Health Care and Managed Care Terms used by Blue Cross and Blue Shield of Georgia

A

Accreditation:
Certification that an organization meets the reviewing organization's standards. Examples: accreditation of HMOs by the National Committee for Quality Assurance (NCQA) or accreditation of PPOs by the American Accreditation HealthCare Commission/URAC.

Acupuncture:
An alternative health procedure based on ancient Chinese methods, gaining acceptance in Western hospitals, involving insertion of thin needles at specific pressure points in the body.

Adjudication:
Determination of the amount of payment for a claim.

Administrative Costs:
The costs assumed by an insurance company or managed care plan for administrative services such as claims processing, billing and overhead costs.

Administrative Services Only (ASO):
An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group but does not assume any financial risk for the payment of benefits.

Agent:
An individual licensed by the State who sells insurance or coverage and provides service to the policyholder on behalf of the insurer or managed care plan. Could be sole-proprietor, member of a large firm or employee of the carrier and is paid a fee/commission by the carrier.

Allergy Treatment:
Treatment of allergy, which may involve allergy testing and physician's services.

Allowable Charge:
The maximum fee that a third party will reimburse a provider for a given service. An allowable charge may not be the same amount as either a reasonable or customary charge.

Ambulatory Care or Services:
Health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients in a hospital.

Ambulatory Surgery:
Surgical procedures performed that do not require an overnight hospital stay. Also called Outpatient Surgery.

American Accreditation HealthCare Commission, Inc./Utilization Review Accreditation Commission, Inc.
(AAHCC/URAC):
An independent, not-for-profit corporation established in 1990 by organizations representing the managed health care industry, health care providers, consumers, and regulators to encourage more efficient and effective managed care.

Ancillary:
A term used to describe additional services performed related to care, such as lab work, x-ray, and anesthesia.

Ancillary Services:
Hospital services other than room and board, and professional services. They may include X-ray, drug, laboratory or other services.

Anniversary:
The start of a group's benefit plan year, which may not necessarily match the fiscal year used by the group.

Appeal(s):
An individual's dispute over the denial of a claim payment or the denial of provision of a health care service, or a coverage denial based on a contractual exclusion or limitation.

Authorization:
The approval of care, for hospitalization, outpatient procedure, certain specialty, etc., by a managed care or insurance company for its member, subscriber, or insured.

B

Beneficiary:
A person who is eligible to receive insurance benefits.

Benefit:
The amount payable by an insurer or employee benefit plan to a claimant, assignee or beneficiary under the terms of in the benefits contract.

Benefit Consultant:
An individual or organization hired by a group planholder to review, analyze, and make recommendations on benefit
strategies, including benefit plan design, carrier selection, pricing, etc. An insurance professional who provides information, advice and counseling for their clients.

Benefits Package:
A term informally used to refer to the employer's benefit plan or to the benefit plan options from which the employee can choose. "Benefits package" highlights the fact a health benefits plan is a compilation of specific benefits.

Benefit Period:
The maximum length of time for which benefits will be paid.

Birthing Center:
A facility that allows mothers to give birth in a home-like setting.

BlueCard Program:
A BCBSA program that links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country and abroad with a single electronic process for professional, outpatient and inpatient claims processing and reimbursement. The program allows members obtaining health care services while out of town to receive the same benefits of their Blue Cross plan and access out-of-town providers' savings. In most cases, providers bill claims directly to their local Plans without requiring up-front payment from the member.

BlueChoice Healthcare Plan:
BlueChoice Healthcare Plan is a health maintenance organization (HMO) product, underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia.* This plan provides preventive care benefits, as well as coverage for treatment of specific illness and injury. Members receive a high level of benefits with low out-of-pocket costs. *Blue Cross Blue Shield Healthcare Plan of Georgia is an independent licensee of the Blue Cross and Blue Shield Association.

