

Glossary

Accident: A sudden unforeseen bodily injury caused by external trauma that requires immediate medical treatment.

Adverse Determination: For purpose of the appeal process means any of the following; a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of any of the following:

- application of utilization review;
- determination that a treatment is investigational;
- determination that a treatment is not Medically Necessary; or
- Billing Dispute

Allowable Fee: The amount which a local Blue Cross and Blue Shield Plan has established as full payment to a Participating or Preferred Provider in accordance with the terms of the Provider agreement.

All-Patient Groupings (APG): System of medically or statistically significant groupings of acute care diagnoses based on factors that include, but are not limited to: principal and secondary diagnoses, surgical procedures and patient's age, gender and discharge status.

Ancillary/Allied Providers: Health care professionals other than MDs, DOs or facilities that are approved by Regence to submit claims.

Appeal Record: Includes all information which was relied upon in making the payment determination; or was submitted, considered, or generated in the course of making the payment determination, whether or not such document, record, or other information was relied upon in making the payment determination; or demonstrates compliance with the Plan's Claims procedures, administrative processes and safeguards; or constitutes a statement of policy or guidance with respect to the payment determination.

Average Sales Price (ASP): Drug pricing methodology developed by the Centers for Medicare & Medicaid Services (CMS). In this method, fees are based on a percentage of the average sales price for specific medications. The average sales price is calculated using sales data required to be submitted to CMS by medication manufacturers. This methodology was introduced as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Average Wholesale Price (AWP): Average price that a wholesaler would charge a pharmacy for a particular medication identified by a National Drug Code (NDC).

Benefit: A service provided to a member that a health insurance plan will pay for. Also, payment provided for covered services.

Benefit Period: The specific period of time in which charges for covered services must be incurred in order to be eligible for payment by the health plan.

Billing Dispute: A dispute with a Provider arising from Covered Services provided to Plan Members by such Providers concerning: (i) Plan's application of coding and payment rules and methodologies for fee for service claims (including bundling and downcoding), (ii) application of a CPT modifier, and/or other reassignment of a code by Blue Plan) to patient specific factual situations, including the appropriate payment when two or more CPT Codes are billed together, or (iii) whether a payment enhancing modifier is appropriate.

BlueCard®: A program used by all Blue Cross and/or Blue Shield Plans that allows members who are traveling or living outside of their Blue Plan's service area the ability to seek service nationwide from any provider who is Participating or Preferred with a Blue Cross and/or Blue Shield Plan. The provider or facility should send claims for these members to the Blue Cross and/or Blue Shield Plan in the state where services were rendered.

Care Management: Program provided by Medical Services to address a member's needs across a wide range of care. Specific program activities are categorized as Case Management, Condition Management, Utilization Management and Health and Wellness.

Case Management: A collaborative process that assesses, plans, implements, coordinates, monitors, manages and evaluates options and services to meet an individual's health needs through communication and use of available resources to promote quality, cost-effective outcomes.

Categories of benefits:

A description of the different benefit levels based on a Regence InnovaSM, EngageSM, ActivateSM or HSA Healthplan 2.0SM member's choice of provider. For example, when a member seeks services from a Preferred network provider, the Category 1 choice (highest benefit level) applies and the member incurs the lowest out-of-pocket cost.

Centers for Medicare & Medicaid Services (CMS): CMS is the federal agency that oversees Medicare and Medicaid programs.

Claim Voucher: A form sent to a provider by a health insurance plan that explains action taken on claims and gives information on any payment accompanying the form. Also known as a Remittance Advice or Explanation of Claims Processed (EOCP).

Claims: A Provider's request for payment submitted in the usual course of business between the Provider and the Plan.

Coinsurance: The percentage of the applicable reimbursement amount that the member's contract requires the member to pay for a covered service.

Concurrent Review: Utilization Management conducted during a member's hospitalization or course of treatment (including outpatient procedures and services) to ensure the care and setting are the most appropriate to treat the member's condition.

