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A. Glossary

Appendix for Section 1

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Access+ Provider Group

A medical group or IPA that participates in the Access+ HMO program. The features of the Access+ Program include Access+ *Satisfaction* and Access+ *Specialist*.

Access+ Satisfaction®

A feature of the Access+ HMO program that allows HMO members to provide feedback regarding services received from HMO network physicians and their office staff.

Access+ SpecialistSM

A feature of the Access+ HMO program that allows HMO members to self-refer, for an increased copayment, to a specialist within their IPA/medical group for Access+ *Specialist* services without a referral from their primary care physician.

Access+ Specialist Services

Services covered under the Access+ *Specialist* option of the Access+ HMO Program.

Activities of Daily Living

Mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care

Care rendered while treating an illness, injury or condition that is marked by a sudden onset or abrupt change of status requiring prompt attention. It may include hospitalization, but of limited duration and not expected to last indefinitely. Acute care is in contrast to chronic care. See *Chronic Care*.

Advance Directives

Documents signed by a member that explain the member's wishes concerning a given course of medical care should a situation arise where he/she is unable to make these wishes known. Advance directives must be documented in a prominent place in the medical record for all Blue Shield members 18 years and older.

Affordable Care Act

The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Allowed Amount

The adjudicated claim cost for covered benefits at the contracted rate, including the member's copayment/co-insurance portion.

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Alternate Care Services Provider

Home health care agencies, pharmacy home infusion suppliers, home infusion suppliers and home medical equipment suppliers.

Ambulatory Surgery Center (ASC)

Any ambulatory surgical center that is certified to participate in the Medicare program under Title XVII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4. It is also known as a “surgicenter.”

Appeal, Member

A request for Blue Shield’s or Blue Shield’s Life’s reconsideration of an initial determination (either verbal or written) which resulted in the following:

- Complete denial of service, benefit or claim
- Reduction of benefits or claim payment
- Redirection of service or benefits
- Delay of prospective authorization for service or benefits
- Underwriting Investigation Unit (UIU) cancellation of coverage or enrollee underwriting denials

Appeal, Provider

A written statement from a provider disputing the decision to reduce, delay, or deny services or benefits, requesting the original decision is altered or overturned.

AuthAccel

A tool that allows providers to submit authorization requests to Blue Shield online, via Provider Connection, instead of calling or faxing to obtain authorization. This tool may only be used to request authorizations for services where Blue Shield is responsible for providing authorization. Requesting providers may use AuthAccel to complete, attach documentation, submit, track and receive determinations for applicable medical and pharmacy prior authorizations. Registered users at Provider Connection may access the tool, in the *Authorizations* section, after logging into the website at www.blueshieldca.com/provider.

When providers submit requests for pharmacy authorizations via AuthAccel, it is not necessary for them to complete a separate California Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), as the required information is built into the tool.

Authorization

A process required for certain services in order to be reimbursed (e.g., approval to receive care from a provider other than the member’s primary care physician). There are two types: pre-certifications or utilization reviews (URs). All non-capitated services require one or the other. Inpatient facility claims, and outpatient surgeries require an UR. Ambulance, home medical equipment and home health care require a pre-certification. Authorizations are performed by the Medical Operations team at each core site.

Balanced Budget Act of 1997 (BBA)

Legislation signed into law by President Clinton in August 1997. This legislation enacts the most significant changes to the Medicare program since its inception 30 years ago.

bcbs.com

Blue Cross and Blue Shield Association's website, which contains useful information for providers.

Benefits

Covered health care services pursuant to the terms of the member's health services contract.

Benefit Period (Blue Shield 65 Plus (HMO) Only)

A way of measuring the use of services under Medicare Part A. A benefit period begins on the first day of a Medicare-covered inpatient hospital stay and ends when a member has been out of the hospital (or other facility that primarily provides skilled nursing or rehabilitative services) for 60 consecutive days, including the day of discharge.

BlueCard Access®

A toll-free number – **(800) 810-BLUE** – for you and members to use to locate healthcare providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard Eligibility®

A toll-free number – **(800) 676-BLUE** – for you to verify eligibility, benefits coverage share of cost information, and prior authorizations on patients from other Blue Plans.

BlueCard National Doctor and Hospital Finder

<http://www.bcbs.com/healthtravel/finder.html>

A website you can use to locate healthcare providers in another Blue Cross and/or Blue Shield Plan's area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

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BlueCard PPO Basic

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield Plan's service area the PPO basic level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Basic provider.