BlueChoice Option:
BlueChoice Option* is a point-of-service plan that offers the advantages of an HMO with the flexibility of a traditional health insurance plan. Members decide where to receive care when they need it at the point-of-service. BlueChoice Option provides two levels of benefits in-network and out-of network. *BlueChoice Option is
underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, an independent licensee of the Blue Cross and Blue Shield Association.

BlueChoice Platinum:
BlueChoice Platinum is a Medicare + Choice health maintenance organization (HMO) product.* This plan provides preventive care benefits for Medicare beneficiaries, as well as coverage for treatment of specific illness or injury. Members receive a high level of benefits with low out-of-pocket costs. *BlueChoice Platinum is underwritten by
Blue Cross Blue Shield Healthcare Plan of Georgia, an independent licensee of the Blue Cross and Blue Shield Association, and an HMO with a Medicare +Choice contract.

BlueChoice PPO:
BlueChoice PPO is a preferred provider organization (PPO) that offers members the flexibility of going in or out-of-network for medical care. If members see a physician, specialist or hospital that is in-network (a preferred provider), they receive more savings and benefits. *BlueChoice PPO is underwritten by Blue Cross and Blue Shield of
Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Board Certified (Boarded, Diplomate):
Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Brand Name Drug(s):
Those drugs that are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection, meaning the manufacturer is the sole source for the product.

C

Case Management:
A utilization management program that assists the patient in determining the most appropriate and cost effective treatment plan. It is used for patients who have prolonged, expensive or chronic conditions, helps determine the treatment location (hospital, other institution or home) and authorizes payment for such care if it is not covered under the patient's benefit agreement. The purpose of case management is to provide optimum patient care in the most cost effective manner.

Certificate Booklet:
A detailed document that serves both as an explanation of the benefit plan and as the certificate of insurance. See certificate of coverage.

Certificate of Coverage:
A description of the benefits included in an insurance plan. The certificate of coverage is required by state insurance laws and represents the coverage provided under the policy issued to the contract holder. The certificate is provided to subscribers via the Certificate Booklet.

Certification:
See Pre-Certification.

Chemotherapy:
Treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic (Care):
An alternative medicine therapy administered by a provider such as a chiropractor, osteopath or physical therapist. The provider adjusts the spine and joints to treat pain and improve general health.

Claim:
A request for payment for benefits received or services rendered. A billing record is generated and submitted by a provider or subscriber using paper or electronic media.

Coinsurance:
An arrangement under which the member pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the member responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Coinsurance Maximum:
The total amount of coinsurance that an individual pays each year before the carrier pays 100% of allowable charges for covered services. Coinsurance amounts differ with each contract.

Community Health Partnership Network (CHPNs):
Networks constructed as regional delivery systems, integrating the delivery of health care through local partnerships with hospitals, physicians and other business coalitions. The overall concept is based on the belief that health care is best delivered and managed at the local level.

Concurrent Review:
A component of Utilization Management program which evaluates a member's coverage for hospital services under the terms of the contract.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA):
The federal law that requires employers with more than 20 employees to extend group health insurance coverage for up to 36 months after a qualifying event (e.g. termination of employment, reduction in hours, divorce). The law contains detail provisions relating, among other things, to an employer's obligation to provide notice of these rights and the circumstances under which such continuation may end.

Continuation:
See COBRA.

Contraception:
Prevention of pregnancy or birth control.

Contract:
A binding written agreement between the insurer and policyholder to evidence the terms and conditions of the policy. The contract between Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia and an insured includes the certificate booklet. Can also be called a Benefit Certificate or Policy.

Contract Holder:
See Subscriber.

Conversion Option: The exercise of an option to purchase individual coverage at a negotiated rate by a person who is leaving an employee group, typically at retirement.

Coordination of Benefits:
The non-duplication provision to limit benefits for multiple group health insurance in a particular case to 100% of the covered charges and to designate the order in which the multiple carriers are to pay benefits. Under a COB provision, one Plan is determined to be primary and its benefits are applied to the claim. The unpaid balance is usually paid by the secondary Plan to the limit of its liability.

