



Glossary

Health Care Terms and Definitions

Preferred Care wants to make it as simple as possible for you to understand and use your health plan, and our web site. Knowing what specific words mean can help. **Click on a letter of the alphabet on the left to “jump” to terms that begin with that letter.**

Important Note: *The Glossary is a large document. On your computer's "print" menu, we recommend that you select the page(s) you wish to print, to avoid printing the entire Glossary.*

A

accreditation: the process by which an organization recognizes a program of study or an institution as meeting a set of standards. One of the organizations that accredit managed care plans is the National Committee for Quality Assurance (NCQA). Preferred Care has achieved the highest level of accreditation (“Excellent”) since 1999.

actual benefits paid by plan: the total amount paid by Preferred Care, calculated by subtracting the copayment, coinsurance, penalty, or deductible from the allowed amount.

actuary: a person who studies insurance statistics and calculates risk, premium rates, trends, and how successful a health plan is at retaining members from year to year.

acute care: a type of health care in which a patient is treated for an acute (immediate and severe) illness, for injuries related to an accident or other emergency, or during recovery from surgery. Acute care is usually given in a hospital by specialized professionals. Acute care is often needed only for a short time.

adjudication: the decision made by a health plan to pay or deny a claim, based on a member's type of coverage and the service being rendered.

Administrative Services Only (ASO): a contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and the self-funded entity assumes all risk. Also see *self-funding, self insurance*.

allowed amount: the maximum fee allowed for a medical service or procedure as outlined in a certificate/contract.

alternative therapies: wellness therapies that offer ways to relieve pain without the use of drugs, such as chiropractic treatments, acupuncture, or massage therapy.

ambulatory care: health care services that do not require a patient to be hospitalized. A patient can receive ambulatory care at a physician's office, clinic, medical center, or outpatient facility.

ambulatory setting: a health facility in which services are provided on an outpatient basis. Ambulatory settings include surgery centers, clinics, or mobile treatment units such as mobile mammography centers.

ancillary service: any service used to treat a patient that is not considered “medical/surgical” or “room and board”; for example: X-ray, laboratory testing, consulting, anesthesia, etc. On an insurance claim, these services are not usually listed separately, but are grouped together as “ancillary services.”

annual deductible: an annual deductible is a set dollar amount you need to pay toward your healthcare costs before your health plan begins paying for your care. You are responsible for paying 100% of your health care costs until you meet your annual deductible.

appeal: a formal request by a member or doctor for a health plan to reconsider a decision on a pre-service, an approval decision, a claim, or the denial of a claim.

B

balance billing: the practice of a health care professional seeking payment from the patient for the portion of that patient’s bill not covered by the government or other third party payers, such as a health plan. For example, a health care provider that accepts Medicare may not “balance bill” patients for costs that Medicare does not cover.

benefit days: the number of days for which a member may receive benefits, which can be based on a period of illness or on a calendar year.

benefit period: a period of time during which a member receives health services that are covered by his or her benefit plan. A benefit period may begin, for example, when a patient is admitted to a hospital and ends after at least 90 days. The benefit period may be extended if the patient is still confined in a hospital or similar institution.

benefits: services that an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

C

capitation (cap): a specific dollar amount established to cover the costs of health care delivered to a member. Capitation usually refers to a negotiated rate that is paid monthly to a health care provider. The provider is then responsible for delivering all health care services required by the member.

care management (CM): a process in which a health plan identifies a member with specific health care needs and works with his or her doctor(s) to develop a plan to help meet the medical and social challenges associated with illness, to help the member feel better, and make the most of life. This term also is sometimes called **Case Management** or **Disease Management**.

case and disease management (CDM): see *care management*.

case mix: a measure of how many patients are admitted to a hospital, and what services are needed and used to treat them. Case mix can be measured by keeping track of what illnesses patients check in with, how severe the illnesses are, what services are used most, and other characteristics of the hospital.

Centers for Medicare & Medicaid Services (CMS): the federal agency responsible for Medicare and Medicaid. Formerly called the Health Care Financing Administration (HCFA).

certificate of coverage: a description of the benefits included in a Preferred Care health plan. The certificate of coverage is required by state laws and represents the coverage provided under the contract issued to an employer.