When you see the "PPOB" in a suitcase logo on the front of the member's Blue Plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

BlueCard PPO Member

A Blue plan patient who carries an ID card with a suitcase symbol containing "PPO" in it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard PPO Network

The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits.

BlueCard PPO Provider

A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers.

BlueCard Routing Logic

A streamlined IT solution that Blue Shield of California developed that integrates with a provider's clearinghouse and/or eligibility and benefits verification vendor's system to simplify and automate selecting the correct California Blue plan for processing BlueCard claims. The BlueCard routing logic is an alternative to using our Claims Routing Tool on the Blue Shield Provider Connection website.

BlueCard Traditional

A national program that offers members traveling or living outside of their Blue plan's service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan's service area. These members will carry an ID card featuring an "empty" suitcase logo.

Blue Shield 65 Plus (HMO)

Blue Shield's Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO) and Blue Shield Trio Medicare (HMO). The terms "Medicare Advantage," "MA-PD," and "Blue Shield 65 Plus (HMO)" may be used interchangeably throughout this manual.

Blue Shield 65 Plus (HMO) Member

An individual who meets each of the applicable eligibility requirements for membership, has voluntarily elected to enroll in Blue Shield 65 Plus (HMO), has paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield 65 Plus (HMO) has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Blue Shield 65 Plus (HMO) Network

A group of physicians, hospitals, and other healthcare providers that contracts with Blue Shield to provide medical and facility based care to Blue Shield 65 Plus (HMO) members. When the member selects a Primary care physician (PCP), he or she is also choosing the hospital and specialty network associated with his/her PCP. This is different than the Access + HMO network.

Blue Shield Global Core®

A program that allows Blue Plan members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of international Blue Cross and/or Blue Shield Plans to access domestic (U.S.) Blue provider networks.

California Children's Services (CCS)

California Children's Services (CCS), formally known as the Crippled Children's Services, was introduced by the California Legislature in 1927. This program was developed to provide medical treatment and rehabilitation to children who suffer from catastrophic medical conditions. CCS is funded through county, state and federal tax dollars, as well as through some fees paid by the families receiving care. CCS is not a Medi-Cal or Medicare program.

Capitation

A prepaid monthly fee paid to the IPA/medical group for each Blue Shield member in exchange for the provision of comprehensive health care services.

Case Rate

The all-inclusive rate paid, in accordance with the hospital contract Exhibit C, for specified types of care that are paid regardless of the type or defined duration of services provided by the hospital. For specified care/diagnoses, Blue Shield pays the stated Case Rate in lieu of the Per Diem rate.

Centers for Medicare & Medicaid Services (CMS)

An agency within the U.S. Department of Health and Human Services which administers the Medicare Program and with whom Blue Shield has entered into a contract to provide healthcare and Medicare prescription drug coverage to Medicare beneficiaries.

Chronic Care

Care (different from acute care) furnished to treat an illness, injury, or condition, which does not require hospitalization (although confinement in a lesser facility might be appropriate), that may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by a recurrence requiring continuous or periodic care as necessary. See *Acute care*.

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COBRA

Consolidated Omnibus Budget Reconciliation Act. It provides for the continuation of group health benefits for certain employees and their dependents (applies to groups of 20 or more employees). A member may elect to continue coverage under COBRA if coverage would continue as a result of a “qualifying event”. (A qualifying event may be termination of employment or reduction of hours, etc.)

Coinsurance

The percentage amount that a member is required to pay for covered services after meeting any applicable Deductible. Specific coinsurance information is provided in the member’s *Summary of Benefits*.

Coinsurance (Blue Shield 65 Plus (HMO))

The percentage of the Blue Shield 65 Plus (HMO) contracted payment rate or Medicare payment rate that a member must pay for certain services.

Commercial Plans or Programs

All plans other than Medicare Advantage plans, including, but not limited to, Blue Shield Preferred Plans, Access+ HMO® group benefit plans, Access+ HMO Plan for Individuals and Families, HMO POS plans, BlueCard, and government-sponsored programs (i.e., Healthy Families and Major Risk Medical Insurance).

Consumer Directed Healthcare/Health Plans (CDHC/CDHP)

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC plans provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

Contracted Provider

A credentialed health care professional or facility that has a contract with Blue Shield to provide services to members.

