

Section 3:

GLOSSARY OF TERMS

Access: Ability to obtain medical services.

Accreditation: Accreditation programs give an official authorization or approval to an organization against a set of industry-derived standards.

Actuary: A person in the insurance field who determines insurance policy rates and conducts various other statistical studies.

Adjudication: Processing a claim through a series of edits to determine proper payment.

Administrative Services Only (ASO) Contract: A contract between an insurance company and a self-insured plan where PacificSource performs administrative services only; for example, claims processing.

Allied Health Professional (AHP): All healthcare providers who are not licensed as doctors of medicine or osteopathy; for example, nurse practitioners, physician assistants, and chiropractors.

Alternative Care: Medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home healthcare and skilled nursing facility care. It also may refer to nontraditional care delivered by providers, such as acupuncturists.

Ambulatory Care: Healthcare services rendered in a hospital's outpatient facility, physician's office or home healthcare; often used synonymously with the term "outpatient care."

Ancillary Medical Service: Covered service necessary for diagnosis and treatment of members. Includes, but is not limited to, ambulance, ambulatory or day surgery, durable medical equipment, imaging service, laboratory, pharmacy, physical or occupational therapy, urgent or emergency care, and other covered service customarily deemed ancillary to the care furnished by primary care or specialist physicians or providers.

Behavioral Healthcare: Treatment of mental health and/or substance abuse disorders.

Benefit Package: Specific services provided by the insurance carrier.

Benefit Plan: Covered services, copayments or deductible requirements, limitations, and exclusions contained in the contract between PacificSource and a member or subscriber group.

Board Certified: A physician who has passed an examination given by a medical specialty board.

Board Eligible: A physician who has graduated from an approved medical school and is eligible to take a specialty board examination.

Call Share: The physicians or providers on whom a practitioner relies for backup coverage during times he/she is unavailable.

Call Share Group: A group of providers with similar specialties who have joined together to provide call share services.

Capitation: A method of paying for medical services on a per-person rather than a per-procedure basis. Under capitation, PacificSource pays a participating physician or provider a fixed amount per month for every PacificSource member he/she takes care of, regardless of the care the member receives.

Carrier: Insurer, underwriter of risk.

Carve Out: An arrangement in which an employer or health plan removes or retains coverage for a specific category of services (for example, mental health, substance abuse, vision care or prescription drugs), and arranges for coverage through a contract with a separate set of providers. The health plan's contract with these providers may specify certain payment and utilization management arrangements.

Case Management: The process whereby a healthcare professional supervises the administration of medical or ancillary services to a patient, typically one who has a catastrophic disorder or who is receiving mental health services. Case managers reduce the costs associated with the care of such patients, while providing high-quality medical services.

Case Rate: A "package price" for a specific procedure or diagnosis-related group.

Clinic: A healthcare facility for providing preventive, diagnostic, and treatment services to patients in an outpatient setting.

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Closed Grievance (also see Grievance): A decision that has been made which cannot be appealed or is not under appeal by the member.

Coinsurance: A policy provision under which the insured pays or shares part of the medical bill, usually according to a fixed percentage.

Complaint: An expression of dissatisfaction about a specific problem encountered by a member, or about a decision by the insurer (or agent acting on behalf of the insurer). A complaint must include a request for action to resolve the problem or change the decision.

Consolidated Omnibus Budget Reconciliation Act (COBRA): A law that requires employers to offer continued health insurance coverage to eligible employees whose health insurance coverage terminates.

Coordination of Benefits (COB): An insurance provision that allocates responsibility for payment of medical services between carriers if a person is covered by more than one insurance plan.

Copayment: The portion of the claim or medical expense that a member (or covered insured) must pay out of pocket.

Cost Containment: A strategy that aims to reduce healthcare costs and encourages cost-effective use of services.

Cost Sharing: A general set of financing arrangements via deductibles, copayments or coinsurance in which a person covered by a health plan must pay some of the cost to receive care.