Child Health Plus (CHP): this is a state-funded, income-based health plan that only covers children.

claim: information submitted by a health care provider or by a member to establish that medical services were provided. Claims are processed by the member's health plan for payment back to the provider or member.

claims history: a record of a member's past claims received by Preferred Care for payment, and the actions taken on each claim.

coinsurance: the amount you will pay your provider for care received. This amount is based on the fee your provider charges. Coinsurance is a percentage of that fee, and is split between you and your health plan.

commercial carrier: usually a for-profit insurance company that competes with not-for-profit health plans for health insurance business.

community rating: a method of determining premiums that is influenced not by how much specific groups use their benefits, but by how often a population pool uses health benefits.

consolidated omnibus budget reconciliation act (COBRA) of 1983: a federal law that requires employers to offer continued health insurance to certain employees and their beneficiaries whose group health insurance coverage has been terminated, and sets a monthly amount that members pay for coverage.

consumer-directed health plan (CDHP): a consumer-directed health plan is a type of health coverage that combines a low-premium, high-deductible health plan with either a health savings account (HSA) or a health reimbursement arrangement (HRA) and Web-based decision tools.

contract: a legal agreement between a health plan and its contract holders (employees or members) that outlines benefits, limitations, and exclusions, as well as the responsibilities of both parties.

contract holder: a person who has entered into a legal agreement (contract) with a health plan for himself or herself and dependents, if any. Also called a *subscriber*.

contract year: the period of time that begins on the effective date of the health plan contract and ends on the expiration date of the contract. Preferred Care's standard contract year is January 1 through December 31.

coordination of benefits (COB): a provision in a health plan contract that applies when a person is covered under more than one insurance program. It requires that payment of benefits be coordinated among all programs to eliminate over-insurance or duplication of benefits. Other insurances may be group medical insurance, no fault auto insurance, or liability insurance. Also known as *other party liability*.

copay or copayment: a copay is a fixed dollar amount you pay for health care services at the time care is received. Copays are common with health maintenance organization (HMO) health plans.

cost sharing: a provision in a health insurance contract that requires the member to share a portion of the cost for his or her use of services. Copayments, deductibles, and coinsurance are examples of cost-sharing.

covered expenses: health care expenses, such as the cost of physician office visits and treatment, care in a hospital, etc. that are included in a member's health plan.

covered services: health care services, such as physician and hospital services, etc. that are included in a member's health plan.

credentialing: a health plan's process of reviewing and approving health care provider who applies to participate in a health plan. Specific guidelines are used to determine every provider's initial and ongoing participation in the health plan.

current procedural terminology (CPT): a list of descriptive terms and codes used to identify health services. CPT is used by health care providers and health plans to report medical services and procedures performed by physicians. CPT is the proprietary information of the American Medical Association (AMA).

custodial care: care that is needed by a patient beyond that which is necessary to recover from a medical treatment or emergency, including help with bathing, dressing, eating, and other daily activities, as in a convalescent nursing home or rest home.

D

date of service: the date on which a patient undergoes a medical procedure, sees a doctor, or receives any other type of service from a health care provider.

deductible: the amount of eligible expense a member must pay each year out of his or her own pocket before an indemnity health plan will pay or reimburse for eligible medical expenses.

dependent: a person covered by someone else's health plan. If you are the contract holder (subscriber) on the policy, a dependent is someone other than you who is eligible to receive care under your contract (for example, a spouse and/or children).

diagnosis related groups (DRG): a system of classification for inpatient hospital services based on a member's principle diagnosis, secondary diagnosis, surgical procedures, age, sex, and the presence of complications. This system of classification is used by the health plan to reimburse hospitals and other selected providers for services rendered.

direct bill/direct pay: subscribers who are billed individually and pay premiums directly to the health plan, rather than through an employer. These subscribers are often referred to as *non-group* or *direct bill members*.

discharge planning: the evaluation of a patient's medical needs in order to arrange for appropriate care after being discharged from an inpatient setting (such as a hospital).

disenrollment: the process by which a person or group leaves a health plan, or an employer ends the coverage of an employee.

DOH: The New York State Department of Health (NYSDOH).

DOI: The New York State Department of Insurance (NYSDOI).

dual diagnosis: the co-existence of more than one medical condition in an individual patient. Dual diagnosis can refer, for example, to a patient who is diagnosed with diabetes in addition to congestive heart failure.

durable medical equipment (DME): equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, is not generally 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.

