent Concurrent: determination made within 72 hours of receipt of request

Urgent Preservice: determination made within 72 hours of receipt of request

Non-urgent Preservice: determination made within 14 days of receipt of request

Prior authorization for **Medicare Part B** prescription drugs will be responded to timely and no later than 72 hours after your request.

Medical Policies and Criteria Guidelines

GlobalHealth uses plan medical policies and nationally recognized guidelines and resources, such as MCG™, Hayes, Inc., National Comprehensive Cancer Network (NCCN), or CMS National and Local Coverage Determinations when conducting medical necessity reviews.

GlobalHealth medical policies are developed in coordination with physicians using evidence-based, peer-reviewed literature, criteria developed by specialty societies, and guidelines adopted by other healthcare organizations.

Decisions are supported by current clinical information relevant to each case. Clinical review is based on published standard criteria and/or internal policies that are developed with input from actively participating physicians. Board-certified practitioners or clinical peers from appropriate specialty areas may be consulted in determinations of medical appropriateness of care.

Services That Require Prior Authorization

NOTE: This list is not all-inclusive and may include other outpatient services that are covered only by certain plans. Other infrequently requested or highly specialized services not listed below may require prior authorization. By requesting prior authorization, the Contracted Provider is representing that the proposed Covered Health Care Services are Medically Necessary.

Acupuncture

Chronic lower back pain

Ambulance

Scheduled, non-emergent ambulance transport from one facility to another location

Urgent air ambulance transportation does not require prior authorization but will be subject to a retrospective medical necessity review.

Behavioral Health

GlobalHealth encourages coordination of care with Beacon Health Options. Beacon Health Options handles the prior authorization process if applicable. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for Beacon Health Options.

Continuous Glucose Monitors

Diagnostic Services

Infertility testing and services

Cardiac stress tests, nuclear cardiac testing, coronary computed tomography angiography, and other cardiographs

Neurology and neuromuscular diagnostic testing, including EMG, NCV, and sleep studies

CT scans, nuclear scans/tests, MRI, MRA, PET scan, and gamma camera

Non-routine, non-preventive, or high-risk maternity care, maternal support services, fetal monitoring, threatened and premature labor treatment

Elective facility-based invasive diagnostic testing

Specialty lab (e.g., genetic testing for treatment purposes)

Drug Waste

Durable Medical Equipment (DME), Prosthetics, and Orthotics

Including enhanced or specialty equipment or supplies

Home Healthcare

All home healthcare, including home infusion therapy, requires prior authorization. Hospice care for MA/MAPD Members should be coordinated under Original Medicare benefits.

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must:

- Be confined to the home.
- Be under the care of a physician or allowed practitioner.
- Be receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner.
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

Refer to § 424.22 “Requirements for home health services” for additional information

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. The receiving hospital is required to notify GlobalHealth within 24 hours of the admission.

Inpatient Care

All inpatient elective care or scheduled procedures require prior authorization by the Contracted Facility. GlobalHealth must be notified by the hospital of all admissions within 24 hours of admission, unless

otherwise specified in your Agreement. If a service does not require prior authorization (e.g., childbirth, etc.), this does not negate the provider's responsibility to *notify* the plan upon admission.

Other Services

Organ transplant services; transplant evaluations, organ donor services, transplant procedures

Stereotactic radiosurgery (e.g., gamma-ray radiosurgery, gamma knife, etc.)

Dialysis, Epoetin alfa, and laboratory services rendered in conjunction with dialysis

Outpatient radiation therapy and chemotherapy

Hyperbaric oxygen treatment

Non-emergency blood transfusions and all infusion therapies/services

Outpatient Hospital/Ambulatory Surgery

Procedures performed in an outpatient hospital (place of service 22) or ambulatory surgical center (place of service 24) require prior authorization.

Outpatient Therapies and Rehabilitation

All therapies and rehabilitation such as physical, occupational and speech therapy, cardiac rehabilitation, pulmonary rehabilitation services, and supervised exercise therapy require prior authorization.

Pharmacy

Certain injectable medications require prior authorization. Certain formulary drugs may be preferred agents or may require prior authorization.

Post-Acute Care

All Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), and Long-Term Acute Care Hospital (LTACH) care requires prior authorization.

Specialty Care Services

Although prior authorization is not required for in-network SCP office visits for MA/MAPD Members, the SCP may determine the Member needs services other than services routinely rendered during the office visit. It then becomes the responsibility of the referring SCP to submit the authorization for additional services. The SCP is expected to continue to coordinate care with the PCP. All out-of-network specialists require a prior authorization.

Submitting Referrals

The PCP is responsible for submitting a Referral when necessary and for supplying complete clinical information. Referrals are required whether GlobalHealth is the primary or secondary payer.

Referrals to Non-Contracted Providers

Services must generally be referred to a Contracted Provider. Exceptions may be made in certain circumstances such as when a terminating provider is transitioning a Member under current treatment to a Contracted Provider. POS plan Members may also see non-contracted providers for certain services with prior authorization. Contact GlobalHealth for assistance when referring to a non-contracted provider.

Prior Authorizations

Prior authorization notification does not guarantee payment for services rendered. Prior authorization notification will only determine if a service is Medically Necessary.

Prior authorization does **not** determine if your patient is a GlobalHealth Member or if the healthcare service requested is a covered benefit. We recommend that you call to verify the Member's enrollment and benefit coverage. A Contracted Provider may also check eligibility on the Portal.

Authorizations generally cover a period of 60 calendar days. There may be exceptions made for specialty care for high-risk pregnancy, oncology, rheumatology, and renal management. Refer to the authorization for specific approval dates.

Specialty Care Providers

MA/MAPD Members may go to a network SCP without prior authorization for office visits only.

Additional Services

If the SCP decides the Member needs services beyond what is generally handled during an office visit, it becomes the responsibility of the SCP to submit the Referral for additional services. If the Provider does not obtain authorization before providing additional tests, services, or procedures, they may not be payable. GlobalHealth expects the SCP to keep the Member's PCP informed about the ongoing care.

- Eligibility must be verified at the time of each visit. Payment will not be made for services rendered to an ineligible Member.
- Notify GlobalHealth within one business day regarding any unexpected services that were Medically Necessary but were not included in the original prior authorization.

Facilities

The facility should report the appropriate clinical information to the referring PCP and coordinate any follow-up referrals with the applicable provider.

- Eligibility must be verified at the time of each visit. Payment will not be made for services rendered to an ineligible Member.
- Notify GlobalHealth within one business day regarding any unexpected services that were Medically Necessary but were not included in the original prior authorization.

How to Obtain a Prior Authorization

Referrals are sent to GlobalHealth's UM department via the Portal:
https://ghprovider.prod.healthaxis.net/login

For expedited authorization, a Contracted Provider may submit Referrals as specified above or contact GlobalHealth's UM department using the information in the Helpful Numbers and Information section of the exhibit for your state.

If the Portal is unavailable for any reason, an authorization request may be sent via fax by completing the Physician's Treatment Request Form available on the Providers menu at www.GlobalHealth.com and faxing it to GlobalHealth's UM Department.

Contracted Providers can check on the status of authorizations and authorization requests in the Portal which is available 24 hours a day, 7 days a week. PCPs can see all the authorizations for each individual Member of their panel.

Non-Approval of Prior Authorizations

If a Pre-service prior authorization is not approved this 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, or consideration of alternative treatment plan options, before authorizing the request. GlobalHealth may contact you for additional information prior to issuing an adverse determination.

When an adverse determination is made due to the provider not participating in GlobalHealth's network, GlobalHealth will coordinate care with a Contracted Provider.

Request for More Information

A review may be extended one time by the plan for up to 14 days for healthcare services and up to 72 hours for Part B drugs if:

You are notified, prior to the expiration of the initial review 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 authorization:

We will tell you specifically what information is needed; and,

The appropriate timing of receipt.

If the information is not provided in a timely manner, does not support medical necessity, or is not a covered benefit, the requesting provider will be sent a denial letter with information about the reason as well as their appeal rights and process. Please see the Provider Appeal of Pre-service Denial section below for additional information.

The Member will also receive a letter regarding the denial, with information about the reason and coverage appeal rights and process.

When Services are Not Medically Necessary

A Contracted Provider may not collect payment from a GlobalHealth Member for services that have been determined not Medically Necessary by the GlobalHealth Medical Director unless an Advanced Beneficiary Notice of Non-Coverage or applicable form (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. You can get a copy of the criteria used to make the decision by contacting GlobalHealth. The criteria are available via mail, email, or telephone.

All adverse medical necessity determinations are issued by the Medical Director (or other physician designee).

Non-covered/Excluded Benefits

GlobalHealth details services that are not covered or excluded in Member materials and will notify the provider of its coverage determination for the requested service(s). GlobalHealth will not reimburse providers for services that are non-covered/excluded, even when provided by a Contracted Provider. Payments for services that are non-covered/excluded are the responsibility of the Member.