Copayment or Copay:
The small payment made by a member of an HMO or point-of-service or the user of a PPO at the time a selected service is rendered. This is usually a percentage of the charges but may also be a dollar amount for specified services. Examples include copayment for each physician's office visit and for each hospital admission.

Cost Containment:
A set of programs to reduce use of unnecessary or inappropriate services and to encourage provisions of necessary and appropriate services in a cost-effective manner.

Covered Medical Expense:
Those expenses payable according to the terms of the member contract. The charges for these services are still subject to any cost sharing components or limits, such as deductibles, coinsurance, copayments and maximums, included in the contract.

Covered Person:
An individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual agreement.

Covered Services:
Hospital, medical and other health care expenses incurred by the covered person that entitle him/her to benefits under a contract. The term defines the type and amount of expense, which will be considered in the calculation of benefits.

Credentialing:
The process of reviewing a provider's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for inclusion in a network are met. Blue Cross and Blue Shield of Georgia and Blue Cross Blue Shield Healthcare Plan of Georgia thoroughly qualify and carefully screen all physicians in their networks. Each physician must meet specific educational and medical practice standards in order to become part of the network.

Custodial Care: Care provided primarily to assist a patient in meeting the activities of daily living, but not care requiring skilled nursing services.

Customary and Reasonable (C&R):
The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and the reasonable cost of services for a given patient after medical review of the case.

D

Day Treatment Center:
An outpatient psychiatric facility that is licensed to provide outpatient care and treatment of mental or nervous disorders or substance abuse under the supervision of physicians.

Deductible:
The amount of covered expenses that must be incurred by each member before benefits become payable by the insurer. For example, if a plan has a $100 deductible, the deductible is met once the first $100 of the covered medical expenses for that year have been paid. After that, the plan begins to pay toward the cost of covered health care services.

Dental Care:
Under a medical plan, dental care is dental treatment which due to the nature of the procedure or patient's medical condition, may be provided in a hospital setting.

Dependent:
Person, (spouse or child), other than the subscriber who meet eligibility requirements under the subscriber's benefit certificate.

Diagnostic Tests:
Tests and procedures ordered by a physician to determine if the patient has a certain condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include radiology, ultrasound, nuclear medicine, laboratory, pathology services or tests.

Discharge Planning:
Component of Utilization Management program which evaluates a member's coverage under the terms of the member's contract for health care services after discharge from an inpatient setting.

Disease Management Programs (Health Management Programs):
Educational programs designed for individuals with chronic diseases designed to help maintain high quality of life and prevent future need for medical resources by using an integrated, comprehensive approach to health care coordinate with the individual's physician. Pharmaceutical care, continuous quality improvement, practice guidelines, and case management all play key roles in this effort.

Drug Formulary:
A list of preferred pharmaceutical products that health plans, working with an expert panel of pharmacists and physicians, have developed to encourage the dispensing of quality, cost effective medications. The list is subject to periodic review and modification by the health plan.

Durable Medical Equipment (DME):
Mechanical devices, equipment and supplies that enable a person to maintain functional ability.

E

Effective Date:
The date on which the coverage or a change in coverage of a contract goes into effect at 12:01 a.m.

Eligibility:
The provisions of the group policy or insurance contract that state requirements that applicants must satisfy to become insured with respect to themselves or their dependents.

Emergency:
A condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in: Placing the member's health in serious jeopardy; Serious impairment to bodily functions; Serious dysfunction of any bodily organ or part; or Other serious medical consequences. Such conditions include but are NOT limited to: chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and other acute conditions.

Emergency Care:
Care for patients with severe or life threatening conditions that require immediate medical attention.

Employee Assistance Program (EAP):
A worksite-based program that is designed to assist in the identification and resolution of productivity problems associated with personal concerns of employees. The program provides employees and their dependents with access to confidential, short-term counseling by qualified practitioners, in person or over the phone.

Employee Retirement Income Security Act (ERISA):
A federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs.

Employer Group:
A group of eligible employees to whom health care benefits are extended through a benefits plan provider. The relationship is formalized through a contract. For the employer group to be recognized, a true employee-employer relationship must exist. Examples of groups which would not qualify include social clubs and independent contractors.