Coverage: Services or benefits provided through a health insurance plan.

Covered Lives: Total of insured members.

Covered Services: Healthcare services which a member is entitled to receive from PacificSource.

Credentialing: A process of screening, selecting and continuously evaluating individuals who provide independent patient care services based on their licensure, education, training, experience, competence, health status, and judgment.

Deductible: The portion of the member's healthcare expenses that must be paid out of pocket before any insurance coverage is applied.

Dependents: Eligible family members of the subscriber covered by a health insurance plan.

Diagnosis: The identification of a disease or condition through examination.

Diagnosis-Related Groups (DRG): A program in which hospital procedures are rated in terms of cost and intensity of services delivered. A standard rate per procedure is paid, regardless of the cost to the hospital to provide that service.

Disability: Any medical condition that results in functional limitations that interfere with an individual's ability to perform his/her normal work, and results in limitations in major life activities.

Disclaimer: A form supplied by PacificSource for managed care physicians and providers to use when a patient presents for services without a referral to a specialist. It may also be used when a patient accesses services of a primary care practitioner who is not the patient's designated PCP or is not in the PCP's call share group. The patient/subscriber is asked to sign this form indicating that they understand they may be financially responsible for charges incurred during the visit.

Dual Option: The choice between two or more different arrangements for medical care (for example, indemnity insurance or a managed care organization).

Durable Medical Equipment (DME): Equipment that can be repeatedly used, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment.

Emergency Medical Condition: A medical condition that manifests itself by symptoms of sufficient severity to convince a prudent layperson that failure to receive immediate medical attention would place the health of a person (or a fetus in the case of a pregnant woman), in serious jeopardy. Examples include heart attacks, cardiovascular accidents, poisonings, and loss of consciousness or respiration.

Emergency Medical Screening Exam: The medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency Services: Healthcare items or services furnished in an emergency department, and ancillary services routinely available to an emergency department, when needed to stabilize a patient. PacificSource expands the definition as the sudden and unexpected onset of a condition requiring immediate medical or surgical care, which

the member secures immediately after the onset, or as soon thereafter as can be made available, but in any case no longer than twenty-four hours after the onset.

Enrolled Group (see also Contract Group): A group of persons enrolled in a health plan through their employer or other common organization of which the persons are members.

Enrollee: A person eligible for service as either a subscriber or a dependent.

Enrollment: The process by which an individual becomes a subscriber for coverage in a health plan.

Episode of Care: All treatment rendered in a specified time frame for a specific disease.

Experience Rating: Rating system by which a plan determines the capitation rate or premium based on the experience of the individual group enrolled.

Experimental Procedures: Also called unproved procedures. All healthcare services, supplies, treatments or drug therapies that PacificSource has determined are not generally accepted by healthcare professionals as effective in treating the illness for which their use is proposed.

Extended Care Facility: A nursing home-type setting that offers skilled, intermediate, or custodial care.

Fee-for-Service: The traditional method of paying for medical services. A doctor charges a fee for each service provided and the insurer pays all or part of that fee.

Fee Schedule: List of fees for specified medical procedures.

Formulary: PacificSource Health Plan's list of approved prescription medications that generally carry a lower copayment.

Full Risk: An arrangement where PacificSource has given the medical group or provider organization financial responsibility for the comprehensive healthcare needs of the patient. Full risk includes both the institutional and professional components of capitation with no sharing of savings with the health plans and generally includes home health, skilled nursing facilities, ambulance, and acute hospital and physician services.

Gatekeeper: See Primary Care Practitioner.

Global: All-inclusive.

Grievance: A written complaint submitted by, or on behalf of, a member regarding any of the following: the availability, delivery, or quality of healthcare services; utilization review decisions; claims payment, handling or reimbursement for healthcare services; or the contractual relationship between a member and an insurer.

Hospice: A healthcare service that provides supportive care for the terminally ill.

Independent Physician Association (IPA): An individual practice association of physicians and/or providers that have entered into a contract with PacificSource to provide certain specific covered services to members.