Condition/Disease Management: System of coordinated health care interventions and communication for populations with conditions in which patient self-care efforts are significant. Further, Disease Management supports the provider/patient relationship; emphasizes prevention and complications; utilizes evidenced-based practice guidelines. Together, this system evaluates clinical, humanistic and economic outcomes on an ongoing basis with a goal of improving overall health.

Consumer Directed Health Plan: A health plan, such as Regence HSA Healthplan 2.0, designed to engage consumers more directly in their health care. Typically, such products are paired with a tax-advantaged account that can be used to cover their medical expenses. [this is Ellen's definition]

Contract Number: The number used by Regence to identify specific members and their enrolled dependents. May also be referred to as "member number" or "policy number." The number is not the same as the member's social security number.

Contracted Provider: See *Participating Provider*.

Contractual Adjustment: Any portion of a charge for a covered service that is in excess of the allowable fee for such service as determined by the Plan. Participating providers have agreed to "write-off" contractual adjustments and not hold the member or Regence financially liable for that amount.

Coordination of Benefits (COB): A system that permits members to receive benefits from all health insurance plans under which they have coverage while assuring that the total, combined payments from all plans are not more than the total allowable fee for the service.

Copayment (copay): A fixed dollar amount, of the applicable reimbursement amount, that the member's contract requires the member to pay for a covered service. The physician, other health care professional or facility may collect copayments at the time of service.

Covered Service: A medically necessary health care service or supply provided to members by participating providers that qualifies for payment under the terms of a member's contract.

Credentialing: A process employed by Regence to determine whether a physician, other health care professional or facility meets Regence's criteria for initial or continued participation in a network.

Deductible: The dollar amount that a member must pay each calendar or contract year before Regence begins to make payments.

Dependent: A husband, wife, child or legally-recognized individual who is covered under the member's benefit contract.

Diagnosis Related Group (DRG): The patient classification method that provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital.

Diagnostic Admissions: Those admissions where a patient is admitted primarily for studies, "work up" or observation, rather than for a specific therapy that is designed to cure or alleviate the symptoms of an illness or injury.

Diagnostic Service: A test or procedure to determine a definite condition of disease because specific symptoms are present.

Discharge Planning: A collaborative process that assesses, plans and implements options and services to meet the needs of a member prior to discharge from an acute hospital or skilled nursing facility.

Dual Coverage: Member's benefit coverage under Regence policies with two different employment groups.

Effective Date: The date shown on the member's card indicating the date benefits coverage begins.

Elective: Medical care/treatment, particularly surgery, not immediately necessary to maintain life or health (can often be scheduled days or weeks in advance).

Eligible Medical Expenses: With respect to Participating Hospitals, Participating Skilled Nursing Facilities, and other facilities that are Participating Providers; the reimbursement amount as provided in the applicable contractual payment schedule; With respect to physicians, and other health care professionals, the amount Participating Physicians/Professionals have agreed to accept as full payment for covered services as determined by individual Regence Plans.

Charges in excess of eligible medical expenses are not deemed reasonable charges and are not reimbursable under the Plan.

Emergency: A medical condition that manifests itself by acute symptoms, of sufficient severity (including severe pain) so that a prudent layperson who has an average

knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a hospital emergency room to result in any one of the following:

- Placing the member's health, or with respect to a pregnant member, her health or the health of her unborn child, in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Evidenced-Based Criteria: Defined by the Blue Cross and Blue Shield Association as “the conscientious, explicit and judicious use of current evidence in making decisions about the care of individual patients.”

Explanation of Benefits (EOB): A form sent to a member by a health plan which explains the action taken on a claim and gives information about any payment, denial or member responsibility.

Explanation of Claims Processed (EOCP), Remittance Advice or Voucher: A form sent to a Participating Provider by a health plan which explains the action taken on a claim and gives information about any payment, denial or member responsibility.