NOTE: A signed Advanced Beneficiary Notice of Non-Coverage or applicable form must be obtained for non-covered services prior to rendering the services to a GlobalHealth Member for a provider to collect from a Member.

Provider Appeal of Pre-Service Denial

Coverage appeal timelines and processes for both standard and expedited appeals are available on GlobalHealth's website, www.GlobalHealth.com.

Behavioral Health Authorization

GlobalHealth strongly encourages Contracted Providers to coordinate care with behavioral health providers.

Beacon Health Options is GlobalHealth's delegated behavioral health administrator. For plan-specified mental health and substance use disorder services that require prior authorization, a Beacon Health Options Contracted Provider will assess the Member for medical necessity criteria, and then contact Beacon Health Options for authorization. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for Beacon Health Options.

Services Not Requiring a Prior Authorization or Referral

The network PCP will coordinate the Covered Health Care Services provided to GlobalHealth Members, but there are a few exceptions. The Member may self-refer to a Contracted Provider for the following services. There may be times a Member needs emergency care or urgently needed services which may be covered at a non-contracted provider without prior authorization. This also applies to plan-directed care. A GlobalHealth Member does not need a Referral from the PCP or authorization from GlobalHealth. However, GlobalHealth encourages coordination of care between the providers of these services and the Member's PCP, in compliance with State and Federal privacy laws.

Anesthesia/Pathology

Services from a hospital-based anesthesiologist or pathologist (excludes pain management or office-based services).

Annual Wellness Exam/Initial Preventive Physical Exam

Chiropractic Care

Manual manipulation of the spine to correct subluxation.

Consulting Physicians

Services from inpatient consulting physicians and outpatient specialty.

Dental

> GlobalHealth strongly encourages Contracted Providers to coordinate care with network dental providers. GlobalHealth administers Medicare-covered dental benefits only. Members also have supplemental dental benefits through DentaQuest. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for DentaQuest.

Services from a network dentist when this benefit is part of the Member's plan and not part of a medical procedure.

Emergency and Urgent Care

All services rendered in any ED or emergency ambulance.

All services rendered in an urgent care facility.

Hearing/Speech Exam

Services available without prior authorization are dependent on plan benefits. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for NationsHearing.

Laboratory services

Mammogram

Routine standard or 3D screening mammogram once every 12 months. (Preventive Services Only)

OB/GYN

Any service from a network health professional that specializes in obstetrics or gynecology within their scope of practice. The OB/GYN is responsible for obtaining prior authorization for services that are not part of a routine office visit.

Preventive Services

All Medicare-covered preventive services

Tests

EKG

Routine lab work

Ultrasound

X-ray

Vision

> GlobalHealth strongly encourages Contracted Providers to coordinate care with network vision providers. GlobalHealth administers Medicare-covered vision benefits only. Members also have supplemental vision benefits through EyeMed. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for EyeMed.

Preventive services during optometrist or ophthalmologist office visits, such as diabetic retinopathy and glaucoma screenings

Eyewear

Hospital Admissions

All inpatient hospital care **must** be provided at a GlobalHealth network participating hospital, except for emergency admissions or when prior authorized by GlobalHealth under special circumstances. GlobalHealth must be notified by the hospital of all admissions within 24 hours of admission.

GlobalHealth concurrently reviews every Inpatient admission for appropriate level of care beginning on the day of admission through discharge. Discharge planning begins at admission.

Concurrent Review

GlobalHealth performs concurrent review from the day of admission through discharge to ensure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary discharge arrangements are being/have been made.

If GlobalHealth has approved a course of treatment (to be provided over a period of time or number of treatments), the provider may request to extend the course of treatment. GlobalHealth will notify the provider of the decision. The Member is not entitled to continued coverage pending the outcome of the request.

Contracted Providers should cooperate with GlobalHealth by:

- Providing concurrent review status reports by telephone, fax, or EMR.
- Allowing access to medical records for the Member.
- Providing admission and discharge notifications 24 hours a day, 7 days a week.

Length of Stay

If a preauthorized admission is expected to extend beyond the initially assigned length of stay, the admission is subject to concurrent review.

Admissions From Emergency Department

GlobalHealth must be notified by the hospital of all ED admissions within one business day of the day the Member's status changes to inpatient.

Discharge Planning

Discharge planning starts at the time of hospital admission or when the admission is authorized and continues throughout the discharge process. It includes the coordination of a Member's continued care needs both in and out of the inpatient setting.

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. A comprehensive discharge plan is expected to include an assessment of needs, including barriers to successful discharge, plan development, plan implementation, and evaluation of effectiveness. Discharge planning activities include:

- Assessing Member'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:
  - Healthcare services;
  - Financial needs;
  - Safe housing;
  - Food access;
  - Transportation; and
  - Language and cultural needs.
- Arranging ICT meetings as appropriate.
- Involving social services in discharge planning as appropriate.
- Coordinating discharge needs such as DME, home health, 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 Beacon Health Options. Refer to the Helpful Numbers and Information section of the exhibit for your state for the contact information for Beacon Health Options.
- Documenting and communicating the discharge plan.
- Ensuring patient understanding of discharge orders and required follow-up care.
- Submitting other authorizations as needed.

Delivering a written notice of non-coverage, if applicable.

Communication of discharge plan, including medications and appointments to PCP and any other post-discharge healthcare providers.

Best efforts should be made by the facility to communicate the full discharge plan to the Member's PCP within one business day of discharge.

GlobalHealth's UM staff will work with the hospital case manager to arrange for any needed services. GlobalHealth's participation in the discharge planning process for coordination of care will vary based on the individual Member's circumstances and occurs by telephone.

Care Management Program

GlobalHealth's Care Management Program assists Members in the management of their healthcare and supports the agreed-upon treatment plan. The objective of the program is to decrease inpatient admissions, readmissions, and unnecessary ED visits by helping Members regain optimal health or improve functional capability. GlobalHealth accomplishes this objective by working with identified Members and their PCPs to:

Evaluate Member health risk.

Verify or create a practical treatment plan, with Member input.

Encourage adherence to the treatment plan.

Provide continuity and coordination of care.

The Care Management Program offers two types of support for GlobalHealth Members: discharge outreach and care management.

Contracted Providers can refer a GlobalHealth Member by contacting Provider Services using the information in the Helpful Numbers section of the exhibit for your state.

Discharge Outreach

Discharge outreach provides support to Members who have recently experienced a transition of care. The discharge team works with Members to support and reinforce treatment plans to prevent readmission and unnecessary ED visits.

Exclusion from program includes:

Female Members who had a vaginal birth with no complications or conditions (hypertension, depression, etc.) and a healthy newborn.

Any Member being discharged to a hospice or nursing home facility.

Care Management

Members can enter into care management through predictive modeling, physician referral, self-referral, or referral from a care team member. Additionally, all C-SNP and D-SNP members will be assigned to care management. Care management assists Members with:

Development and implementation of a care plan.

Monitoring and follow-up.

Access to medical, behavioral health, and social services.

Access to affordable, long-term supports and services and preventive health.

Coordination of care across all health care settings.

Improving health outcomes.

Behavioral Health Benefits

Members can directly access mental health and/or substance use disorder services by calling the Beacon Health Options Customer Care number listed on the back of their Member ID card. Assistance is available for those that need translation or are hearing impaired.

Beacon Health Options can assist Members with:

- Finding a Contracted Provider.
- Crisis intervention.
- Referrals to community resources and self-help groups.

Pharmacy

CVS Caremark is the Pharmacy Benefit Manager (PBM) for MAPD Members

Optimizing Member Benefits

There are several ways you can help your patient save money:

Prescribe a 90- or 100-day supply where appropriate; lower drug tiers generally have cost-sharing breaks for the Member for extended day supplies.

Prescribe a generic whenever appropriate.

Members may save money by filling prescriptions at a preferred cost-sharing pharmacy rather than a standard cost-sharing pharmacy.

Please refer to the plan-specific documentation on our website for information about drug tiers and cost shares.

Real Time Benefits Tool

Member-specific benefit information is pulled directly from the PBM and delivered to clinicians' EMR. This will allow Providers and Members to make more informed treatment decisions by ensuring they understand exactly what the Member will pay out-of-pocket and being able to see if there are any clinically appropriate lower-cost alternatives covered under the plan. The tool will also communicate which therapy options require prior authorization (PA) or have other restrictions. Providers are able to process a PA in real-time from the EMR. Providers should contact their EMR vendor or EMR system administrator to ensure real-time prescription benefits information is enabled or will be included in the next upgrade.

GlobalHealth's Formulary Drug List

Formularies are specific to the plan benefits. Covered drugs are listed in the Drug Formulary.