Encounter:
Information submitted by a capitated provider to establish that medical services were provided to a covered person.

Enrollee:
An individual who is enrolled and eligible for coverage under a health plan contract. Synonymous with member.

Exclusions:
Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.

Experimental Procedures:
Procedures that are not recognized under generally accepted medical standards as safe and effective for treating a particular condition.

Expiration Date:
The date coverage expires.

Explanation of Benefits (EOB):
A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

F

Fee-for-Service Reimbursement:
A method of reimbursement by which a provider charges, and is reimbursed, separately for each patient encounter or service rendered.

FEP:
The "Federal Employee Program" is a group contract to provide health care benefits to federal employees, underwritten by Blue Cross and Blue Shield Plans. The official name of the program is the Government-Wide Service Benefit Plan.

FLEXPLUS:
FLEXPLUS* is comprehensive major medical health plan that allows members to visit any physician or hospital they choose. This plan provides extensive benefits for individuals and families who do not have access to group health coverage. *FLEXPLUS is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Formulary:
See Drug Formulary.

Full-Time Employee: An employee who meets the eligibility requirements for full-time employees as outlined in the Benefit Agreement.

G

Gatekeeper: Term given to a primary care provider who coordinates all medical care for a patient and determines whether services such as tests or referral to a specialist are necessary.

Generic Prescription Drug (generic drug):
Safe, effective and equivalent to brand name medications that may cost considerably less than the brand name medications. Generic drugs must meet the same high standards of quality as brand name drugs and are formulated to have the same effect in the body as the brand name version. Generic drugs often become available when a brand name drug's patent expires.

Group Health Coverage:
A health benefits plan that covers a group of people as permitted by state and federal law.

H

Health Benefit Plan:
A health insurance product offered by a health plan company that is defined by the benefit contract and represents a set of covered services and a provider network.

Health Care Financing Administration (HCFA):
Federal government agency that administers Medicare and Medicaid.

Health Insurance Portability and Accountability Act (HIPAA):
A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; requires guaranteed issue and renewal of insurance coverage; prohibits plans from charging individuals higher premiums, co-payments, and/or deductibles based on health status.

Health Maintenance Organization (HMO):
An organized system of health care that assures the delivery of a comprehensive range of health services to members who enroll voluntarily and pay a fixed, prepaid fee. Such services include a wide variety of medical treatments and counsel, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. Members are generally limited to using providers designated by the HMO.

Hearing Services:
Testing and services related to hearing.

HEDIS®:
Health Plan Employer Data and Information Set (HEDIS®), the nation's premier measurement tool for managed care quality and service, is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans.

Blue Cross Blue Shield Healthcare Plan of Georgia:
BlueChoice Healthcare Plan is a health maintenance organization (HMO) product, underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia.* This plan provides preventive care benefits, as well as coverage for treatment of specific illness and injury. Members receive a high level of benefits with low out-of-pocket costs *Blue Cross Blue Shield Healthcare Plan of Georgia is an independent licensee of the Blue Cross and Blue Shield Association.

HMO:
See Health Maintenance Organization.

Home Health Agency:
A facility or program licensed, certified or otherwise authorized pursuant to state and federal laws as a home health agency; approved by the health plan to provide health services covered under the contract.

Home Health Care:
Health services rendered to an individual as needed in the home. Such services are provided to aged, disabled, sick or convalescent individuals who do not need institutional care.

Home Infusion Therapy: The administration of intravenous drug therapy in the home. Home infusion therapy includes the following services: solutions and pharmaceutical additives; pharmacy compounding and dispensing services; durable medical equipment; ancillary medical supplies; and nursing services.

Hospice:
A facility or service that provides care for terminally ill patients and support to their families, either directly or on a consulting basis with the patient's physician. Emphasis is on symptom control and support before and after death.

Hospital:
An institution whose primary function is to provide inpatient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and non-surgical. In addition, most hospitals provide some outpatient services, particularly emergency care.