Extended Care: Long-term care to aid in the process of recovery from illness or surgery requiring an inpatient stay in a facility such as a skilled nursing facility or rehabilitation hospital.

External Review: Review of a Billing Dispute Appeal or a Medical Necessity/Investigational Procedure Appeal submitted to the External Review Organization with which the Plan has contracted to review services by a Provider in compliance with the terms of the Adverse Determination Appeal Process.

External Review Organization (“ERO”): An independent organization employing physicians and other medically qualified individuals or experts that acts as the decision maker for External Reviews, through an independent contractor relationship with the Plan.

Facility: Hospital, skilled nursing facility and ambulatory surgical center or rehabilitation hospital that provides specified health care services in a centralized facility. For the purposes of the manual and for simplicity's sake, the term “provider” will be used collectively to refer to any physician, practitioner, health care professional or facility.

Group: The employer, association or other organization that provides health insurance for a member and enrolled dependents.

Group Contract: A Participating Provider contract issued to a group of associated providers who provide services under a common tax identification number. Reimbursement for services rendered under a group contract will be made payable to

the group, not the rendering provider. Criteria to qualify as a “group” are established by the individual Regence Plan.

Health Care Professional: Health care professionals other than MDs, DOs or facilities that are approved to submit claims by the applicable Regence Plan.

Health Insurance Portability & Accountability Act of 1996 (HIPAA): Federal statute designed to:

- Improve efficiency in health care delivery by standardizing electronic data interchange.
- Protect confidentiality by providing unique health identifiers for individuals, employers, health plans and health care providers.
- Establish security standards to protect the confidentiality and integrity of "individually identifiable health information," past, present or future.

Health Reimbursement Arrangement (HRA): A tax-advantaged program that helps employers offset health care costs. The account allows employers to reimburse medical expenses paid by participating employees.

Health Risk Assessment: A validated tool designed to measure critical health factors and used to interpret the current health status of an individual. It is also used as an educational instrument that identifies both positive and negative influences on personal health.

Health Savings Account (HSA): A medical savings account, available to individuals who are enrolled in a qualified high-deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. If not used, the funds accumulate from one year to the next.

Hold Harmless: To adjust, “write-off” or not charge a member for balances other than those amounts identified as patient responsibility such as deductible, coinsurance, copayment amounts and for services that are not a benefit of the member’s contract.

Hospital: A short-term, acute-care facility licensed by the state in which it is located, and that:

- Primarily provides facilities for diagnosis and therapy for medical/surgical treatment and for the care of obstetrical cases under the supervision of a staff of physicians
- Provides 24-hour nursing service under the supervision of registered nurses.

Hospital-based physicians: Physicians employed by or under contract with a hospital and billing with the hospital’s tax identification number for the furnishing of services including, but not limited to: radiologists, anesthesiologists, pathologists, hospitalists and emergency medicine physicians.

Inliers: Facility claims with charges or length of stay that are less than the APG-DRG rate.

In-network Services: Services provided by a Participating Provider or facility.

Inpatient: A person who receives hospital services and meets Regence criteria for inpatient stays.

Investigational: The definition provided in the member's benefit contract/summary of benefits. To the extent that the member's benefit contract/summary of benefits does not provide a definition of Investigational, the following definition shall apply: treatment or procedure unsupported by reasonable and substantive scientific evaluation, which effectiveness has not been established, or the procedure or treatment has not been accepted and generally used by the medical provider community for a period of five (5) years.

Lifetime: The period of time a member is covered under the Plan.

Maintenance of Benefits (MOB): A system that permits members to receive benefits from all health plans under which they have coverage, while maintaining patient responsibility for coinsurance and/or copayment amounts.

Managed Care: A collection of interdependent systems that coordinate the financing and delivery of health care services. More specifically, managed care health plans incorporate the following elements:

- Arrangement with selected physicians or other health care professionals to furnish health care services to members.
- Formal programs for ongoing quality assurance and utilization review.

