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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* (see definitions below).

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+ *Specialist* SM
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. (See Access+ *Specialist* above).

Accountable Care Organization (ACO)
An accountable care organization is an alliance formed with physician groups and hospitals who, together with Blue Shield, share responsibility and accountability for the quality, cost, and overall care of a defined group of patients with the goal of improving healthcare quality and lowering healthcare costs. As with a traditional HMO plan, a member's care is coordinated by a primary care physician.

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 in the course of 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.

Allowed Amount
The total amount Blue Shield pays for covered services rendered, or the provider's billed charge for those covered services, whichever is less.

Alternate Care Services Provider
Home health care agencies, pharmacy home infusion suppliers, home infusion suppliers, and home medical equipment suppliers.

Glossary

Ambulatory Surgery Center (ASC)
Any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (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 reconsideration of an initial decision to deny a request for service, a claim payment or a requested service or procedure.

Appeal (Provider)
A written statement from a provider disputing the decision to reduce, delay, or deny services or benefits, requesting the original decision be altered or overturned.

AuthAccel
An online tool for submitting authorization requests to Blue Shield. This tool may only be used to request authorizations for services where the division of financial responsibility in the IPA/medical group's contract identifies Blue Shield as responsible for prior authorization. Requesting providers may use AuthAccel to complete, attach documentation, submit, track status, 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.

For medical authorizations, AuthAccel is an option, in addition to calling or faxing, for submitting authorization requests to Blue Shield.

For pharmacy authorizations, providers may fax or submit through AuthAccel. When providers submit pharmacy authorization requests 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
The procedure for obtaining Blue Shield's and/or the IPA/medical group's prior approval for all services, except primary care physician, Access+ *Specialist,* and emergency services, provided to members under the terms of their health services contract.

Balanced Budget Act of 1997 (BBA)
Signed into law in August 1997, this legislation enacts the most significant changes to the Medicare program since its inception.

Benefits
Covered health care services, pursuant to the terms of the member's health services contract. For Blue Shield Medicare Advantage, basic benefits include all healthcare services that are covered under the base Blue Shield Medicare Advantage plan, but do not include services provided under the Premium Plan (i.e., Complementary Care).

Benefit Period (Blue Shield Medicare Advantage plan – Individual and Group)
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.

Biosimilar
A biosimilar is a biologic medical product highly similar to another already approved biological medicine.

Blue Shield Medicare Advantage HMO Network
A group of physicians, hospitals, and other healthcare providers that contract with Blue Shield to provide medical care to Blue Shield Medicare Advantage HMO plan 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 network is different from the Access + HMO network.

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

Blue Shield Medicare Advantage Plan Member
An individual who meets all of the applicable eligibility requirements for membership, has voluntarily elected to enroll in a Blue Shield Medicare Advantage HMO or PPO plan, has paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare Advantage HMO or PPO plan has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Blue Web
Blue Cross and Blue Shield Association's website at https://blueweb.bcbs.com which contains useful information for providers.

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 Medi-Care 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*.

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 otherwise terminate 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 members' *Summary of Benefits*.

Coinsurance (Blue Shield Medicare Advantage HMO and PPO Plans)
The percentage of the Blue Shield Medicare Advantage HMO and PPO plans 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 and government-sponsored programs.

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 provides 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.

Contract Year (Blue Shield Medicare Advantage HMO and PPO Plans)
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 (e.g., July 1st or October 1st) and continues for a 12-month period.

Coordination of Benefits
A term used to describe a process to determine carrier responsibility when a plan member is covered by more than one group health plan. 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 members' *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.

Covered Services
Those medically necessary services and supplies which a member is entitled to receive pursuant to the terms of the group or individual health services contract.

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 reasonable 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.

Dependent (Commercial Only)
A dependent is an individual who is enrolled and maintains coverage in the Plan, and who are defined as:

1. A subscriber's legally married spouse who is:
   a. Not covered for benefits as a subscriber; and
   b. Not legally separated from the subscriber; or,
2. A subscriber's domestic partner who is not covered for benefits as a subscriber; or,
3. A child of, adopted by, or in legal guardianship of the subscriber, spouse, or domestic partner. This category includes any stepchild or 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, who is not covered for benefits as a subscriber, is less than 26 years of age, has been enrolled and accepted by Blue Shield of California as a dependent, and has maintained membership in accordance with the contract.

   Note: Children of dependent children (i.e., grandchildren of the subscriber, spouse, or domestic partner) are not dependents 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, benefits for such dependent 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 submits 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
   c. Thereafter, certification of continuing disability and dependency from a physician is submitted to Blue Shield on the following schedule:
      i. Within 24 months after the month when the dependent would otherwise have been terminated; and
      ii. Annually thereafter on the same month when certification was made in accordance with item 4 (a) above. In no event will coverage be continued beyond the date when the dependent child becomes ineligible for coverage under this plan for any reason other than attained age.