I

ID Card/Identification Card:
See Member ID Card

Immunizations:
Specific types of injections to prevent infectious diseases and viral infections.

In-Network:
In-network means seeing a provider that has contracted with Blue Cross and Blue Shield of Georgia and/or Blue Cross Blue Shield Healthcare Plan of Georgia to participate in the network of physicians and hospitals.

Indemnity:
Indemnity or "traditional" insurance is a plan which reimburses physicians of covered charges for services performed, or insures for medical expenses incurred.

Individual Insurance:
Health care coverage for individuals or single family units.

Infertility:
Term used to describe the inability to conceive or an inability to carry a pregnancy to a live birth. Also includes the presence of a condition recognized by a physician as the cause of infertility.

Infusion Therapy:
The administration of intravenous drug therapy. Infusion therapy includes the following services: solutions and pharmaceutical additives; pharmacy compounding and dispensing services; durable medical equipment; ancillary medical supplies; and nursing services.

Inpatient:
A person admitted to a hospital as a bed patient for more than a specific number of hours.

Investigative Procedures or Medications:
Those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

L

Length of Stay (LOS):
The number of days that a member stayed in an inpatient facility.

Lifetime Maximum:
Maximum amount the plan will pay toward a member's coverage in a lifetime. The amount varies depending on the type of coverage the member carries.

M

Managed Care:
A prepaid health plan or insurance program in which beneficiaries receive medical service in a coordinated manner to eliminate unnecessary medical services. In managed care health plans, the member seeks specialist or hospital care after prior approval of coverage by designated health care professionals, such as primary care physicians, utilization review nurses, or employer-designated professionals. The primary goal is to deliver cost-effective health care without sacrificing quality or access.

Maternity Care:
The care of women before and during childbirth as well as the care of newborn babies.

Medical Equipment: See Durable Medical Equipment.

Medical Necessity:
The Plan only pays the cost of covered services it considers medically necessary under the terms of the member's contract. The Plan reserves the right to determine whether a service or supply is medically necessary. The fact that a physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it medically necessary and a covered service. A service is considered medically necessary if it is:

Appropriate and consistent with the diagnosis and could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; Compatible with the standards of acceptable medical practice in the United States; Provided not solely for a member's convenience or the convenience of the physician or hospital; Not primarily custodial care; and, The least costly level of service that can be safely provided. For example, a hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Medicare:
Title XVIII of the Social Security Act which provides a hospital and medical insurance program for the aged, totally disabled, and those with end-stage renal disease (ESRD). There are two parts – A and B. Part A is the hospital portion and is mandatory for all eligibles. Those who elect part B coverage, pay an additional premium to the federal government.

Member:
An individual or dependent who is enrolled in and covered by a health care plan. Also called enrollee or beneficiary.

Member Handbook:
A booklet that highlights the basic elements of a member's health care coverage as well as special features that may be specific to their plan. Each member receives a member handbook.

Member ID Card:
A card given to each member by Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia which introduces the member to physicians and hospitals. Although the cards do not guarantee eligibility for medical care benefits at any given time, they increase the convenience of obtaining health insurance services. The card is subsequently used by the provider to determine benefit levels and to prepare billing statement.

Mental Health/Behavioral Health:
Conditions that affect thinking and the ability to figure things out which affect perceptions, mood and behavior. Such disorders are recognized primarily by symptoms or signs that appear as distortions of normal thinking or distortions of the way things are perceived (seeing or hearing things that are not there). Disorders can also be recognized by moodiness, sudden or extreme changes in mood, depression, and highly agitated or unusual behavior.

N

NCQA:
The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization dedicated to measuring the quality of America's health care. NCQA's mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed decisions. The NCQA Accreditation survey process included rigorous on-site and off-site evaluations of over 60 standards and selected HEDIS® performance measures. A team of physicians and managed care experts conducts Accreditation surveys. A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level based on the performance level of each plan being evaluated to NCQA's
standards.