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 in the highest tier. Specialty medications are limited to no more than a one-month supply and must be pre-approved by CVS Caremark.

Formulary Abbreviations

Type	Description
B vs D (B/D)	Drugs that require review to determine whether the medication will be covered as Part B or Part D.
Excluded Drug (ED)	Drugs not normally covered by Part D such as erectile dysfunction drugs, vitamins, etc.; however, GlobalHealth covers them as a supplemental benefit. The amount the Member pays to fill a prescription for these drugs does not count towards the Member's total drug costs. In addition, if the Member is receiving Extra Help to pay for their prescriptions, they will not get any Extra

Type	Description
	Help to pay for these drugs. These drugs may not be covered after reaching the Coverage Gap.
Gap Coverage (GC)	Plan offers additional coverage in the Coverage Gap phase for these medications. Refer to the Evidence of Coverage (EOC) for cost-sharing information.
Limited Access (LA)	Prescription may only be available at certain pharmacies. Providers will need to consult the Pharmacy Directory or call Customer Care using the contact information in the Helpful Numbers and Information section of the exhibit for your state.
Not Mail Order (NM)	Drugs that are not available through mail order.
Prior Authorization (PA)	Providers 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.
Quantity Limits (QL)	There are limits to the amount of certain medications that may be filled. These drugs, if taken inappropriately for too long a time, could be unsafe and cause adverse effects.
Step Therapy (ST)	Step therapy requires one or more prerequisite, clinically equivalent drugs to be tried before a step therapy drug will be covered.

Prescription Drug Utilization Management

Some medications have requirements that must be met before they can be filled. These programs are based on current medical findings, FDA-approved manufacturer labeling information, cost, and manufacturer rate agreements. The formulary indicates if the drug has any requirements. CVS Caremark conducts all Part D reviews for MAPD plans.

Exception Process

Standard Exception

Members can request that GlobalHealth waive coverage restrictions and limits. Call the Part D Coverage Determinations Department using the contact information in the Helpful Numbers and Information section of the exhibit for your state to request an exception. A Member may submit their request in writing, electronically, or telephonically. Providers may also call the Part D Coverage Determinations Department or fax completed forms to CVS Caremark at (855) 633-7673. Requests for coverage determinations and redeterminations can be submitted online using the "Request for Medicare Prescription Drug Coverage Determination (or Redetermination) Form." To access these forms, visit www.GlobalHealth.com > Providers > Prescription Drug Prior Authorization Forms, and scroll down to "For Medicare Advantage Plans…"

Medicare beneficiaries who are new to GlobalHealth MAPD can receive a transition supply of medication during the first 90 days of their membership under certain circumstances. The transition supply will be for a maximum of a cumulative 30-day supply (31 days if the Member is in Long-Term Care).

Expedited Exception

You may request an expedited exception when the Member is suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function.

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

If granted, our approval is usually valid until the end of the plan year. This is true as long as the physician continues to prescribe the drug for the patient and that drug continues to be safe and effective for treating the condition.

If your exception request is denied, you may appeal.

Pharmacy Types

Mail Order Pharmacy Service

CVS Caremark offers the convenience of mail order. Providers can contact CVS Caremark at (800) 378-5697 or fax completed form and prescription to CVS Caremark at (800) 378-0323. Forms are available on our website, www.GlobalHealth.com, under Medicare > Pharmacy Tools > Mail Order. Maintenance medications are mailed to the Member's home in up to a 90-day supply, or up to a 100-day supply for certain plans.

Retail Pharmacy Network

The Member may receive up to a 30-day or up to a 90- or 100-day supply of a maintenance drug at a retail network pharmacy for the applicable Copayment or Coinsurance. Retail network pharmacies can be found in the Pharmacy Directory or by using the Find Care Providers tool on our website, www.GlobalHealth.com.

Standard and Preferred Cost-Sharing Pharmacies

GlobalHealth MAPD Members may choose pharmacies that either offer standard cost-sharing or discounted cost-sharing. Their Evidence of Coverage explains the different Member responsibility amounts. Pharmacy status is indicated on the results of the Find Care Providers tool on our website, www.GlobalHealth.com.

Specialty Pharmacies

Contracted specialty pharmacies may fill prescriptions for specialty medications and arrange for delivery to the Member's home or other requested location. Some retail pharmacies can also fill specialty drug prescriptions. Specialty medications sent to and administered by a doctor are covered under the Member's office visit cost share. 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 in the Pharmacy Directory or by using the Find Care Providers tool on our website, www.GlobalHealth.com.

Medication Therapy Management Program

GlobalHealth MAPD Members qualify for our Medication Therapy Management program if at least one of the following criteria are met: 1) have coverage limitation(s) in place for medication(s) with a high risk for dependence and/or abuse, 2) have three or more targeted chronic conditions, or 3) are likely to incur the minimum annual cost threshold as established by CMS. 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 MAPD Members. Member participation is voluntary and does not affect Member's coverage. Benefits include personalized service from registered pharmacists and staff.

ATTENTION: PRESCRIPTION PAIN RELIEVERS CAN BE HIGHLY ADDICTIVE!

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, have a serious discussion regarding the potential for addiction and overdose. Or if you have patients who have been taking this type of medication, consider titrating them off as soon as possible. GlobalHealth urges prescribers to conduct at least annual medication reviews that include over-the-counter products, prescriptions, and supplements with their patients.

If you have a patient who has become addicted to any medication, contact Beacon Health Options 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, and residential substance abuse treatment as well as assisting Members with locating community resources that will help in their recovery process.

Claims and Payments

Providers must submit Clean Claims to GlobalHealth within the timely filing period specified in the Agreement 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 on the date shown on the primary carrier's Remittance Advice (RA) reflecting payment or denial.

Claims Reimbursement

GlobalHealth will reimburse for Covered Health Care Services on timely filed Clean Claims in accordance with your Agreement and applicable statutory requirements less any applicable Copayments, Coinsurance, and/or Deductibles owed by the Member. Unless otherwise specified, GlobalHealth follows 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) Report detailing how each service was processed. This information can be accessed through the online Portal. Electronic RAs can also be accessed online through Zelis. Register online at www.zelis.com. Click Provider Enrollment to create an account.

Claims Submission

Claims must be submitted electronically. GlobalHealth utilizes a preferred clearinghouse, Change Healthcare (Emdeon), for electronic claims submission. GlobalHealth's electronic data interchange (EDI) number can be found in the Helpful Numbers and Information section of the exhibit for your state. In the unlikely event that electronic filing is not available, refer to the Helpful Numbers section of the exhibit for your state for our claims mailing address.

Proof of Timely Filing

The clearinghouse vendor can supply a report of accepted electronically filed claims. That report can be used for proof of timely filing for electronic claims. For Providers who submit claims on paper, proof of timely filing would consist of a printout from their billing system showing when the claim was billed.

Claims Adjudication

GlobalHealth reviews and evaluates claims for:

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

Approved forms:

- Electronic filing
- CMS-1500
- UB-04

Responsibility for Payment

Members are responsible for payment of:

Their Deductible, Copayments, or Coinsurance for approved Covered Health Care Services.

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.

Copayments/Coinsurance

Members are required to pay a Copayment or Coinsurance for certain benefits. Copayment amounts are generally listed on the Member's GlobalHealth ID card. Coinsurance should be billed when you receive the RA from GlobalHealth.

No Copayment or Coinsurance should be collected from or billed to the Member for preventive care services.

Maximum Out-of-Pocket (MOOP)

For GlobalHealth plans, Member expenses are limited by an annual MOOP amount. If a Member has reached the MOOP, a Contracted Provider should not apply any Member cost share for Covered Health Care Services. Contracted Providers may obtain a Member's MOOP information via the Portal or by contacting GlobalHealth. If the Contracted Provider collected a cost share from the Member, GlobalHealth will notify the Contracted Provider of the amount in excess of the MOOP and the Contracted Provider shall promptly reimburse the Member.

If GlobalHealth determines that the Contracted 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 Contracted Provider. GlobalHealth will notify the Contracted Provider of any such recoupment 30 days prior to such recoupment.

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

Members are not responsible for:

Any amounts owed by GlobalHealth to a Contracted 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 Health Care Services;

The services were approved by GlobalHealth;

The services were provided by a Contracted Provider; and

The Member has paid the required cost share.

Balance Billing

A Contracted Provider and Facility accepts the GlobalHealth reimbursement as payment in full and may not "balance bill" a GlobalHealth Member. In other words, the Contracted Provider may not seek payment from a GlobalHealth Member for Covered Health Care Services beyond the Member's applicable Deductible, Copayment, and/or Coinsurance amounts. Balance billing is a violation of the Agreement and may result in termination of the Contracted Provider from the GlobalHealth network.