Contract Year (Blue Shield 65 Plus (HMO) Only)

The contract year for Medicare beneficiaries begins on January 1st and continues for a 12-month period. Note: the contract year for Group MA-PD members could begin at varying times of the year (for example July 1st or October 1st) and continues for a 12-month period.

Coordination of Benefits (COB)

A term used to describe a process to determine carrier responsibility when a member is covered by two or more group health plans. One of the carriers is considered the primary carrier and its benefits are paid first. Any balance is then processed by the secondary carrier, up to the limit of its contractual liability.

Copayment

The fixed dollar amount that a member is required to pay for covered services after meeting any applicable deductible. Specific copayment information is provided in the member’s *Evidence of Coverage* or *Summary of Benefits*.

Cosmetic Procedure

Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic within the broad range of normal, but which is considered unpleasing or unsightly.

Covered Services

Those services provided to a member pursuant to the terms of a group or individual health services contract and noted in the member's *Evidence of Coverage*. Medically necessary health care services, which a member is entitled to receive pursuant to the *Health Services Contract* and *Evidence of Coverage* applicable to the member. Except as otherwise noted in the member's *Health Services Contract* and *Evidence of Coverage*, covered services must generally be referred and authorized in conformity with Blue Shield's Utilization Management programs.

Credentialing

The process in which Blue Shield verifies the evidence of a physician's education, residency training, clinical capabilities, licenses, references, board certification, state and federal disciplinary sanctions and other components of the physician's professional abilities and history.

Custodial Care

Care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory care by a physician); or care furnished to a member who is mentally or physically disabled, and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or when despite such treatment, there is no reasonably likelihood that the disability will be so reduced..

Delegation

The process by which Blue Shield allows the IPA/medical group to perform certain functions that are considered the responsibility of Blue Shield for the purpose of providing appropriate and timely care for Blue Shield members.

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Dependent (Commercial Only)

A dependent is an individual who is enrolled and maintains coverage in the Plan, and who meets one of the following eligibility requirements, as:

1. A dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.
2. A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner in the member's plan.
3. A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship). A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner) unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, benefits for such Dependent child will be continued upon the following conditions:
 - a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
 - b. the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and thereafter, certification of continuing disability and dependency from a physician must be submitted to Blue Shield on the following schedule:
 - i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
 - ii. annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

Direct Contract

An executed agreement between Blue Shield and an individual or group of individual providers for the purpose of providing health care services to Blue Shield enrollees.

Domestic Partner (California Family Code)

An individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Downstream Entity

All participating providers or other entities contracted or subcontracted with the IPA/medical group, including but not limited to individual physicians, ancillary providers, subcontracted administrative services vendors, third party administrators or management companies, as defined by CMS and the Medicare Advantage regulations.

Durable Medical Equipment (DME)

Equipment designed for repeated use, which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment such as oxygen ostomy and medical supplies.

Durable Power of Attorney

See *Advance Directives*.

Electronic Claim Submission

Electronic claim submission is the paperless submission of claims generated by computer software that is transmitted electronically to Blue Shield. Claim files are submitted to Blue Shield in the ASC X12 835 5010 format.

Electronic Data Interchange (EDI)

A computer-to-computer exchange of information between businesses. Use of electronic data interchange is considered an industry best-practice to optimize administrative efficiency, lower cost and reduce overall revenue cycle time.

Electronic Funds Transfer (EFT)

EFT is the electronic transfer of claim payments into a designated bank account based on information submitted by the provider. The EFT process is set up to ensure privacy in addition to being quick and efficient.

Electronic Provider Access (EPA)

Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area member's Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log into Provider Connection at blueshieldca.com/provider and click on the *Pre-Service Review for Out-of-area Members* within the *Authorizations* section. Choose the *Electronic Provider Access* option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.

Electronic Remittance Advice (ERA)

ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.

Eligibility Report

A report of members determined by Blue Shield to be eligible for benefits and for whom Blue Shield providers are compensated.

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Emergency Services

Services necessary to screen and stabilize members in cases where an enrollee reasonably believed he/she had an emergency medical or psychiatric condition given the enrollee's age, personality, education, background and other similar factors.

Employer Group

The organization, firm, or other entity that has at least two employees and who contracts with Blue Shield to arrange health care services for its employees and their dependents.