Negotiated Rate:
The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Network:
A group of health care providers under contract with Blue Cross and Blue Shield of Georgia within a specific geographic area.

Network Provider:
See Provider Network.

Non-Participating Provider:
A non-participating provider is a physician, hospital or other medical provider that has not entered into a service agreement with Blue Cross and Blue Shield of Georgia to provide benefits upon certain terms including specified rates.

O

Occupational Therapy:
Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, toiling and bathing.

Open Enrollment:
A period when eligible persons can enroll in a health benefits plan.

Out-Of-Network:
The use of health care providers who have not contracted with the carrier to provide services. HMO members are generally not reimbursed if they go out-of-network except in emergency situations. Covered persons of preferred provider organizations and HMOs with point-of-service options may go out-of-network, but must pay additional costs including deductibles and coinsurance.

Out-Of-Pocket:
Those medical expenses which an insured is required to pay because they are not covered under the group contract.

Out-Of-Pocket Maximum:
Refers to the maximum amount that a covered person will have to pay for expenses covered under the plan. It is a sum of deductible and coinsurance amounts.

Outpatient:
A patient who visits a clinic or hospital to receive medical diagnosis or treatment, but does not occupy a hospital bed for a specified minimum stay.

Outpatient Surgery:
Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center or physician office.

P

Partial Day Treatment:
A program offered by appropriately licensed psychiatric facilities that includes either a day or evening treatment program for mental health or substance abuse. Such care is an alternative to inpatient treatment.

Participating Provider:
A participating provider is a physician, hospital or other medical provider that has entered into a service agreement with Blue Cross and Blue Shield of Georgia or Blue Cross Blue Shield Healthcare Plan of Georgia to provide benefits upon certain terms including specified rates.

PCP:
See Primary Care Physician.

Per Member Per Month (PM/PM):
The unit of measure related to each effective member for each month the member was effective. The calculation is: # of units/member months (MM).

Physician's Current Procedural Terminology (CPT):
A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting physician procedures and services, thereby providing an effective method of nationwide communication.

Physical Therapy:
Treatment involving physical movement to relieve pain, restore function and prevent disability following disease, injury or loss of limb.

Plan Benefit Maximum:
Maximum amount the carrier will pay toward an individual's coverage. The amount varies depending on the type of coverage the individual carries.

Point-of-Service (POS):
An option provided by some HMOs that allows covered persons to go outside the plan's provider network for care, but requires they pay higher cost-sharing than they would for network providers.

Pre-admission Certification:
A component of a Utilization Management program which reviews an inpatient hospital stay prospectively to determine coverage.

Preauthorization:
A prospective process to verify coverage of proposed care, to establish covered length of stay and to set a date for concurrent review.

Pre-Certification:
Refers to certifying the medical necessity and level of care in advance. Pre-certification does not guarantee that contract benefits will be available.

Pre-Certification Review:
Utilization management performed prior to a patient's admission, stay, or other service or course of treatment. Also known as Prior Authorization.

Pre-Existing Condition: A health condition or medical problem that was diagnosed or treated before enrollment in a new health plan or insurance policy. Some pre-existing conditions may be excluded from coverage.

Preferred Provider Organization (PPO):
A network of hospitals and physicians who agree to provide services at less than their usual fees. Members of this type of product may incur out-of-pocket expenses for covered services received outside the PPO if the charge exceeds the PPO payment rate. The PPO does not assume insurance risk, and it does not facilitate the sharing of risk by its covered persons.

Prescription:
A written order or refill notice issued by a licensed medical professional for drugs, which are only available through a pharmacy.

Preventive Care:
Proactive health care designed to keep people from getting sick or hurt. It includes immunizations and screenings. A key part of preventive medicine is making sure patients know how to improve their health by altering their lifestyles. Refers to certifying the medical necessity and level of care in advance.

Primary Care Physician (PCP):
A primary care physician is a physician who is a family or general practitioner, internist or pediatrician. PCPs provide a broad range of routine medical services and refers patients to specialists, hospital and other providers as necessary. Each covered family member who participates in BlueChoice Healthcare Plan or BlueChoice Option,
chooses his or her own PCP from the network's physicians.