Individual Practice Association (IPA): An individual practice association of physicians and/or providers that entered into a contract with PacificSource to provide certain specific covered services to members.

Inpatient Care: Healthcare provided in a licensed bed in a hospital, nursing home, or other medical or psychiatric institution.

Inquiry: A written request for information or clarification about any matter related to the member's health plan. An inquiry is not a complaint.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): A private, nonprofit organization that evaluates and accredits healthcare organizations providing mental health care, ambulatory care, home care, and long-term care services.

Loss Ratio: The ratio of a health maintenance organization's actual incurred expenses to total premiums.

Managed Care: A system of healthcare delivery developed to manage the cost, quality, and access of care. It is characterized by a contracted panel of physicians and/or providers; use of a primary care practitioner; limitations on benefits provided by non-contracted physicians and/or providers; and a referral authorization system for obtaining care from someone other than the primary care practitioner.

Managed Care Coordinator/Committee: An individual and/or committee that receives referral authorization requests and, based on a strict set of criteria, either approves or denies a request for referral authorization.

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Managed Fee-for-Service Product: Plan in which the insurer pays the cost of covered services after the services have been used. Various managed care tools such as preauthorization, second surgical opinion and utilization review are used to control inappropriate utilization.

Medicaid: The federal-state health insurance program for low-income U.S. citizens. Medicaid also covers nursing-home care for the indigent elderly.

Medical Group: A group of physicians and/or providers organized as a single professional entity that is recognized under state law as an entity to practice a medical profession.

Medical Services Contract: A contract to provide medical or mental health services that exists between an insurer, physician or provider, and independent practice association; between an insurer and a physician or provider; between an independent practice association and a provider or organization of providers; between medical or mental health clinics; or between a medical or mental health clinic and a physician or provider. This does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapters 58, 60 or 70, or other similar professional organizations permitted by statute.

Medically Necessary Covered Services: Services that PacificSource determines, through its professional review process, are (i) appropriate for the symptoms and diagnosis or treatment of a member's medical condition, (ii) provided for the diagnosis or the direct care and treatment of that medical condition, (iii) provided in accordance with standards of good medical practice, (iv) not primarily for the convenience of the member or the member's provider of care, and (v) the most appropriate level of service that can be safely provided to the member.

Medicare: The federal health insurance program for older U.S. citizens and the disabled.

Member: Any PacificSource subscriber or dependent as determined by PacificSource.

Negotiated Discount: Method of reimbursement for contracted physicians and providers that stipulates a specific percentage by which a charge may be reduced if included in the physician's or provider's contract or agreement.

Network: The doctors, clinics, health centers, medical group practices, hospitals, and other providers that PacificSource has selected and contracted with to provide healthcare for its members.

Noncovered Services: Those services excluded from coverage by PacificSource.

Nonemergent Condition: Routine physical or eye examinations, diagnostic work-ups for chronic conditions, routine prenatal care, elective surgery and scheduled follow up visits for prior emergency conditions. In these instances, no benefits are payable for service/treatment provided in an emergency room setting.

Nonformulary Covered Prescriptions: A list of prescription drugs that generally carry a higher copayment.

Nonparticipating Provider: A healthcare physician or provider who has not contracted with PacificSource Health Plans.

Nurse Practitioner: A registered nurse who has advanced skills, training and licensure in the assessment of physical and psychosocial health status of individuals, families and groups.

Out-of-Area: Any area that is outside the PacificSource service area.

Out-of-Panel Physician or Provider: A physician or provider who is not a part of the panel.

Outpatient Care: Care given to a person not requiring a stay in a licensed hospital or nursing home bed.

PacificSource Health Plans: A healthcare service contractor licensed under state law that contracts for the provision of comprehensive healthcare services for its members enrolled in various benefit plans.

PacificSource Policies and Procedures: The terms and conditions adopted by PacificSource for the administration of health benefits.