Essential Community Providers

Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

Evidence of Coverage and Disclosure

A summary of the Plan's coverage and general provisions under the health services contract. The *Evidence of Coverage* includes a description of covered benefits, member cost-sharing, limitations and exclusion.

Exclusions

An item or service that is not covered by Blue Shield as defined in the *Evidence of Coverage and Disclosure*.

Exclusive Provider Organization (EPO)

An Exclusive Provider Organization (EPO) is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

Expedited Appeals

An appeal that requires resolution as soon as possible to accommodate the member's condition not to exceed seventy-two (72) hours from the initial request. To qualify as an expedited appeal, the routine decision making process might seriously jeopardize the life or health of a person, or when the person is experiencing severe pain.

Expedited Initial Determination

When Blue Shield's routine decision making process might pose an imminent or serious threat to a member's health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, Blue Shield will make a decision on prior authorization requests relating to admissions, continued stays, or other healthcare services, as soon as medically indicated but no longer than 72 hours.

Expedited Review or Decision

The Knox Keene Act requires and provides for an expedited review (initial determination) and appeal process. When a member believes that his/her health and ability to function could be seriously harmed by waiting the 30 days for a standard appeal, he/she may request an expedited review (initial determination) or appeal. NCQA CMS requirements, standards, and Blue Shield require that this request be processed within 72 hours. This request may be filed by the member, his/her representative or his/her physician on behalf of the member.

Experimental/Investigational Treatments

- Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that are not recognized, in accordance with generally accepted professional medical standards, as being safe and effective for use in the treatment of an illness, injury, or condition
- Any service that requires federal or state agency approval prior to its use, where such approval has not been granted at the time the service or supply was provided
- Services or supplies which themselves are not approved or recognized, in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients

Explanation of Benefits (EOB)

A written statement to members identifying which services rendered are covered and not covered under their health plan. Services that are not covered are the member's financial responsibility.

External Independent Medical Review (Blue Shield 65 Plus (HMO) Only)

For Blue Shield 65 Plus (HMO) members, CMS has contracted with a national independent review body, MAXIMUS Federal Services, Inc. MAXIMUS Federal Services, Inc. is an independent CMS contractor that review appeals by members of Medicare managed care plans, including Blue Shield 65 Plus (HMO).

External Review

An option provided to commercial members for consideration of:

- A medical necessity decision following an appeal;
- An appeal under the Friedman/Knowles Experimental Treatment Act in which care for a member with a terminal illness has been denied on the grounds that the treatment is experimental;
- Where the case is sent to an independent, external review organization for an opinion, which is binding on Blue Shield.

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Fee-for-Service

A payment system by Medicare. Fee-for-service doctors, hospitals, and other providers are paid for each service performed. For Blue Shield 65 Plus (HMO), this is also known as traditional or original Medicare.

FEP

The Federal Employee Program.

Formulary

A continually updated list of prescription medications that Blue Shield maintains for use under the Outpatient Prescription Drug program. The list is based on evidence-based review of drugs by members of the Blue Shield Pharmacy & Therapeutics Committee. This committee is made up of physicians and pharmacists, including practicing network physicians and pharmacists who are not employees of Blue Shield, many of whom are providers and experts in the diagnosis and treatment of disease. The formulary contains both brand-name, generic and biologic drugs.

Fraud, Waste and Abuse (FWA)

Comprehensive program to detect, correct and prevent fraud, waste and abuse in the Part D benefit.

Functional Acknowledgment (997)

For providers submitting electronic claims, Blue Shield sends a 997 transaction to identify the acceptance or rejection of the functional group, transaction sets or segments.

Grievance

An expression of dissatisfaction by a member, member representative or provider on the member's behalf, and categorized as a potential quality issue, appeal (*see Appeals*) or complaint.

Health Maintenance Organization (HMO)

A health care service plan that requires its members to use the services of designated physicians, hospitals or other providers of medical care except in a medical emergency. HMOs have a greater control of utilization and typically use a capitation payment system.

Health Services Contract

The employer group or individual contract that establishes the benefits that subscribers and dependents are entitled to receive.