Dependent (Commercial Only) *(cont'd.)*

5. AB 570 requires an individual health plan/policy that provides dependent coverage to make dependent coverage available to a parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the health care service plan's service area.
    a. The bill redefines "dependent" under both the Health and Safety Code and the Insurance Code to include the "parent or stepparent" of an individual, subject to applicable terms of the health benefit plan.
    b. Under Section 152(d) of Title 26 of the United States Code, the term "qualifying relative" means, with respect to any taxpayer for any taxable year, an individual:
        i. who bears a relationship to the taxpayer described in the statute, including parent or stepparent,
        ii. whose gross income for the calendar year in which such taxable year begins is less than the exemption amount (as defined in 26 USC Section 151(d), currently listed as $2000),
        iii. with respect to whom the taxpayer provides over one-half of the individual's support for the calendar year in which such taxable year begins, and
        iv. who is not a qualifying child of such taxpayer or of any other taxpayer for any taxable year beginning in the calendar year in which such taxable year begins.

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 including oxygen, ostomy, and incontinence supplies.

Durable Power of Attorney
See *Advance Directives*.

Electronic Data Interchange (EDI)
A computer-to-computer exchange of information between businesses. Blue Shield 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 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. The ERA replaces the paper Explanation of Payment (EOP).

Electronic Claim Submission
Electronic claim submission is the paperless submission of claims generated by computer software that is transmitted electronically to Blue Shield. Claims are submitted in the ASC X12 837 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.

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.

Evidence of Coverage and Disclosure Form
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.

Exclusion
An item or service that is not covered under the Blue Shield health services contract.

Expedited Appeals
A member, a member representative, or a physician on behalf of the member may request an expedited appeal of a denied prior authorization request because a member is experiencing severe pain or a member's health or ability to function could be seriously harmed by waiting for a standard appeal decision. Blue Shield will make a decision on an expedited appeal as soon as possible to accommodate the patient's condition not to exceed 72 hours from receipt of the request.

A request for a 72-hour/fast appeal consideration of a prior authorization request denial in which the health plan determines a member's health or ability to function could be seriously harmed by waiting for a standard appeal decision. A member, member representative, or physician on behalf of the member may request an expedited appeal.

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 30 days for a standard appeal, he/she may request an expedited review (initial determination) or appeal. NCQA standards, CMS, 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 at issue.
- 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 Medicare Advantage HMO and PPO Plans)
For Blue Shield Medicare Advantage plan 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 Medicare Advantage plans.

External Review
An option provided to commercial members for consideration of:

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

Fee for Service
A payment system by which doctors, hospitals and other providers are paid for each service performed.

Formulary
A continually updated list of prescription medications that are approved by the Food and Drug Administration (FDA) and are selected based on safety, effectiveness, and cost for coverage 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 brand-name, generic, and biologic drugs.

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

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

Health Services Contract
The contract for health coverage between Blue Shield and the employer group or individual 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 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) is the main regulatory agency responsible for implementing the provisions of HIPAA. The provisions related to portability were effective in July 1997. The provisions relating to Administrative Simplification will be effective at various times during 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.

HMO Benefit Guidelines (HBG)
The *HBG* supplements the *HMO IPA/Medical Group Procedures Manual* and provides Blue Shield HMO basic plan benefit interpretations and policies.

Home Health Care
Medically necessary healthcare services, including services provided by a home health agency, PKU related formulas and special food products, and home infusion/home injectable therapy at the patient's home, as prescribed by the primary care 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 a CMS-approved accreditation agency, or
- A "psychiatric health facility" as defined in Section 1250.2 of the Health and Safety Code.

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

In Area
Refers to services performed within the Blue Shield HMO primary care physician's service area.

Individual Family Plan (IFP)
A health plan purchased by an individual subscriber to cover an individual or family.

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

1. A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
2. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

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.

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 Advantage will pay for these services.

Maximum Enrollee Out-of-Pocket Costs (Blue Shield Medicare Advantage HMO and PPO Plans)
The beneficiary's maximum dollar liability amount for a specified period. For Blue Shield Medicare Advantage plan members, the maximum out-of-pocket 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 Medicare Advantage plan 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.

MAXIMUS Federal Services, Inc. (Blue Shield Medicare Advantage HMO and PPO plans)
An independent Centers for Medicare & Medicaid Services (CMS) contractor that reviews appeals by members of Medicare-managed care plans, including Blue Shield Medicare Advantage plan.