Qualified Medicare Beneficiary

Medicare providers and suppliers may not bill GlobalHealth Members in the Qualified Medicare Beneficiary (QMB) program for Medicare Deductibles, Coinsurance, or Copayments, but state Medicaid programs may pay for those costs. Under some circumstances, Federal law lets states limit how much they pay providers for Medicare cost-sharing. Even when that's the case, people in the QMB program have no legal obligation to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may not refuse to serve members due to assistance with Medicare cost-sharing received from a state Medicaid program. For more information visit www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB

Remittance Advice (RA)

The RA GlobalHealth issues summarizes the claim and explains how benefits were applied. Use the RA to determine how a claim was paid including non-allowed amounts and adjustments. The RA will note any non-covered services and cost-sharing 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 the online Portal or through Zelis.

When reviewing RAs to determine Member responsibility, please note that both the "Discount" and "Adjusted Amount" fields are the Provider's responsibility. The Member should never be billed more than the "Patient Liability" amount shown in the lower right-hand corner.

Member:
Member ID:
Provider/Practioner:
Provider NPI:
Paid Date:

Birthdate:
Patient Acct #:
Claim #:

Provider Network: **In-Network**
Group Name: **GlobalHealth of Oklahoma**
Global Payment#:

Dates of Service	Procedure	Modifier	Units	Remark Codes	Billed Amount	Allowed Amount	Discount	Adjusted Amount	CoPay	Co-Insurance	WithHold	Incentive Paid	Paid Amount	COB Amount
		PO	1		$4,194.45	$1,267.60	$2,926.85	$0.00	$250.00	$0.00	$10.18	$0.00	$1,007.42	$0.00
		PO	2		$1,449.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
		PO	1		$537.71	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
		PO	4		$615.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
				Column Totals:	$6,796.40	$1,267.60	$2,926.85	$0.00	$250.00	$0.00	$10.18	$0.00	$1,007.42	$0.00

Patient Liability:	**$250.00**
Prior Payment Paid:	**$0.00**
Paid on this Claim:	**$1,007.42**

Reasons for Payment Delays

GlobalHealth will process claims as expeditiously as possible. In order to do so, it is essential that complete and accurate claims are submitted. Common mistakes that delay payment include:

Missing Provider Group NPI or Place of Service.

Missing employer or group number or Member number.

Missing authorization numbers.

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 the Portal to obtain claims status. The Portal is available here: https://ghprovider.prod.healthaxis.net/.

Circumstances That May Affect Hospital Reimbursement

Reimbursement for inpatient services may be affected in certain circumstances described below:

Pended for Case Review

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 upon admission as defined by the CMS.

Hospital Readmissions

GlobalHealth does not make additional, separate DRG payments for readmissions that are reasonably avoidable and at the same Contracted 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 evidence-based criteria such as CMS guidelines, MCG™, NCCN, and other applicable industry guidance in determinations not to reimburse for a subsequent hospitalization.

Never Events

GlobalHealth does not reimburse for charges that are related to "Never Events" (NE) or "Serious Reportable Events" (SRE) as defined by the CMS and National Quality Forum (NQF).

Healthcare services or diagnosis not supported due to inadequate documentation in the requested medical record

Coding and Billing, Industry Standards, and Best Practices

GlobalHealth does not reimburse for charges that are not in adherence with coding and billing best practices and standards or supported by documentation. GlobalHealth utilizes but is not limited to the following resources:

CMS Guidelines as stated in CMS' Medicare Managed Care Manual

Medicare Local and National Coverage Determinations

GlobalHealth Provider Manual, claims payment and UM policies, and Member materials

National Uniform Billing Code Guidelines from National Uniform Billing Committee

American Medical Association Current Procedural Terminology System (CPT) guidelines

Healthcare Common Procedure Coding System (HCPCS) rules

ICD-10 Official Guidelines for Coding and Reporting

American Association of Medical Audit Specialists National Health Care Billing Audit Guidelines

National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUE)

Medicare Code Editor (MCE)

Integrated Outpatient Code Editor (I/OCE)

American Hospital Association Coding Clinic Guidelines

UB-40 Data Specifications Manual

GlobalHealth does not reimburse for charges that do not adhere to industry standards of care. GlobalHealth utilizes but is not limited to the following resources:

Industry standard UM criteria and/or care guidelines, including MCG™, Hayes, Inc., NCCN, CALOCUS or LOCAT (current edition on date of service)

Social Security Act

U.S. Food and Drug Administration Guidance

National professional medical societies' guidelines and consensus statements

Publications from specialty societies such as the American Society for Parenteral and Enteral Nutrition, American Thoracic Society, Infectious Diseases Society of America, etc.

Department of Health and Human Services final rules, regulations, and instructions published in the Federal Register

Nationally recognized, evidenced-based published literature from such sources as: World Health Organization, Medscape, American College of Cardiology Foundation/American Heart Association Task Force, American Diabetes Association, and American Psychiatric Association

Claim Denial

GlobalHealth will notify the provider of a denial or partial denial as outlined in the Agreement. This period may be extended one time by GlobalHealth, provided that GlobalHealth determines:

An extension is necessary due to matters beyond its control;

GlobalHealth notifies the provider and the Member, prior to the end of the initial review 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. A response is required within the timeframe outlined in the Agreement.

If the claim was denied due to missing or incomplete information, the provider may resubmit the claim with the necessary information to complete the claim processing.

Provider Payment Disputes/Claim Reviews

A provider may request a claim review if any part of a claim submitted for payment is either fully or partially denied. The appropriate claim review form can be found on the All Forms & Resources page, accessed via the Providers menu of our website at www.GlobalHealth.com. Claim reviews may be

resolved by attaching any pertinent documents to support the claim (e.g., sending proof of timely filing, sending a copy of the authorizations for claims denied for no authorization). The request for claim review must be submitted in writing and 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 is located in your Agreement with GlobalHealth.

Claims Payment Recovery

If GlobalHealth overpays a claim for healthcare services, GlobalHealth may request a refund. When this occurs, the provider will be notified of any overpayment amount with a request for a refund. In the notification, GlobalHealth will provide the name of the Member for whom an overpayment was made, and the relevant date or dates of service. This notification process occurs within the timeframe specified in the Agreement. GlobalHealth may recoup overpayment amounts by subtracting such amounts from future payments. You can locate identifying information on the RA.

Laboratory Testing

If the Contracted Provider has a CLIA-approved lab on site, they may provide and bill for those tests if approved and contracted to perform them. All other test(s) must be performed at a laboratory facility that is contracted with GlobalHealth. If the Contracted Provider does not have a lab onsite, either refer the Member to a GlobalHealth contracted laboratory or draw and send the specimen to a GlobalHealth contracted laboratory.

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, Waste, and Abuse (FWA)
- Education and training
- Hotline for reporting compliance concerns
- Policies and procedures
- Remediation/corrective action when problems are identified

All Contracted Providers are expected to adhere to the GlobalHealth Compliance Program.

Chief Compliance Officer

The Chief Compliance Officer oversees the Compliance Program. Contracted Providers are encouraged to speak directly with the GlobalHealth Compliance Officer regarding any compliance matters, policy questions, or other concerns using the contact information in the Helpful Numbers and Information section.

Code of Conduct

All participating Providers are expected to adhere to the GlobalHealth Compliance Program, including the Code of Conduct. A link to the Code of Conduct can be found in the exhibit for your state.

Auditing and Monitoring

FWA

GlobalHealth is committed to an effective FWA Program to detect, correct, and prevent FWA.

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 Member cost share)
- Offering gifts or money for treatment or services that are not needed
- Offering free services, equipment, or supplies in exchange for using a GlobalHealth Member ID number
- A 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

A link to current FWA alerts can be found in the exhibit for your state.

Audit

GlobalHealth reserves the right to audit claims and make or request adjustments. These decisions are made based on comparison of medical records to claims payments as well as determination of appropriateness of covered healthcare services. GlobalHealth reserves the right to perform on-site audits. 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.

Education and Training

A link to FWA education and training can be found in the exhibit for your state. Additionally, the GlobalHealth Compliance department will provide FWA and other compliance-related training to Contracted Providers upon request.

Hotline

Contracted Providers are expected to report known or suspected compliance violations. For any question about the Compliance Program or to report a concern, call our reporting line and leave a message. Please provide as much detailed information as possible. You may remain anonymous if you choose. You may email Compliance if you prefer. GlobalHealth will promptly investigate any reported potential violations of Federal or State laws, regulations, or other policies. Contact information is available on the Helpful Numbers page.

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.

Policies and Procedures

GlobalHealth maintains written policies and procedures to address compliance, ethical, and legal concerns. For questions, contact our Compliance Officer.

Remediation and Corrective Action

Compliance remediation is the process of recognizing problems, creating a plan to correct and prevent them from occurring in the future, and executing that plan. Follow-up auditing and monitoring is conducted to ensure the corrective action plan is being followed and is effective.