E

eligibility: the right to receive benefits, based on the type of health plan contract.

eligibility date: a defined date when a person becomes eligible for benefits under an existing contract.

emergency: a serious medical condition arising from injury, sickness, or mental illness that occurs suddenly and requires immediate care and treatment, generally within twenty-four hours of onset, to avoid jeopardy to the life or health of a person.

employee assistance program (EAP): services designed to assist employers, employees, and their family members in finding solutions for workplace and personal problems. Services may include assistance for family/marital conditions, legal or financial problems, elder care, childcare, substance abuse, emotional/stress issues, and other daily living concerns. EAP may address violence in the workplace, sexual harassment, dealing with troubled employees, transition in the

workplace, and other events that increase the rate of employee absenteeism or employee turnover, lower productivity, and other issues that impact an employer's financial success or employee relations with management. EAPs also can provide access (voluntary or mandatory) to behavioral health benefits.

employer-funded: employer-funded refers to benefits that are paid for by your employer. Examples include premium payments and contributions to a health reimbursement arrangement (HRA).

enrollment: the process by which groups and individuals join a health plan. The total number of covered persons in a health plan is referred to as *total enrollment*.

exclusions: contract provisions that outline situations, conditions, or treatments that are not covered by a health plan.

exclusive provider organization (EPO): EPOs offer a wide range of services. There is a set copayment when a member uses the plan's network of doctors and facilities. The member selects a Primary Care Physician (PCP) from the network, who coordinates the member's care and manages referrals and precertifications to other network providers, as necessary. Services not received from or ordered by the member's PCP are generally not covered by the plan.

experience rating: a method of determining premiums based on the cost and use of benefits by the members of an employer group.

experimental procedures: also called investigational or unproven procedures, this covers all health care services, supplies, treatments, or drug therapies that have been determined by the health plan to not be generally accepted by health care professionals as effective in treating the illness for which their use is proposed.

explanation of benefits (EOB): a statement sent to an indemnity plan member that explains what action was taken by the health plan regarding a claim filed on his or her behalf. HMO members do not receive EOBs.

E

Family Health Plus (FHP): a state-funded, income based health plan available to cover qualified families.

fee-for-service: an arrangement under which doctors, hospitals, or other health care providers are paid for each service rendered.

fee schedule: a comprehensive listing of fees used by either a health care plan or the government to reimburse doctors and/or other health care providers on a fee-for-service basis.

flexible benefit plan: a type of benefit program offered by some employers in which employees are presented with a number of benefit options each year, allowing employees to tailor health benefits to their specific needs. See also *section 125 plan*.

flexible spending account (FSA): a flexible spending account takes advantage of the Internal Revenue Code section (Section 125) that provides a tax-effective way for employees to be reimbursed for certain types of health care and/or dependent care expenses.

- **A Medical FSA** offers a tax-effective way to pay for health-related expenses such as deductibles, coinsurance, and other charges not covered under a medical, dental, or vision care plan.
- **A Dependent Care FSA** provides similar tax savings for expenses associated with caring for dependents, such as children or elderly parents, while employees are at work.

formulary: a health plan's approved list of prescription drugs and their appropriate dosages shown to be most useful and cost effective for patient care. HMOs develop a formulary by consulting a pharmacy and therapeutics committee. In most health plans, physicians are required to prescribe from the formulary. Preferred Care uses an open formulary, meaning that doctors are NOT required to prescribe from the formulary.

G

generic drug: a drug in which the active ingredient is the same as in a brand name drug whose patent has expired. A generic drug is typically less expensive than the "brand name" drug and sold under a common or "generic" name (for example, the name for one tranquilizer is Valium, but it also is available under generic name diazepam). Also called *generic equivalent*.

group coverage: a collection of individuals treated as a single entity; usually, an employer purchasing medical coverage on behalf of its full-time employees.

group model HMO: in the group model HMO, the HMO contracts with a physician group, which is paid a fixed amount per patient to provide specific services. The group's administrator then decides how the HMO payments are distributed to each member physician. This type of HMO is usually located in a hospital or clinic setting and may include a pharmacy.

H

HCFA Common Procedural Coding System (HCPCS): A listing of services, procedures, and supplies offered by doctors and other providers. The HCPCS codes beginning with A through V are developed for use on a national level by HCFA (now called the Centers for Medicare & Medicaid Services). Codes beginning with W through Z are developed by local Medicare carriers.

health maintenance organization (HMO): an entity that provides, offers, or arranges for coverage of health services needed by plan members for a fixed, prepaid premium.