Medically Necessary
See *Section 5.1.*

Medicare Advantage Organization (MAO)
A public or private entity that contracts with CMS to offer a Medicare Advantage plan. Blue Shield of California is a MAO that offers Blue Shield Medicare Advantage HMO and PPO 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 and medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B 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 Part D vaccine administration.

Under Medicare guidelines, 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. This includes injectable drugs that are not usually self-administered. CMS' understanding that the practice of "brown bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members. In essence, if the injection is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. In addition, member's share of cost for these types of medications are usually higher under Part D due to the tiering structure of the plan and are not eligible for tier exceptions. 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).

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.

Non-Covered Services
Health care services that are not benefits under the terms of the group or individual health services contract.

National Drug Code (NDC)
The NDC is a universal number that identifies a drug or a related drug item. The NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2-digit format.

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

Opt-Out
The act of a member seeking care without a referral from the primary care physician. Depending upon the 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."

Out-of-Area Follow-up Care
Out-of-area services which are non-emergent and medically necessary in nature to evaluate 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, provides medical and/or surgical services on an outpatient basis.

Part B Premium (Blue Shield Medicare Advantage HMO and PPO Plans)
A monthly premium paid (usually deducted from a person's Social Security check) to cover Part B services in fee-for-service Medicare. Members of Blue Shield Medicare Advantage plans must continue to pay this premium to receive full coverage and be eligible to join and stay in a Blue Shield Medicare Advantage plan.

Part D Premium (Blue Shield Medicare Advantage HMO and PPO Plans)
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 and substance use disorder services.

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

Peer Review
A physician review for the purpose 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.

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.

Place of Care
The options for the physical location in which a medication can be administered. Places of care include the physician's office, outpatient facility, ambulatory infusion center or home health/home infusion.

Plan
The member's health care service plan, e.g., HMO, PPO, EPO, or 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 credentialed health care professional or facility that has an agreement with Blue Shield or an IPA/medical group to provide 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 may obtain services through their HMO primary care physician or may use the PPO network option and seek care from a Blue Shield participating provider or from a non-participating provider, without consulting their primary care physician. Services received under the PPO network options are subject to applicable deductibles, copayments, and coinsurance. Services received from non-network providers are covered at the lowest benefit level. When members receive services from non-network providers, they are financially responsible for the difference between the amount Blue Shield allows for those services and the amount billed by the non-network physician. Mental health and substance use disorder 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.

Premium Plan Benefits (Blue Shield Medicare Advantage HMO and PPO Plans)
Additional benefits beyond Medicare covered benefits. There is a plan premium associated with premium plan benefits.

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. primary care physician is the terminology used in Blue Shield HMO/POS plans.

Primary Care Physician (PCP) Behavioral Health Toolkit
Blue Shield's new online toolkit designed specifically for primary care providers to help them manage or coordinate their patients' behavioral health needs. Providers can log into www.blueshieldca.com/provider, select the *Guidelines & Resources* tab, then click *PCP Behavioral Health Toolkit* in the *Patient Care Resources* section to find information for managing a behavioral health condition or making a referral to a behavioral health provider, as well as consultation contact information, patient educational materials, and more.

Provider Inquiry
A telephone 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 Connection
Blue Shield's provider website at www.blueshieldca.com/provider.

Provider Manual
The Blue Shield *HMO IPA/Medical Group Procedures Manual*, which sets forth the operational rules and procedures applicable to Blue Shield HMO IPA/medical groups, 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 medical policy, which may, from time to time, be communicated to physicians and providers.

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

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

Quality Improvement Organization (QIO)
A Quality Improvement Organization (QIO) is 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.

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

Referral
The process by which a member obtains authorization for covered services rendered by providers other than the member's primary care physician. In the Access+ HMO program, an HMO member may self-refer, for an increased copayment, to a specialist in the same IPA/medical group for Access+ *Specialist* services.

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 mental health and substance use disorders, 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 and Substance Use Disorder 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.

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

Service Area (Blue Shield Medicare Advantage HMO and PPO Plans)
The geographic area in which a person must permanently reside for initial or continued eligibility as a member of a Blue Shield Medicare Advantage plan. Blue Shield Medicare Advantage 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.

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.

Stop-Loss
An agreement limiting the financial liability of an IPA/medical group for any given member to a specific threshold.

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.

Trio HMO
The Trio Health Maintenance Organization (HMO) is a product supported by a network of Accountable Care Organization (ACO) providers. Trio uses an integrated network delivery model across specialties and hospitals that provides coordinated care and leverages relationships with select providers in specific regions. As with a traditional HMO plan, members' care is coordinated by a primary care physician.

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.

Waivered Condition
A condition that is excluded from coverage for charges and expenses incurred during the six (6) month period beginning as of the effective date of coverage. A waivered condition applies only to a condition for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the effective date of coverage.

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