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

HIPAA is the 1996 federal legislation that changes health coverage requirements in the group and individual markets. It contains provisions regarding portability of health coverage, Administrative Simplification, Medical Savings Accounts (MSAs), and fraud and abuse. The Centers for Medicare & Medicaid Services (CMS), formerly is the main regulatory agency responsible for implementing the provisions of HIPAA. The provisions relating to Administrative Simplification were effective in 2002 and 2003. Administrative Simplification is intended to reduce the costs and administrative burdens of health care by establishing national standards (including security) and procedures for electronic storage and transmission of health care information. Administrative Simplification affects health plans, health care providers, and clearinghouses that transmit or collect health information electronically.

HIPAA EDI Validation Report

Blue Shield validates inbound electronic claim files for HIPAA compliance, and produces a report to providers submitting electronic claims. Blue Shield utilizes Edifecs as its HIPAA validator.

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.

Home Health Care (HHC)

A comprehensive, medically necessary range of health services provided by a recognized provider organization to a patient at home, usually under the supervision of a physician.

Hospice Care

Care and services provided in a home or facility by a licensed or certified provider that is:

- Designed to be palliative and supportive care to individuals who are terminally ill, and
- Directed and coordinated by medical professionals authorized by the Plan

Hospital

- A licensed and accredited health facility engaged primarily in providing (for compensation from patients) medical, diagnostic, and surgical facilities for the care and treatment of sick and injured members on an inpatient basis, and that provides such facilities under the supervision of a staff of physicians and 24-hour a day nursing services by registered nurses (not including facilities that are principally rest homes, nursing homes, or homes for the aged),
- A psychiatric hospital licensed as a health facility and accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
- A “psychiatric health facility” as defined in Section 1250.2 of the Health and Safety Code.

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Hospitalist

A physician who specializes in the care of patients who are hospitalized.

In Area

Refers to services performed *within* the Blue Shield service area.

Individual Family Plan (IFP)

A health plan purchased to cover an individual or family, as opposed to a group plan. It differs from a group plan in the following respects: (1) the individual applying for IFP coverage is the contract-holder rather than the employer, (2) underwriting evaluation of a health statement ordinarily is required for everyone to be covered under an IFP contract, and (3) choice of plans is restricted to predetermined benefits.

Infertility

The member who has a current diagnosis of infertility and who is actively trying to conceive and has either:

- 1) The presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or
- 2) For women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or
- 3) For women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or
- 4) Failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a physician (The initial six cycles of artificial insemination are not a benefit of this plan); or
- 5) Three or more pregnancy losses.

Initial Decision/Initial Determination

When a physician group, hospital or Blue Shield makes an initial determination for a requested service or a claim for services rendered.

Inpatient

An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

Interchange Acknowledgment (TA1)

For providers submitting electronic claims, Blue Shield provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Limitations

Refers to services that are covered by Blue Shield but only under certain conditions.

Lock-In

A provision for an HMO that requires the member to obtain all medical care through Blue Shield except in the following situations:

- Emergency services, anywhere
- Urgently needed services outside of the service area and (under limited circumstances) inside the service area
- Referrals to non-plan providers or Away-from-Home care

Members that use non-plan providers, except under the conditions mentioned, will be obligated to pay for these services. Neither Blue Shield nor Medicare will pay for these services.

Marketplace Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally-facilitated Marketplace in any state that does not do so, or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013. MAXIMUS Federal Services, Inc. (Blue Shield 65 Plus (HMO) Only).

MAXIMUS Federal Services, Inc. (Blue Shield 65 Plus (HMO) Only)

An independent Centers for Medicare & Medicaid Services (CMS) contractor that review appeals by members of Medicare managed care plans, including Blue Shield 65 Plus (HMO).

Maximum Enrollee Out-of-Pocket Costs (Blue Shield 65 Plus (HMO) Only)

For Blue Shield 65 Plus (HMO) members, the maximum out-of-pocket (MOOP) amount is the most that they will pay during the calendar year for in-network covered Medicare Part A and Part B services. Amounts paid for plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If a Blue Shield 65 Plus (HMO) member reaches this amount, they will not have to pay any out-of-pocket costs for the remainder of the year for covered in-network Part A and Part B services. For specific guidelines on how to submit claims for MOOP electronically, contact the EDI Help Desk at (800) 480- 1221.

Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women. Medicaid is governed by overall Federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

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Medically Necessary

Benefits are provided for covered services that are medically necessary. Medically necessary services include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness or injury and which, as determined by Blue Shield, are:

- Consistent with Blue Shield medical policy; and,
- Consistent with the symptoms or diagnosis; and,
- Not furnished primarily for the convenience of the patient, the attending physician or other provider; and,
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.