Maximum Benefit: When payments total the specified amount or when benefits have been provided for a specified number of days, visits or services, no more payments will be made by Regence. When the maximum benefit is for a specified time period such as a calendar year, no more payments will be made during the remainder of the specified time period.

MedAdvantage (Regence MedAdvantage): Medicare Advantage PPO plan which provides the same benefits available from Medicare plus some additional benefits. Provides incentives for members to seek services from physicians, other health care professionals and facilities contracted with the Regence MedAdvantage network.

Medicare Advantage Plan: CMS-approved alternative to Medicare Parts A and B programs and Medicare supplement plans.

Medically Necessary: Health care services that a physician, other health care professional or facility exercising prudent clinical judgment would provide to a patient for

the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that are:

- (a) in accordance with generally accepted standards of medical practice
- (b) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease
- (c) not primarily for the convenience of the patient, facility, physician, or other health care professional, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member: A person covered under any Regence Plan, as well as participants in other Blue Cross and Blue Shield Plans who may require services.

Member Choice Account: The online bank account on **myRegence.com** for members enrolled in our ActivateSM product. Activate members use the account to view their current Member Choice Fund (see definition below) balance and initiate requests for funds to be paid for their eligible medical expenses.

Member Choice Fund: When Activate members engage in qualified wellness activities, they earn points which convert into dollars that can be used to pay for covered medical expenses including deductibles and coinsurance.

Member Contract: A contract between Regence and an individual or group in which Regence agrees to provide, indemnify for or administer health care benefits.

National Provider Identifier (NPI): A standard unique health identifier for physicians, other health care professionals and facilities. This identifier, implemented in 2007, will be used by all health plans, including Medicare and Medicaid to identify the provider.

Network Provider: *See Participating Provider.*

Nonparticipating Provider: A provider who does not have an effective contract with Regence to provide services and supplies to members in the state in which he practices.

Notification: Notification sent by a member or provider to the health plan to inform them of a member's confinement or service. Notification does **not** include a prospective determination of medical necessity; however, concurrent review may follow the initial

notification. Notification is not applicable to governmental programs or regulatory requirements.

Outlier: Facility claim where charges or length of stay exceed an established DRG or per diem threshold and additional payment is appropriate.

Out-of-Area Care: Care received by Managed Care members when they are treated outside the Managed Care service area.

Outpatient: A person who receives hospital services and meets Regence criteria for outpatient stays.

Participating Facility: Facility that has signed a state-specific Regence contract (or a facility outside the Regence service area that has a contract with another Blue Cross and/or Blue Shield organization for the BlueCard Program) and has agreed to provide services to members of Regence Plans.

Participating Provider: Any physician, other health care professional or facility that is legally qualified to provide medical services or supplies; has contracted with Regence, directly or through intermediaries, to furnish Covered Services to members; and is eligible for reimbursement under a member Contract.

Pre-authorization: A determination of medical necessity and appropriateness made prior to a proposed service, treatment or visit. Pre-authorization does not guarantee payment. Services requiring pre-authorization are included on the *Medical Pre-authorization Lists* and the *Pharmacy Prior Authorization List* available online in the Care Management section of the *Provider Web Site*.

Precertification: A determination of medical necessity and appropriateness made prior to a proposed confinement; it may include a level of care assessment, appropriate placement prior to delivery of confinement or authorization of an initial length of stay.

Pre-existing condition: A health condition diagnosed, treated, or for which medication was taken within a given period prior to enrollment.

Preferred Provider Organization (PPO): An arrangement between a health insurance plan and a limited number of health care providers who agree to certain requirements in exchange for the potential to increase their volume of patients. Patients who use a Preferred Provider generally receive a higher level of benefits.

Preferred Provider: A provider who has signed a state-specific Preferred Provider contract with Regence and agreed to provide services to our managed care members. (Used interchangeably with Participating Provider except in relation to the Federal Employee Program [FEP]).