Quality Improvement Program (QIP)

GlobalHealth is committed to supporting quality healthcare and the preservation of good health. The QIP provides the framework to assess and improve the quality of care and services provided by Contracted Providers. 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 CMS.

The program identifies issues and opportunities for improvement. The program consists of multi-disciplinary work groups, including GlobalHealth employees and Contracted 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 Contracted 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 healthcare delivery systems and health plan management activities. Its purpose is to ensure quality care and service.

Quality improvement activities are evaluated annually. GlobalHealth will implement changes to address identified opportunities and follow up in areas that need improvement.

Medicare Advantage Plan Ratings (Star Ratings)

Every year, CMS evaluates MA/MAPD plans based on a 5-star rating system. CMS scores how well plans perform in certain categories, including quality of care and customer service. Ratings range from 1 to 5 stars, with 5 being the highest and 1 being the lowest.

The **Overall Star Rating** combines scores for the types of services each health plan offers. For health 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 experience with the health plan.

Member complaints and changes in the health plan's performance: Includes how often Medicare found problems with the health plan and how often Members had problems with the health plan. Includes how much the health plan's performance has improved (if at all) over time.

Health plan customer service: Includes how well the health plan handles Member appeals.

Drug plan customer service: Includes how well the health plan handles Member appeals.

Member complaints and changes in the drug plan's performance: Includes how often Medicare found problems with the health plan and how often Members had problems with the plan. Includes how much the health plan's performance has improved (if at all) over time.

Member experience with plan's drug services: Includes ratings of Member experience with the health plan.

Drug safety and accuracy of drug pricing: Includes how accurate the health 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.

Medicare Advantage Quality Portal

Effective June 1, 2022, GlobalHealth has launched a new Quality Incentive Portal. This Portal allows both Providers and Provider Administrators (for non-independent physician groups) the ability to see real time updates for both Part C and Part D Stars Scores. The Portal can be accessed at https://qualityportal.globalhealthportals.com/. Reporting and User Guides can be accessed at https://www.GlobalHealth.com/oklahoma/providers/globallink/ by selecting "Medicare Advantage" from the drop-down menu.

Preventive Care and Clinical Practice Guidelines

GlobalHealth adheres to all applicable preventive care guidelines. Not everyone needs every preventive service. You should determine which services are right for each individual Member. Refer to the Centers for Disease Control and Prevention for additional guidance.

CMS requires coverage at no cost share to MA/MAPD Members for the following services:

Alcohol Misuse Screening & Counseling

Annual Wellness Visit

Bone Mass Measurements

Cardiovascular Disease Screening Tests

Colorectal Cancer Screening

Counseling to Prevent Tobacco Use

Depression Screening

Diabetes Screening

Diabetes Self-Management Training

Glaucoma Screening

Hepatitis B Vaccine & Administration for high or intermediate risk Members

Hepatitis C Virus Screening

HIV Screening

IBT for Cardiovascular Disease

IBT for Obesity

Influenza Virus Vaccine & Administration

Initial Preventive Physical Examination

Lung Cancer Screening

Medical Nutrition Therapy

Medicare Diabetes Prevention Program

Pneumococcal Vaccine & Administration

Prostate Cancer Screening

Screening for Cervical Cancer

Screening for STIs and HIBC to Prevent STIs

Screening Mammography

Screening Pap Tests

Screening Pelvic Examinations

Ultrasound Screening for AAA

Medical Review Program

As part of our quality improvement efforts, GlobalHealth recognizes the CMS Hospital Readmissions Reduction Program (HRRP) and Hospital-Acquired Conditions Reduction Program (HACRP). GlobalHealth expects its Contracted Providers to follow established evidence-based standards of care.

Contracted Providers are expected to make medical records and other requested information available to support the review of services rendered. EMR access will be utilized when possible to complete the reviews. GlobalHealth encourages providers to allow EMR access to facilitate coordination of care and support plan operations in a timely, cost-efficient manner.

Cases that may be subject to review include, but are not limited to, reasonably avoidable readmissions, potential coding discrepancies, and clinical concerns such as preventable complications, Never Events (NE) or Serious Reportable Events (SRE) as defined by the National Quality Forum (NQF) and CMS, quality of care provided, and associated prepayment and post-payment facility and professional claims. Cases may be referred from, but are not limited to, Utilization Management (UM), Claims, Customer Care, Claims Payment Accuracy, or Compliance Departments, and Members.

Never Events include:

- Surgery or invasive procedure events
- Product or device events
- Patient protection events
- Care management events
- Environmental events
- Radiologic events
- Potential criminal events

Examples of NE include wrong patient, wrong surgical site, procedure errors, medication errors, inappropriate restraint usage, delayed treatment, incompatible blood group hemolytic transfusion reactions, stage III and stage IV pressure ulcers, and falls or trauma resulting in death or serious disability.

GlobalHealth does not reimburse for additional costs associated with these types of concerns or events.

A reasonably avoidable readmission (as defined by CMS) is a readmission to the same acute care hospital within 30 days of hospital discharge for the same, similar, or related conditions.

Clinical concerns include, but may not be limited to, preventable hospital-acquired or associated conditions (HAC) as defined by CMS, surgical complications including accidental lacerations and punctures, preventable perioperative or postoperative conditions (as defined by CMS), development of infections during hospitalization, premature discharge, inadequate discharge planning and/or failure to identify or treat HAC prior to discharge.

Presumption of "preventable" complications includes consideration if the condition contributed to the need for:

- Additional procedures or surgery
- Higher inpatient level of care
- Extended hospitalization

Placed the Member at risk for or subjected to serious harm or death

Potential coding discrepancies include but may not be limited to:

Hospital-assigned diagnosis code(s) unsupported in the medical record

Hospital failure to assign primary/secondary diagnosis code

Invalid/incorrect hospital-assigned primary or secondary diagnosis code(s)

Incorrect hospital assignment of present/not present on admission (POA) status

GlobalHealth reserves the right to audit claims and make or request adjustments based on comparison of medical records to claims payment, as well as determine the appropriateness of covered health services furnished by provider. GlobalHealth reserves the right to perform onsite audits. Provider agrees to cooperate with such reasonable audit requests.

Member Complaints and Grievances

If a Member files a complaint against a provider, GlobalHealth will contact the provider for additional information, which may include a request for an explanation or medical records, to ensure all the facts are obtained before responding to the grievance. Providers must respond to requests within 15 days so the response can be included in the investigation. GlobalHealth is subject to timeliness standards that require a response within a specific period. A quick response to the inquiry will ensure compliance with State, Federal, and CMS regulations.

Complaints and grievances related to prescription benefits covered by the PBM will be reviewed by the PBM. Complaints and grievances related to mental health services covered by Beacon Health Options will be reviewed by Beacon Health Options.

Resources

Hospital Readmission Reduction Program: www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html

Hospital-Acquired Condition Reduction Program: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html

HEDIS®

The Healthcare Effectiveness Data and Information Set (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.

HEDIS® is used by CMS to monitor the performance of managed care organizations. Data are collected for measures related to preventive care. As a health plan, GlobalHealth is responsible for collecting data on these performance measures and one of the ways to do that is through medical record review. Each year, a sample of medical records is randomly selected for review to ensure quality care is being provided to GlobalHealth Members. If the data are 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. Contracted Provider office assistance throughout the year minimizes the number of records needed in

the HEDIS® season. GlobalHealth will use EMR access when possible to conduct the reviews or provider will permit on-site access to review patient medical records or other documentation.

There are several ways GlobalHealth may send record requests for HEDIS® purposes. For individual or very small amounts of records, compliant fax requests are sent with detailed instructions on how to return the request. GlobalHealth also employs auditors that may call to schedule an on-site visit to review appropriate medical records. They will provide a detailed list of information to prepare for the visit. We ask that Contracted Provider offices schedule these visits quickly on a day that is convenient. These visits are not a "pass or fail" situation. GlobalHealth is simply reviewing records to determine if they meet HEDIS® measure compliance. In some cases, the auditor may make recommendations on changes to improve your overall compliance. On-site visits are designed to take the burden of complicated record review away from provider office staff. Any questions about HEDIS® record review should be directed to the contact information that is provided in the request.

HEDIS® 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.