PacificSource Service Area: The geographic area defined by the boundaries of the state of Oregon; the Washington counties of Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum; and the Idaho counties of Ada, Boise, Canyon, Elmore, Gem, Owyhee, Payette, and Washington.

Panel Physician or Provider: An individual physician or provider who has entered into an agreement with an IPA, or other association of healthcare practitioners to provide certain contracted services to PacificSource members.

Participating Provider Panel: An IPA or other association of physicians and/or providers organized as a single professional entity, which enters into a service agreement with PacificSource for the provision of certain covered services to PacificSource members.

PCP: See Primary Care Practitioner.

Per Diem: The negotiated daily payment rate for delivery of all inpatient or residential services provided in one day, regardless of the actual services provided. Per diems can also be developed by type of care (for example, one per diem rate for general medical/surgical care and a different rate for intensive care).

Per Member Per Month (PMPM): A negotiated rate of payment per enrollee per month. A fixed amount determined by a negotiated rate between an insurance carrier and physician or provider.

Physician: A person duly licensed and qualified to practice medicine in the state where his/her practice is located.

Physician Assistant: A healthcare professional qualified by education, training, experience and personal character to provide medical services under the direction and supervision of a licensed physician in active practice and in good standing with the Board.

Physician-Hospital Organization (PHO): A healthcare delivery organization including both physicians and providers and a hospital or hospitals, which has entered into a contract with PacificSource to provide specified covered services to members.

Plan: See Group Health Plan.

Plan Administration: Management of a plan, including accounting, billing, personnel, marketing, legal services, purchasing, and servicing of accounts.

Plan Sponsorship: A group that organizes the group health plan, oversees its facilities, and provides managerial authority.

Point of Service: A health plan that allows members to choose a participating or non-participating provider (with or without a referral), with benefit levels that differ depending on whether or not the provider participates in the plan's network.

Policyholder: The employer or individual to which a contract is issued and in whose name a policy is written. In a plan contracted directly with the individual or family, the policyholder is the individual to whom the contract is issued.

Portability: Access to continuous health coverage so the insured does not lose insurance coverage due to any change in health or personal status (such as employment, marriage or divorce).

Preauthorization: An approval process prior to the provision of services, usually requested by the physician or provider. Factors determining authorization may be eligibility, benefits of a specific plan, or setting of care.

Pre-existing Condition: Physical condition of an insured person that existed before the issuance of a policy or enrollment in a plan. Pre-existing conditions may result in a limitation in the contract on coverage or benefits.

Preferred Provider Organization (PPO): Fee-for-service product where participants have financial incentives to seek care from participating physicians and providers, but are allowed to go to non-participating physicians and providers at a reduced benefit.

Premium: Rate that is paid for a specific health service.

Preventive Care: An approach to healthcare emphasizing preventive measures, such as routine physical exams, diagnostic tests (e.g. PAP tests) and immunizations.

Primary Care Practitioner (PCP): Physician or provider selected by a member who shall have the responsibility of providing initial and primary care and for referring, supervising and coordinating the provision of all other covered services to the member. A PCP may be either a family physician or provider, general practitioner, internist, pediatrician, obstetrician, gynecologist or other practitioner or nurse practitioner who has otherwise limited his/her practice of medicine to general practice or a specialist practitioner who has agreed to be designated as a primary care practitioner. Managed Care plans require that each enrollee be assigned to a primary care practitioner who functions as a gatekeeper.

Protocol: Description of a course of treatment or an established practice pattern.

Provider: A person licensed, certified or otherwise authorized by federal and/or state law to administer medical or mental health services in the ordinary course of business or practice of a profession. PacificSource further defines providers as physicians, dentists, nurses, physician's assistants, podiatrists, chiropractors, acupuncturists, naturopaths, optometrists, mental health professionals, physical, speech and occupational therapists, pharmacists, and other healthcare facilities or entities, including Individual Practice Associations or Medical Groups engaged in the delivery of healthcare services.