Health Plan Employer Data and Information Set (HEDIS®): a set of performance measures that assist employers in evaluating health plan performance.

health reimbursement arrangement (HRA): in this version of a consumer-directed health plan, an employer deposits money into an account for each covered employee. Employees then seek reimbursement for a qualified health care expense. HRA funds should be thought of as a credit

rather than as money. Unused money still in the account at the end of the plan year can be carried over to the next year. This type of fund is not portable. It is owned by your employer. If you leave your current company, the funds stay with the company.

health savings account (HSA): a health savings account is a tax-free way to save money to pay for qualified medical expenses (as defined by the IRS). Both employers and employees may contribute to the HRA, but the money belongs to the employee, rolls over from year to year and may be taken with the employee if he or she takes a new job or retires.

high deductible health plan (HDHP): a high-deductible health plan is a health plan with a higher annual deductible compared to a traditional health plan. With the exception of preventive care, an annual deductible must be met before plan benefits are paid. HDHP's are usually paired with an HRA or HSA so that the money in such an account can help to offset the higher deductible. An HSA must be set up in conjunction with a HDHP.

HIPAA: HIPAA stands for the "Health Insurance Portability and Accountability Act", a federal law protecting the use and disclosure of individually-identifiable health information. Preferred Care has prepared a Privacy Notice describing how members' HIPAA-protected health plan information may be used or disclosed, as well as members' rights and choices concerning this information. Except as provided in the Privacy Notices, Preferred Care employees will not use or disclose members' HIPAA-protected information without express authorization.

HMO report card: The HMO Report Card is published every year by the New York State Health Accountability Foundation, an independent, not-for-profit organization. The report helps to guide employers who are purchasers of health care products.

home health care: skilled services including nursing, physical, occupational, and speech therapy given at a patient's home. If a member is receiving skilled services, they may be eligible for home health care aid services. This is a covered service for Preferred Care subscribers and the federal Medicare program.

hospice care: a program that provides supportive care for terminally ill patients and their families.

I

indemnity: traditional fee-for-service coverage in which health care providers are paid according to the service performed.

indemnity benefits: established dollar allowances for covered services that a health plan will reimburse for a person covered by an indemnity plan. Payments are made toward that established charge, which is not necessarily the total cost of the service. Indemnity plans often have deductibles and coinsurance.

Individual Practice Association (IPA) HMO model: a source of health care services provided by a group of independent care providers who agree to provide care for a corporation, company, or association at rates agreed upon by both parties. Preferred Care contracts with three IPA's: Preferred Health Network (PHN), Greater Rochester Independent Practice Association (GRIPA), and Lifetime Health.

in-network: in-network refers to covered services that are provided by a Preferred Care contracted health care provider. Costs are usually lower when you visit in-network providers.

inpatient: an individual who occupies a hospital bed while receiving hospital care. Inpatient services include room, board, and general nursing care.

intermediary: an organization selected to process and pay claims for the services of health care providers based on guidelines issued by a sponsoring organization, usually the federal government (Medicare). Medicare intermediaries pay claims for Medicare Part A only.

International Classification of Diseases - (9th Edition) ICD-9: a list of codes that represent diagnoses and procedures. All health care providers use ICD-9 diagnosis codes to describe why service was rendered. Facilities like hospitals use ICD-9 procedure codes to describe what services were performed.

J

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): a private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations that provide home care, mental health care, ambulatory care, and long-term care services.

K

No current listings.

L

lifetime maximum amount: the maximum amount payable for an individual person under a benefit plan.

M

major medical: benefit programs designed to help offset high costs of catastrophic (a condition that results in substantial medical expense) or prolonged illness or injury. Most of these programs incorporate deductibles and out-of-pocket maximum amounts.

managed care: a system of health care delivery that influences the use and cost of medical services, and measures performance. The goal is a system that provides members with quality, cost-effective health care.

Medicaid: a medical assistance program enacted by Congress in 1965 that is managed by individual state governments. Medicaid provides medical benefits to members who are eligible because of health status or income. Federal, state, and local governments share the program's costs.

Medicare: a nationwide, federally-administered health benefits program for persons 65 years of age and older or those under 65 who are totally disabled as determined by the Social Security Administration. Medicare covers the costs of hospitalization, medical care, and some related services for eligible members.

Medicare has two parts:

Part A covers inpatient hospital, skilled nursing facility, and home health care costs.

Part B covers outpatient medical and surgical costs.

Medicare Advantage: As part of the federal government's initiatives to modernize and improve Medicare, Medicare Advantage (formerly called Medicare+Choice plans) offers older adults the option of enrolling in low-cost and high-coverage managed care plans, similar to those available today under Medicare. Medicare Advantage includes plans that offer a subsidized drug benefit, and all plans are able to offer extra benefits, as many private plans do today.