If there are two or more medically necessary services that may provide for the illness, injury, or medical condition, Blue Shield will provide benefits based on the most cost-effective services.

Hospital inpatient services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

Inpatient services which are not medically necessary include hospitalization in the following cases:

- For diagnostic studies that could have been provided on an outpatient basis;
- For medical observation or evaluation;
- For personal comfort;
- In a pain management center to treat or cure chronic pain; or
- For inpatient rehabilitation that can be provided on an outpatient basis.

Blue Shield reserves the right to review all services to determine whether they are medically necessary.

Medicare Advantage Organization (MAO)

A public or private entity that contracts with CMS to offer a Medicare Advantage plan. Blue Shield of California is an MAO that offers Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO) and Blue Shield Trio Medicare (HMO) MA-PD plans.

Medicare Advantage (MA) Program

Section 4001 of the BBA created the MA Program as a new Part C of Title XVIII of the Social Security Act. On June 19, 1998, the Centers for Medicare & Medicaid Services (CMS), issued the regulation implementing the MA Program required by the BBA. Under this program, eligible individuals may elect to receive Medicare benefits through enrollment in one of an array of private health plan choices beyond the original Medicare program or the plans now available through managed care organizations.

Medicare-Covered Charges

The maximum amounts Medicare will pay for Medicare-covered services.

Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Guidelines

The rules and regulations used by CMS to determine the services that Medicare covers under Part A (Hospital Insurance protection) and Part B (Medical Insurance protection).

Medicare Part D Covered Drug

A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k)(6) of the Act). A covered Part D drug includes prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act. The definition of a covered Part D drug excludes any drug, biological product, insulin, or vaccine for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual. In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Medicare Part D excludes fees for drug administration, except for administration fees associated with the administration of a Part D vaccine.

Under Medicare guidelines, some drugs may be covered under Medicare Part B or Medicare Part D depending upon the characteristics of the beneficiary and/or medical use of the drug. Unless otherwise indicated in the Division of Financial Responsibilities, Medicare Part B Covered Services are Group responsibility and Medicare Part D Covered Services are Blue Shield responsibility. Group is delegated for authorization of Medicare Part B drugs. If a drug does not meet LCD Medicare Part B coverage guidelines, Blue Shield will review for potential coverage under Part D, using the LCD Medicare guidelines and Blue Shield prior authorization coverage criteria. An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

Medicare Supplemental (Medigap)

Medicare Supplemental (Medigap) pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn't cover.

Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

Glossary

Member

An individual, either a subscriber or eligible dependent, who is enrolled and maintains coverage in a Blue Shield Plan under the health services contract. This term also applies to Medicare beneficiaries enrolled in the Blue Shield Medicare Advantage plan or a Blue Shield Medicare prescription drug plan.

National Account

An employer group with employee and/or retiree locations in more than one Blue Plan's service area.

National Provider Identifier (NPI)

The NPI is a unique 10 digit numeric identification number. The NPI will be issued by CMS to all eligible health care individual practitioners, groups and facilities. The NPI is required on all HIPAA compliant standard electronic transactions.

Non-Covered Services

Health care services that are not benefits under the subscriber's Evidence of Coverage/Disclosure Form.

Opt-Out

The act of a member seeking care without a referral from the primary care physician. Depending upon with type of HMO plan involved, opt-outs might or might not be covered. If covered, members who opt out are responsible for higher out-of-pocket costs. Also called "self-referral."

Other Party Liability (OPL)

A cost containment program that ensure Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation and no-fault auto insurance.

Out-of-Area Follow-up Care

Out-of-area services which are non-emergent and medically necessary in nature to establish the member's progress following an initial emergency or urgent service.

Out-of-Pocket Maximum

The highest deductible, copayment and coinsurance amount an individual or family is required to pay for designated covered services each year as indicated in the *Summary of Benefits*. Charges for services that are not covered and charges in excess of the allowable amount or contracted rate do not accrue to the out-of-pocket maximum.

Note: Members are financially responsible for any services which are not covered by the Plan. This may result in total member payments in excess of the out-of-pocket maximum.

Outpatient

An individual receiving services under the direction of a plan provider but not requiring hospital admission.

Note: For Blue Shield Preferred Plans, a length of stay past midnight is considered an inpatient admission.