CAHPS®

GlobalHealth participates in the CAHPS® 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. 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 Specialist Physicians
- Smoking cessation discussion/counseling
- Annual flu vaccine

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

Patient Rights and Protections

As a partner with GlobalHealth, you should be aware of Medicare's patient rights and protections. Please visit the Medicare website for more information: https://www.medicare.gov/basics/your-medicare-rights

Rights for everyone with Medicare:

- Be treated with courtesy, dignity, and respect at all times
- Be protected from discrimination. Every company or agency that works with Medicare must obey the law. Patients can't be treated differently because of their race, color, national origin, disability, age, religion, or sex.
- Have their personal and health information kept private
- Have access to doctors, specialists, and hospitals for medically necessary services
- Get Medicare-covered services in an emergency
- Get information in a way they understand from Medicare, health care providers, and, under certain circumstances, contractors.
- Learn about their treatment choices in clear language that they can understand, and participate in treatment decisions.
- Get Medicare information and health care services in a language they understand.
- Get their Medicare information in an accessible format, like braille or large print.
- Get answers to their Medicare questions.
- Get a decision about health care payment, coverage of items and services, or drug coverage. When they or their provider file a claim, they'll get a notice letting them know what will and won't be covered. This notice comes from one of these:
    - Medicare
    - Medicare Advantage Plan (Part C) or other Medicare health plan
    - Medicare drug plan for Medicare drug coverage (Part D)

If they disagree with the decision of their claim, they have the right to file an appeal. They may:

- Request a review (appeal) of certain decisions about health care payment, coverage of items and services, or drug coverage.
- Be able to file complaints (sometimes called "grievances"), including complaints about the quality of their care. They can file a complaint if they have concerns about the quality of care and other services they get from a Medicare provider.
- In addition to the rights and protections listed above, patients in an MA plan also have the right to:
- Choose health care providers within the plan.
- Get a treatment plan from their doctor.
    - If they have a complex or serious medical condition, a treatment plan lets them directly see a specialist within the plan as many times as they and their doctor think they need.
    - Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.
- Know how their doctors are paid.
    - When they ask their plan how it pays its doctors, the plan must tell them.
    - Medicare doesn't allow a plan to pay doctors in a way that could interfere with them getting the care they need.

- Request an appeal to resolve differences with their plan.
- File a complaint (grievance) about other concerns or problems with their plan.
- Get a coverage decision or coverage information from their plan before getting services.

In addition to the rights and protections listed above, patients in an MAPD plan also have the right to:

- Get a written explanation for drug coverage decisions (coverage determinations) from their Medicare drug plan
    - A coverage determination is the first decision the Medicare drug plan (not the pharmacy) makes about their benefits. This can be a decision about if their drug is covered, if they met the plan's requirements to cover the drug, or how much they pay for the drug.
    - They'll also get a coverage determination decision if they ask their plan to make an exception to its rules to cover their drug.
- File a complaint (grievance) with the plan.
- Have the privacy of their Medicare health and drug information protected.

Risk Adjustment Program

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 Member's disease. In order to achieve the calculation, CMS and HHS require us to annually provide demographic and health status of our MA/MAPD 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 date you submit must be complete and accurate.

GlobalHealth and providers have a mutual interest in ensuring (1) the provision of quality care to Members including the assessment and treatment of existing medical conditions, that is supported by appropriate medical record documentation; (2) the correct assignment of diagnosis and/or procedure coding for services rendered to Members; and (3) the submission of accurate claims to GlobalHealth. Contracted Providers are expected to participate in the diagnosis coding review process, which includes the use of an individual Member Condition Report that contains all Risk Adjustment related conditions for a given member, OR an Open Gaps Report which contains all Risk Adjustment related conditions for a Provider and/or Provider Group that remain open for the current year. These conditions may be either historically captured for the member or suspected conditions. GlobalHealth conducts HCC reviews all year. In order to provide the required documentation, GlobalHealth requests records from Contracted Providers.

- Provider will evaluate, treat, and appropriately document and code all conditions identified during office visits.
- Provider will review the Member Condition Report and/or the Open Gaps Report for accuracy and completeness. Completed Member Condition Reports will be returned to GlobalHealth Medicare Risk Adjustment Department.
- Provider will use best efforts to coordinate with SCPs to ensure accuracy and completeness of the medical record.
- GlobalHealth will use EMR access, when possible, to conduct the reviews.
- Provider will be reasonably available for risk adjustment meetings.
- Risk Adjustment meetings may address, but are not limited to, the following:
    - Specific coding and documentation concerns and/or questions
    - Unaddressed diagnosis coding gaps

Credentialing and Re-Credentialing

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.

Council for Affordable Quality Healthcare (CAQH) is our preferred credentialing application source. This application is free to providers. Access CAQH at https://proview.caqh.org. If a Provider does not have a CAQH number, please contact the Credentialing Department for a standardized application.

You have the right to request the status of your credentialing application, correct erroneous information, and to review the information we obtained that pertains to our credentialing decision.

Provider Credentialing Requirements

The following requirements must be met to become a credentialed Provider:

- Current unrestricted State license
- Graduation from an appropriately accredited medical or professional school
- Completion of a formal accredited training program
- Current and unrestricted DEA certificate and Controlled Dangerous Substance certificate (for Oklahoma providers only), if applicable
- Board certification or Board eligibility, if applicable
- Enrolled for Medicare participation (not on the Medicare Preclusion List)
- Current and unrestricted admitting privileges in good standing at a GlobalHealth contracted hospital as applicable
- Demonstration of current professional liability insurance minimum requirements
- 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
- 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
- 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
- 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
- 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

Absence of chemical dependency/substance misuse; 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 misuse exists that would affect applicant's ability to adequately perform the professional duties for which applicant is contracted

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

Evidence of the capability to provide 24 hours a day, 7 days a week coverage as applicable

Work history for at least the past five years

Cooperation with office surveys, which may include a structured review of the office site and evaluation of the medical recordkeeping system and practices

Advanced Practice Registered Nurse Credentialing Requirements

In addition to the Provider Credentialing Requirements above, APRNs must have a board certificate from an accredited nursing board, as well as a supervising physician as required by the state nursing board. If acting as a PCP, at least one supervising physician must be a Contracted Provider with GlobalHealth.

Physician Assistant Credentialing Requirements

In addition to the Provider Credentialing Requirements above, Physician Assistants must have a supervising physician as required by the state physician assistant board.

Hospital 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 may require an on-site review to ensure the entity meets quality standards established by TJC and GlobalHealth and/or a current (within the past 36 months) copy of a state licensing agency Site Visit Report. Any deficiencies identified during the on-site visit are communicated to the entity with a request for a corrective action plan within GlobalHealth's requested timeframe. Failure to correct deficiencies in a timely manner may result in a determination not to credential the organization. GlobalHealth will confirm the entity continues to be licensed and in good standing with State and Federal bodies at least once every 36 months.

Hospital and/or Contracted Facility must provide the following:

Submit a completed GlobalHealth "Ancillary & Facility Application" along with the necessary attachments:

Evidence of Medicare certification

Copy of current accreditation approval letter (e.g., TJC) and state licensure or waiver upon renewal with issuing body

A current and unrestricted DEA certificate, Controlled Dangerous Substance certificate, CLIA/CAP certification if applicable, and any other relevant certifications

W-9

Current unrestricted state license

Demonstration of current professional liability insurance minimum requirements

Entities must also have an acceptable malpractice claims history as approved by GlobalHealth.

Re-credentialing

To remain in the GlobalHealth network, all Contracted Providers must be re-credentialed, at a minimum, every 36 months. Providers are expected to submit all appropriate documentation to ensure reappointment is timely. Information and status inquiries can be submitted to the Credentialing department using the contact information in the Helpful Numbers and Information section of the exhibit for your state.

Credentialing/Re-credentialing Appeal Process

GlobalHealth will:

Provide written notification when a provider has been denied participation in the GlobalHealth network which will include reasons for the denial.

Allow practitioners to request a hearing and provide the specific time period for submitting the request.

Allow up to 30 calendar days after the notification for practitioners to request a hearing.

Allow practitioners to be represented by a legal representative or another entity of their choice.

Appoint a hearing officer or a panel of individuals to review the appeal. This panel will include, at a minimum, the GlobalHealth Medical Director, or designated MD or equal practitioners, GlobalHealth Chief Compliance Officer, GlobalHealth Senior Director of Provider Relations, and one network practitioner to participate in the appeal. Designees may be included as needed.

Provide written notification of the appeal decision within 10 business days. When applicable, notification will contain the specific reason for the decision.

Follow all applicable State law requirements.

There are no appeal rights and processes when a practitioner is terminated or denied for administrative reasons, including but not limited to the following:

Network need

Failure to comply with credentialing or recredentialing process

Failure to meet the terms of minimum licensure

Failure to comply with the Agreement

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 (FCA) and Fraud Enforcement Recovery Act (FERA)
- 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)
- The Anti-Kickback Statute
- The Americans with Disabilities Act (ADA)

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

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 (FCA) and Fraud Enforcement Recovery Act (FERA)

The Federal False Claims Act (FCA) was enacted by Congress as an effective tool in combating fraud against the Federal government. It prohibits any person from knowingly making a false statement or claim for payment from the Federal government. It also 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. The Fraud Enforcement and Recovery Act (FERA), enacted in 2009, implemented significant changes to the FCA, including the expansion of prohibited conduct under the FCA to include not just the improper filing to collect monies, but also the known retention of overpayments by healthcare providers (also known as "Reverse False Claims").