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Provider Complaint and Grievance Procedure: The system for the receipt, handling and disposition of provider complaints and grievances, as described in the PacificSource Policies and Procedures.

Quality Assurance Program: A program and process that is carried out by PacificSource and contracted physicians and providers to monitor, maintain and improve the quality of services provided to members as described in PacificSource Policies and Procedures.

Quality Improvement: A continuous process that identifies problems in healthcare delivery, tests solutions to those problems, and monitors the solutions for improvement.

Referral: The process by which the member's primary care practitioner directs the member to seek and obtain covered services from other physicians and providers.

Referral Authorization: The process of reviewing and authorizing referrals to specialists by primary care practitioners.

Reinsurance: Insurance purchased by a carrier from another insurance company to protect itself against all or part of the losses that may be incurred by claims for its members (e.g. catastrophic care).

Resource-Based Relative Value Scale (RBRVS): A financing mechanism that reimburses healthcare providers on a classification system.

Risk: A possibility that revenues of the insurer will not sufficiently cover expenditures incurred in the delivery of contractual services.

Risk Contract: An arrangement through which a healthcare provider agrees to provide a full range of medical services to a set population of patients for a prepaid sum of money or a predetermined budget. The physician or provider is responsible for managing the care of these patients, and risks losing money if total expenses exceed the predetermined amount of funds.

Risk Pool: A category of services that are subject to some type of projected expense target. Typically, amounts over or under this target are shared with the medical group "at risk" for these services. For example, if the risk pool is set at \$25.00 (per member per month) for hospital services and the actual amount comes in at \$26.00, the \$1.00 over the targeted amount may be deducted from other areas of reimbursement to the medical group.

Risk Sharing: An arrangement in which financial liabilities are apportioned between two or more entities. For example, PacificSource and a provider may each agree to share the risk of excessive healthcare cost over budgeted amounts on a 50-50 basis.

Self-Insured: Management in which health services are delivered by physicians and/or providers, but the cost of these services is covered by the member's employer, instead of by the insurance firm.

Service Areas: Geographic areas covered by a PacificSource insurance plan where direct services are provided.

Skilled Nursing Facility (SNF): A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and/or medical care that is of a lesser intensity than that received in a hospital.

Solo Practice: Individual practice of medicine by a physician or provider who does not practice in a group or share personnel, facilities, or equipment with other physicians.

Specialist Physician/Provider: A physician or provider whose training and expertise are in a specific area of medicine.

Stabilization: A state in which, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

Stop-Loss: Risk protection from withhold losses resulting from claims greater than a specific dollar amount per member per year.

Subrogation: When healthcare costs of enrollees are the responsibility of an entity other than the insurer, such as workers' compensation, third party negligence liability, or automobile medical coverage.

Subscriber: The person who is responsible for payment to PacificSource, or whose employment or other status (except for family dependency), is the basis for eligibility for membership in PacificSource.

Supplemental Medicare: A plan that covers some copayments, deductibles, and other services not covered under traditional Medicare.

Tertiary Care: Healthcare services that are not available through a community hospital setting. This may include complex cancer procedures, transplants, and neonatal intensive care.

Third Party Administrator (TPA): An independent person or corporate entity that administers group benefits, claims, and administration for a self-insured group or insurance company. A TPA does not underwrite risk.

Third Party Payment: Payment for healthcare by a party other than the member.

Triage: The classification of sick or injured persons, according to severity, in order to direct care and ensure efficient use of medical and nursing staff and facilities.

Underwriting: The process PacificSource uses to determine the basis on which it will accept an application for insurance.

Urgent Care Clinic: A healthcare facility whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions.

Utilization: The extent to which the members of a covered group use the services or procedures of a particular healthcare benefit plan.

Utilization Review: A set of formal techniques used by (or delegated by) an insurer that are designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of healthcare services, procedures or settings.

Utilization Management Program: The programs and processes established and carried out by PacificSource with the cooperation of contracted physicians and providers to authorize and monitor the utilization of covered services provided to subscribers.