Outpatient Facility

A licensed facility, not a physician's office or a hospital, that provides medical and/or surgical services on an outpatient basis.

Part B Premium (Blue Shield 65 Plus (HMO))

A monthly premium paid (usually deducted from a person's Social Security check) to cover Part B Premiums for Original Medicare fee-for-service. Members of Blue Shield 65 Plus (HMO) must continue to pay this premium by themselves, Medicaid, or another third party, to receive full coverage and be eligible to join and stay in Blue Shield 65 Plus (HMO).

Part D Premium (Blue Shield 65 Plus (HMO))

Referred to as the Income Related Medicare Adjustment Amount (IRMAA). Beginning in 2011, the Affordable Care Act requires Part D enrollees whose incomes exceed certain thresholds, pay a monthly adjustment amount. This new premium applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. Like Part B, the premium will usually be deducted from the person's Social Security check.

Participating Provider

A provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members enrolled in a designated Plan. This definition does not include providers who contract with Blue Shield's mental health service administrator (MHSA) to provide covered mental health or substance abuse services.

Payor

The entity that accepts the financial risk for the provision of health care services.

Peer Review

A physician review for the purposes of determining the existence of an actual or potential quality of care issue. This review process includes a review of the clinical and administrative information available. It is the evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise.

Percent of Billed Charges

A payment arrangement under which a provider is reimbursed at a previously agreed upon percentage of the total billed amount, not to include non-benefit items or items previously excepted from the payment arrangement.

Glossary

Per Diem Rate

A negotiated rate per day for payment of all covered inpatient services provided to a patient in a preferred hospital.

Physician Advisor Review

A physician review of a utilization management request for prospective, concurrent and/or retrospective reviews for the purpose of determining medical necessity and/or appropriateness of care or services.

Plan

The member's health care service plan, e.g. HMO, PPO, EPO, and POS.

Plan Hospital

A hospital licensed under applicable state law contracting with Blue Shield specifically to provide HMO Plan benefits to members.

Plan Provider

A provider who has an agreement with Blue Shield to provide covered services to HMO members.

Plan Specialist

A physician (M.D. or D.O.) other than a primary care physician, who has an agreement with Blue Shield to provide covered services to HMO members according to an authorized referral by a primary care physician, or according to the Access+ *Specialist* program, or during a well-woman examination.

Point-of-Service (POS)

A type of managed care plan whereby members have the option of choosing to obtain covered medical services from the provider of their choice from a provider within Blue Shield network or from an out-of-network provider, or through their primary care physician who manages their care and refers members to participating hospitals, physicians, and other providers within a select HMO network. POS members who obtain their medical care through their primary care physician receive HMO level benefits. Members who self-refer to in-network or out-of-network providers are subject to applicable deductibles, copayments and coinsurance. Care received from out-of-network providers is covered at the lowest benefit level. When members receive services from out-of-network providers they are financially responsible for the difference between the amount Blue Shield allows for those services and the amount billed by the out-of-network provider. Mental health and substance abuse services are provided at the HMO and PPO non-participating levels of care.

Preferred Provider Organization (PPO)

A network of providers (usually physicians, hospitals, and allied health care professionals) that contract with a payor to deliver services to the enrollees of a designated health care service plan. These providers agree to accept the payor's allowances plus any enrollee coinsurance, copayment, or deductible as payment in full.

Preferred Provider Organization, Basic (PPOB)

A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

Prefix

Three characters preceding the subscriber identification number on the Blue Plan ID cards. The prefix identifies the member's Blue Plan or national account and is required for routing claims.

Prescription Drug Plan (PDP)

Medicare Part D prescription drug coverage that is offered under a policy, contract or plan that has been approved by the Centers for Medicare & Medicaid Services (CMS) as specified in 42 C.F.R. § 423.272 to offer qualified prescription drug coverage.

Primary Care Physician (PCP)

A general practitioner, board-certified (if not board certified, must at least have completed a two-year residency program) eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has contracted with Blue Shield through an IPA/medical group to provide benefits to members and to refer, authorize, supervise and coordinate the provision of all benefits to members in accordance with their health services contract and the Plan service delivery guidelines.

Provider Connection

Blue Shield's provider website at <http://www.blueshieldca.com/provider>.