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 protected health information (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 disclosed and used between GlobalHealth and Providers, without the Member's written authorization, for purposes related to treatment, payment, and plan operations.

To report a possible privacy violation or breach, please contact the GlobalHealth Compliance and Privacy Officer using the contact information on the Helpful Numbers page.

The HIPAA Security Rule establishes national standards to protect individuals' electronic PHI that is created, received, used, or maintained by a covered entity, like a provider or health plan. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic PHI.

Notice of Privacy Practices (NPP)

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

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 Plan 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).

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 disclosure your PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclosure 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, please contact our Privacy Officer.

You may also file a complaint with the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

Effective Date: 08/01/2021

Original Notice: 04/01/2003

Revised: 04/01/2011
04/01/2013
08/01/2021

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.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law prohibits a physician from referring a patient for designated health services (DHS) to an entity in which he or she (or their immediate family member) has a financial interest, either directly or indirectly, unless an exception applies. CMS published the self-referral disclosure protocol (SRDP) that sets forth a process to enable healthcare providers to self-disclose actual or potential violations of the physician self-referral statute.

The Medicare Improvements for Patients and Providers Act (MIPPA)

The Medicare Improvements for Patients and Providers Act (MIPPA) supports states and tribes through grants to provide outreach and assistance to eligible Medicare beneficiaries to apply for benefit programs that help to lower the costs of their Medicare premiums and deductibles. Grantees help educate beneficiaries about the Low-Income Subsidy (LIS) program for Medicare Part D, Medicare Savings Programs (MSPs), and Medicare Preventive Services. This initiative includes special efforts to target rural areas and Native American elders.

The Anti-Kickback Statute

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

The Americans with Disabilities Act

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in several areas, including employment, transportation, public accommodations, communications, and access to state and local government programs and services. Provider's offices are required to adhere to 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 professionally certified medical interpreters. Please have Members call the Customer Care Number on the back of their ID card.

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 failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: ATTN: Senior Director, Compliance & Legal Services, 210 Park Ave, Suite 2800, Oklahoma City, OK 73102 or Email: compliance@globalhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Care is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Exhibit 1: Oklahoma Generations MA/MAPD Plans

This Exhibit contains information specific to GlobalHealth's Oklahoma MA/MAPD Plans.

Page 6: New information for 2023

Chronic Special Needs Plan (C-SNP) and Dual Special Needs Plan (D-SNP)

These plans will be available in all 26 Oklahoma counties that GlobalHealth serves. MOC training information is available on our website at www.GlobalHealth.com/oklahoma/providers/provider-training. Providers participating in an Interdisciplinary Care Team (ICT) are required to complete this training.

CPGs can be found on our website at www.GlobalHealth.com/oklahoma/quality-improvement-program/.

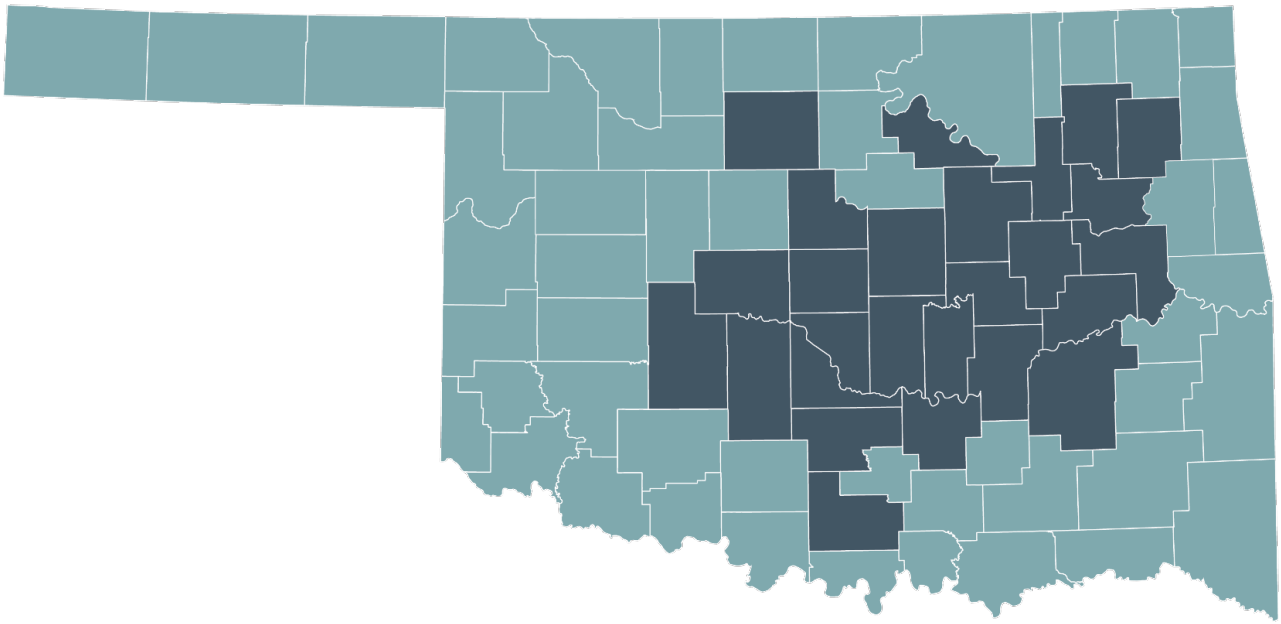
Provider Portal

Please access Provider Portal training at www.GlobalHealth.com/oklahoma/providers/provider-training.

Service Area Reduction

GlobalHealth plans will be available in 26 Oklahoma counties.

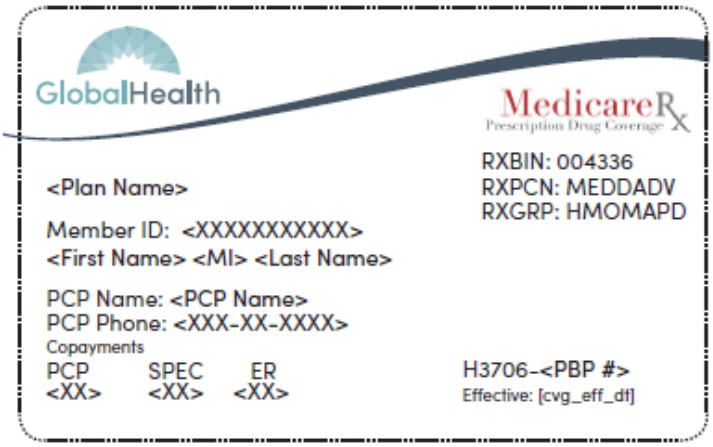
Caddo	Grady	Muskogee	Pottawatomie
Canadian	Hughes	Okfuskee	Rogers
Carter	Lincoln	Oklahoma	Seminole
Cleveland	Logan	Okmulgee	Tulsa
Creek	Mayes	Pawnee	Wagoner
Garfield	McClain	Pittsburg	
Garvin	McIntosh	Pontotoc	



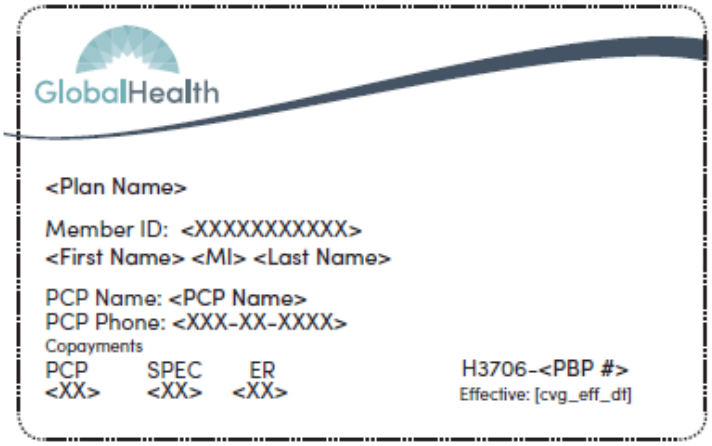
Page 7: GlobalHealth Products

Sample GlobalHealth Member ID Cards

Medicare Advantage with Drug Plan (back of card may vary slightly depending on plan)



Medicare Advantage without Drug Plan



If you have issues retrieving a member with a legacy ID number (11 digits beginning with 370), drop the 01 from the end and try again.