Primary Plan: The insurance plan that has the primary responsibility to pay benefits when a member is covered by more than one group health plan.

Provider: A physician or other health care professional who is eligible to provide covered diagnostic, medical, surgical, dental or hospital services. For the purposes of the manual and for simplicity's sake, the term "provider" will be used collectively to refer to any physician, practitioner, health care professional or facility.

Provider Agreement: A Contract, including its attachments, exhibits, addenda, and amendments, signed by a physician or other health care professional, in which a physician or other health care professional agrees to the terms of participation in a given provider network, or networks, including medical or reimbursement policies as established by Regence.

Provider Identification Number (PIN): A number assigned by a Regence Plan that identifies the provider by name, address and tax identification number. A PIN is required on every paper claim submission. On May 23, 2008, the NPI will replace the Regence provider identification number for electronic claims. Claims that are submitted on paper can use either the Regence provider identification number or the NPI.

Provider Network: A network of Participating Providers that have contracted with Regence to provide Covered Services to members in accordance with specific payment and related policies and procedures established by Regence for that network.

Provider Services: A department located in each Regence state to act as a liaison between the provider community and Regence.

Quality Assurance (QA): The process that ensures health care services received by our members meet accepted standards of care.

Regence: A global term used to identify Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah and Regence BlueShield (in Washington) as a group.

Regence Online Services: Web-based applications available to our members, Participating Providers and facilities and our employees regarding Regence-specific information.

Remittance Advice: A form sent to a provider by a health insurance plan that explains action taken on claims and gives information on any payment accompanying the form. Also known as a voucher.

Resource Based Relative Value Scale (RBRVS): A standardized schedule of unit value or "relative weights" assigned to different medical services and procedures by CMS. This unit measurement is then converted to a reimbursement value. The RBRVS

payment methodology assures comparable providers are reimbursed equitably for similar procedures.

Retrospective Review: A review of claims and medical records for appropriateness and medical necessity after care is rendered.

Secondary Plan: The plan which pays any balances remaining up to its coverage limits after the primary plan has paid when a member is covered by more than one health insurance plan.

Self-managed plans:

Products such as Regence InnovaSM, EngageSM and ActivateSM that focus on personal decisions and cost accountability. Self-managed plans offer member's choices and resources to make informed health care decisions.

Skilled Nursing Facility (SNF): A facility or distinct part of a facility which is licensed by the applicable state agency as a nursing care facility, and which provides skilled nursing services by or under the direction and supervision of a registered nurse.

Site of Service (SOS): SOS is a professional (e.g., physician or other health care professional) reimbursement methodology originated by the Centers for Medicare & Medicaid Services (CMS) that considers the place of treatment when determining the allowance for any given procedure.

The Regence Group: The holding company for Regence BlueShield of Idaho; Regence BlueCross BlueShield of Oregon; Regence BlueCross BlueShield of Utah; Regence BlueShield; Regence Life and Health Insurance Company; Asuris Northwest Health (not a BlueCross BlueShield licensee); and their respective subsidiaries.

Traditional Coverage: The established fee-for-service indemnity type of health coverage.

Urgent Care: Care for an acute illness or injury that is not emergent, which needs immediate treatment or treatment within 24 hours.

Utilization Management: Process of evaluating and determining the appropriate use of health care resources and promoting the efficient, cost-effective use of health care benefits. Utilization management activities include pre-authorization, case management, discharge planning and retrospective review.

Vendor: Entity with whom Regence partners and pays to provide services or products.

Voucher: A form sent to a provider by a health insurance plan that explains action taken on claims and gives information on any payment accompanying the form. Also known as a Remittance Advice.

Waiting Period: Period of time a member may be required to wait after enrolling to become eligible for certain benefits.

Write-Off: To adjust, “hold harmless” or not charge a member for balances other than those amounts identified as patient responsibility such as deductible, coinsurance, copayment amounts and for services that are not a benefit of the member’s contract.