Provider Inquiry

A telephoned or written request from a provider to explain the rationale for a decision to reduce, delay, or deny services or benefits. This inquiry may or may not alter the original decision.

Provider Manual

The *Hospital and Facility Guidelines* manual, which sets forth the operational rules and procedures applicable to the hospital and the performance of services described in the hospital agreement and which is amended and updated by Blue Shield at least annually. The Provider Manual shall include the rules, regulations or policies adopted by Blue Shield, including Blue Shield's payment and medical policies, which may, from time to time, be communicated to physicians and providers.

Prudent Layperson

A non-medically trained individual using reasonable judgement under the circumstances. For emergency services, coverage is provided when a prudent layperson reasonably would believe that an emergency situation exists.

Glossary

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- A) An immediate danger to himself or to herself, or to others.
- B) Immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental disorder.

Qualified Health Plan (QHP)

Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Quality Improvement Organization (QIO)

A group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs work under the direction of the Centers for Medicare & Medicaid Services (CMS) to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund. Formerly known as a Peer Review Organization (PRO). Health Services Advisory Group (HSAG) is the QIO for California.

Referral

The process by which a member obtains authorization for covered services rendered by providers other than the member's primary care physician.

Referred Services

A covered health service, performed by a referred-to provider, that is:

- Authorized in advance by the primary care physician and/or the IPA/medical group
- Limited in scope, duration or number of services, as authorized

Referred-To Provider

A provider to whom a member is referred for services.

Rehabilitation Service

Inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, to restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Residential Care

Mental Health or Substance Abuse services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for members who do not require acute inpatient care.

Secure File Transfer Protocol (SFTP)

A service (communication protocol) specially designed to establish a connection to a particular computer, so that files can be securely transferred between computers. This protocol encrypts the data transferred to the receiving computer and prevents unauthorized access during the operation.

Service Area (Blue Shield 65 Plus (HMO))

The geographic area in which a person must permanently reside in to be able to become or remain a member of a Blue Shield 65 Plus plan. Blue Shield 65 Plus has multiple service areas within California. The specific service area in which the member permanently resides determines the Medicare Advantage plan(s) in which they may enroll. More than one Blue Shield Medicare Advantage plan may be offered in a service area.

Service Area (HMO)

The geographic area as defined in the Blue Shield HMO contract generally considered to be located within a 30-mile radius from the IPA/medical group's primary care physician facilities.

If members receive care outside their primary care physician's service area, it must be for an urgent or emergency condition or authorized by their primary care physician. When processing claims and encounters, the zip code of the attending physician (for professional claims) or the billing provider (for facility claims) is compared to the IPA/medical group's table of zip codes stored in Blue Shield's system to determine if the claim is for out-of-area services.

Shared Savings Services

Covered services paid by Blue Shield from a budget that is subject to a periodic settlement. Any surplus or deficit from this budget is shared between the IPA/medical group and Blue Shield.

Skilled Nursing Facility (SNF)

A facility with a valid license issued by the California Department of Public Health as a "Skilled Nursing Facility" or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing Unit within a Hospital.

State Children's Health Insurance Program (SCHIP)

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Glossary

Stop-Loss

A contractual agreement with day or dollar threshold criteria that allows payment beyond the normal case or per-diem rate.

Sub-Acute Care

Skilled nursing or skilled rehabilitative care provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services; physical, occupational, or speech therapy; a coordinated program of multiple therapies; or who have medical needs that require daily monitoring by a registered nurse. A facility that is primarily a rest home, convalescent facility or home for the aged is not included in this definition.

Subscriber

A group employee or individual who is enrolled in and maintains coverage under the health services contract.

Third Party Liability

A provision of the health services contract that allows recovery of reasonable costs from a third party when a member is injured through the act or omission of a third party.

Traditional Coverage

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

Unsolicited Claim Status Inquiry Report (U277) v 4040

Blue Shield validates inbound electronic claim files for HIPAA compliance, and returns results back to submitters in an ASCX12 U277 file format. Blue Shield utilizes Claredi Corporation's Faciledi as its HIPAA validator.

Urgent Services

Those covered services rendered outside of the primary care physician's service area (other than Emergency Services) which are medically necessary to prevent serious deterioration of a member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the member returns to the primary care physician's service area.

Validation Reports

Blue Shield generates a validation report for electronic submitters of claims and encounters summarizing the number of claims and encounters that have been received and processed.