Page 8: Helpful Numbers and Information

Claims Submission
GlobalHealth
Attn: Claims
P.O. Box 2718
Oklahoma City, OK 73101-2718

Compliance & FWA
Toll-free Hotline (877) 280-5852
Email compliance@globalhealth.com

Contracting

https://www.GlobalHealth.com/oklahoma/providers/how-to-become-a-globalhealth-provider/

Credentialing
Phone (405) 280-5886
Toll-free (844) 322-5222
Fax (405) 552-3003
Email ghcredentialing@globalhealth.com

Customer Care
Phone (844) 280-5555

EDI
Change Healthcare: Payor ID GHOKC0001

EDI set up requests
Email edienrollment@globalhealth.com

Part D Coverage Determinations
Phone (855) 344-0930
Fax (855) 633-7673

Privacy/HIPAA
Toll Free Hotline (877) 280-5852
Email privacy@globalhealth.com

Provider Portal
https://ghprovider.prod.healthaxis.net/

Provider Relations
Fax (405) 280-5251
Email provider.relations@globalhealth.com

Provider Services
Phone (844) 280-5555

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

Utilization Management
Phone (844) 280-5555
Fax (405) 280-5398

Helpful Numbers and Information – Supplemental Plan Benefits

Advance Care Planning Services: Vital Decisions
https://globalhealth.mylivingvoice.com

Behavioral Health: Beacon Health Options

Phone (888) 434-9202

Dental: DentaQuest
Phone (833) 955-3417

Hearing: NationsHearing
Phone (877) 241-4736

Home Health Support Benefits: Papa Pals
Phone (855) 485-9692

Over-the-Counter (OTC) Products: NationsBenefits
Phone (877) 241-4736

Smart Wallet: NationsBenefits
Phone (877) 241-4736

Transportation: RoundTrip
Phone (877) 565-1612

Vision: EyeMed
Phone (800) 884-6321

Various forms and resources can be found on our website at:
www.GlobalHealth.com/oklahoma/providers/forms-and-resources/

Member benefit information can be found on our website at:
www.GlobalHealth.com/oklahoma/medicare-advantage/member-materials

Page 22: Services That Require Prior Authorization

Pharmacy

More information is also available on our website: www.GlobalHealth.com/oklahoma/medicare-advantage/utilization-management-program

Step therapy protocols apply to Part B prescription drugs. A list of Part B drugs that may be subject to Step Therapy is available on our website at www.GlobalHealth.com/oklahoma/pharmacy/drug-formularies/. Under this policy, step therapy will only be applied to new prescriptions or administrations of Part B drugs for Members that are not actively receiving the affected medication. This means that no Member currently receiving drugs under Part B will have to change their medication.

Page 24: Referrals to Non-Contracted Providers

GlobalHealth Members covered by Generations Valor (HMO-POS) may seek care out of the network. Please submit a Referral to GlobalHealth for all out-of-network services.

Page 42: Code of Conduct

A current copy of the Code of Conduct is available on our website at www.GlobalHealth.com/oklahoma/compliance.

Current FWA alerts are available on our website at www.GlobalHealth.com/oklahoma/fwa-alerts.

Page 43: Education and Training

FWA education and training is available on our website at www.GlobalHealth.com/oklahoma/compliance.

Exhibit 2: Texas
GlobalHealth of Texas MA/MAPD Plans

This Exhibit contains information specific to GlobalHealth of Texas's Medicare Advantage Plans.

Page 6: New information for 2023

Dual Special Needs Plan (D-SNP)

These plans will be available in all Texas counties that GlobalHealth serves. MOC training information is available on our website at www.GlobalHealth.com/texas/providers/provider-training. Providers participating in an Interdisciplinary Care Team (ICT) are required to complete this training.

CPGs can be found on our website at www.GlobalHealth.com/texas/quality-improvement-program/.

Service Area

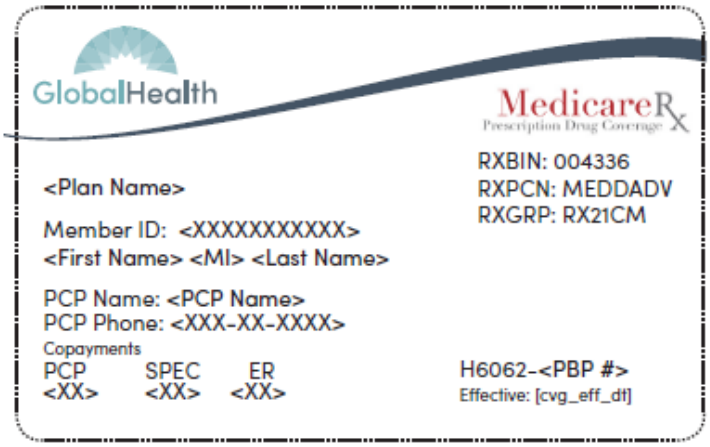
GlobalHealth of Texas plans will be available in 6 counties.

Collin
Dallas
Denton
Fort Bend
Montgomery
Tarrant

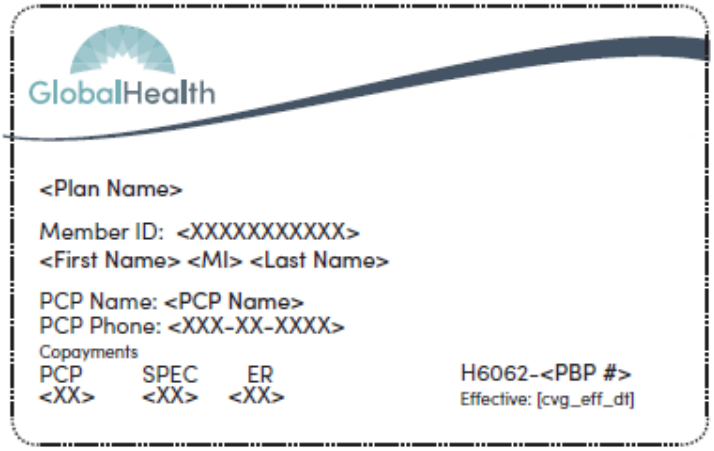
Page 7: GlobalHealth Products

Sample GlobalHealth of Texas Member ID Cards

Medicare Advantage with Drug Plan (back of card may vary slightly depending on plan)



Medicare Advantage without Drug Plan (back of card may vary slightly depending on plan)



Page 8: Helpful Numbers and Information

Claims Submission
GlobalHealth
Attn: Claims
P.O. Box 2718
Oklahoma City, OK 73101-2718

Compliance & FWA
Toll-free Hotline (877) 280-5852
Email compliance@globalhealth.com

Contracting
https://www.GlobalHealth.com/texas/providers/how-to-become-a-globalhealth-provider/

Credentialing
Phone (405) 280-5886
Toll-free (844) 322-5222

Fax (405) 609-6327
Email ghcredentialingTX@globalhealth.com

Customer Care
Phone (844) 200-8167

EDI
Change Healthcare: Payor ID GHTX0

EDI set up requests
Email edienrollment@globalhealth.com

Part D Coverage Determinations
Phone (855) 344-0930
Fax (855) 633-7673

Privacy/HIPAA
Toll Free Hotline (877) 280-5852
Email privacy@globalhealth.com

Provider Portal
https://ghprovider.prod.healthaxis.net/

Provider Relations
Fax (405) 280-5251
Email txproviderrelations@globalhealth.com

Provider Services
Phone (844) 200-8167

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

Utilization Management
Phone (844) 200-8167
Fax (405) 280-5398

Helpful Numbers and Information – Supplemental Plan Benefits

Advance Care Planning Services: Vital Decisions
https://globalhealth.mylivingvoice.com

Behavioral Health: Beacon Health Options
Phone (888) 434-9202

Dental: DentaQuest
Phone (888) 308-9345

Hearing: NationsHearing
Phone (877) 202-4718

Home Health Support Benefits: Papa Pals
Phone (855) 486-4037

Over-the-Counter (OTC) Products: NationsBenefits
Phone (877) 202-4718

Smart Wallet: NationsBenefits
Phone (877) 202-4718

Transportation: RoundTrip
Phone (877) 565-1637

Vision: EyeMed
Phone (800) 884-6321

Various forms and resources can be found on our website at:
www.GlobalHealth.com/texas/providers/forms-and-resources/

Member benefit information can be found on our website at:
www.GlobalHealth.com/texas/medicare-advantage/member-materials

Page 22: Services That Require Prior Authorization

Pharmacy

More information is also available on our website: www.GlobalHealth.com/texas/medicare-advantage/utilization-management-program

Page 24: Referrals to Non-Contracted Providers

GlobalHealth Members participating in Texas LoneStar Valor (HMO-POS) may seek care out of the network. Please submit a Referral to GlobalHealth for all out-of-network services.

Page 32: Pharmacy

Prior authorization forms for MAPD can be accessed via www.GlobalHealth.com > Providers > Prescription Drug Prior Authorization Forms, then click "Continue to…"

Page 42: Code of Conduct

A current copy of the Code of Conduct is available on our website at www.GlobalHealth.com/texas/compliance.

Current FWA alerts are available on our website at www.GlobalHealth.com/texas/fwa-alerts.

Page 43: Education and Training

FWA education and training is available on our website at www.GlobalHealth.com/texas/compliance.

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