Prior Authorization: The process of obtaining pre-approval of coverage for a health care service or medication.

Prosthetic Devices: A device that replaces all or a portion of a part of the human body. These devices are necessary because a part of the body is permanently damaged, is absent or is malfunctioning.

Provider:
A licensed health care facility, program, agency or health professional that delivers health care services.

Provider Network: That set of providers contracted with a health plan to provide services to the enrollees. In the case of a "fee-for-service" or non-network health plan, the provider network is generally all licensed providers of covered services.

R

Radiation Therapy:
Treatment of disease by x-ray, radium, cobalt or high energy particle sources.

Reasonable and Customary:
The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community) and the reasonable cost of services for a given patient after medical review of the case. Also known as Usual and Customary (U&C) or Customary and Reasonable (C&R).

Referral:
If a primary care physician (PCP) determines a member has a condition which requires the attention of a specialist, the PCP makes a referral to a specialist. Members of BlueChoice Healthcare Plan must receive a referral prior to seeing most specialists in order to receive their full benefits. BlueChoice Option members can opt to self-refer but benefits will be paid at a reduced level.

Respiratory Therapy:
Treatment of illness or disease that is accomplished by introducing dry or moist gases into the lungs.

Retrospective Review:
A review of claims and medical records for medical necessity and appropriateness after the episode of care is concluded and before and/or after the claim is submitted by the provider.

S

Second Opinion:
The voluntary option or mandatory requirement to visit another physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.

Service Area:
The geographic area a provider network designates as its boundary limits for enrolling members.

Skilled Nursing Facility:
An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.

Specialists:
Providers whose practices are limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose and throat), or specific procedures (e.g., oral surgery).

Speech Therapy: Treatment or the correction of a speech impairment that resulted from birth, or from disease, injury or prior medical treatment.

Subscriber:
The individual in whose name a contract is issued or the employee covered under an employer's group health contract.

Substance Abuse/Chemical Dependency:
Conditions that include, but are not limited to (1) psychoactive substance induced mental disorders; (2) psychoactive substance use dependence; and (3) psychoactive substance use abuse. Chemical dependency does not include addition to or dependency on, tobacco or food substances (or dependency on items not ingested).

65PLUS:
65PLUS* offers Medicare beneficiaries a choice of five of the federally approved Medicare supplement plans: Plans A, B, C, E and F. Because Medicare only pays a portion of hospital and physician charges, these supplements provide certain benefits otherwise unavailable from Medicare. *65PLUS is underwritten by Blue Cross and Blue Shield of Georgia, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Urgent Care:
The services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, that requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Usual, Customary and Reasonable:
A "usual" charge is the amount that is most consistently charged by an individual physician for a given service. A "customary" charge is the amount that falls within a specified range of usual charges for a given service billed by most physicians with similar training and experience within a given geographic area. A "reasonable" charge is a charge that meets the Usual and Customary criteria, or is otherwise reasonable in light of the complexity of treatment of the particular case. Under a UCR Program, the payment is the lowest of the actual billed charge, the physician's usual charge or the area customary charge for any given covered service.

U

Utilization Management:
The process of evaluating a proposed hospitalization, service, or procedure and determining whether the hospitalization, service or procedure meets established guidelines and criteria to be covered under a member's contract.

Utilization Review:
A review process designed to evaluate the appropriateness of health care services.

W

Well Baby/Well Child Care:
Routine care, testing, checkups and immunizations for a generally healthy child from birth through the age of six.

Wellness Program:
A health management program that incorporates the components of disease prevention, medical self-care, and health promotion. It utilizes proven health behavior techniques that focus on preventive illness and disability, which respond positively to lifestyle related interventions. Programs are designed to integrate with existing health care benefits; e.g., flex benefits, HMO, PPO; support the reduction in the demand for health care resources; and address the issues of dependent coverage and services for high-risk employees.