Medicare Part D Prescription Drug Coverage: Medicare prescription drug plans are available to help people with Medicare to cover the cost of prescription drugs. There are plenty of plans to choose from. No doubt you've received information from all sorts of companies that are offering Medicare Part D drug coverage in 2006. Like with other types of insurance, if you join a Medicare Part D drug plan you will pay a monthly premium for prescription drug coverage, and a share of the cost of your prescriptions. Costs vary, depending on if you decide to buy your drug coverage through:

- Your current Medicare Advantage health plan
- A different Medicare Advantage health plan
- A stand-alone prescription drug plan (called a PDP, which covers only drugs)

You have until May 15, 2006 to join Medicare Part D in 2006. From then on there will be annual enrollment periods. Like other insurance, the longer you wait, the higher your premium may be. Keep in mind that:

- Joining is voluntary. But if you don't join when you are first eligible, your monthly premium may be higher because there's an additional fee for late enrollment (you will not pay this higher premium if you have other drug coverage that is at least as good as Medicare, such as an employer plan, EPIC, VA and some other plans).
- If you decide not to join a Medicare D plan at this time, you will not be disenrolled from your Medicare Advantage plan.
- The next opportunity to enroll will be Nov. 15 – Dec. 31, 2006.

members: any person who is eligible to receive benefits under a health plan contract, whether it is the subscriber (contract holder), or his or her spouse and dependents, if any.

membership: Preferred Care's membership includes all covered members (HMO), insured members (indemnity), and self-insured health plan participants (ASO).

N

NCQA: The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization that evaluates and reports on the quality of the nation's managed care plans through accreditation and performance programs. To earn NCQA accreditation, a health plan must undergo an audit every three years and report its performance annually in areas such as member satisfaction and quality of care.

Preferred Care is one of the health plans surveyed every three years by NCQA for accreditation. NCQA also measures the public's experience with our care and service performance every year using the NCQA's Health Plan Employer Data and Information Set (HEDIS®). Preferred Care has achieved the highest level of accreditation ("Excellent") for its Commercial and Medicare health plans since 1999.

network: a network is a specific group of health care providers that have contracted with Preferred Care to provide services at a negotiated rate of reimbursement.

national account: a benefit program designed to provide uniform coverage to an organization that has members in more than one geographical coverage area.

non-group member: See *direct bill/direct pay*.

non-participating provider: a health care provider who has no agreement with Preferred Care to provide contract benefits to members.

Q

open enrollment period: a time during which subscribers in a health benefit program have an opportunity to re-enroll or select a different health plan offered to them. Open enrollment periods can be year-round, or limited to one or two 30-day periods annually.

outcomes: results achieved for a patient through health care services, use of a prescription drug, or through a surgical procedure.

other party liability (OPL): see *coordination of benefits (COB)*.

out-of-network: refers to a health care professional who provide services but does not have a contract with Preferred Care.

out-of-pocket expenses: the health plan establishes out-of-pocket payments for which each member is responsible; the amount of money a member must pay for health services, as stated in the contract. Beyond these amounts, the health plan generally pays 100%, with no out-of-pocket responsibility on the part of the member. Examples of out-of-pocket expenses include the copay, deductible, and coinsurance.

out-of-pocket maximum: your out-of-pocket maximum is a set dollar amount. It is different from your annual deductible. Your annual deductible counts toward your out-of-pocket maximum. This is

the most you will personally pay for health care in a calendar year. Any additional care you receive after you meet this amount is covered at 100%.

outpatient: a patient who receives health care services without being admitted to a hospital.

P

participating provider: a health care provider who has an agreement with Preferred Care to provide benefits to our members, such as a physician, specialist, physical or occupational therapist, etc.

patient portion: the amount for which members are responsible, including copayment, deductible, coinsurance, and/or penalty charges; a member's paid portion does not include any amounts from denied services not covered by his or her health plan.

payer: a public or private organization that pays for (underwrites) insurance coverage for health care expenses.

peer review: an evaluation conducted by practicing physicians or other health care providers of the effectiveness of services provided by other members of the same profession.

peer review organizations (PRO): Peer review organizations perform "quality of care" reviews for Medicare hospital patients. The Peer Review Organization Act of 1982 authorizes one PRO for each state.

penalty: PPO Plans (such as Preferred Care USdirect) require that a plan participant be responsible for contacting your health plan any time you or one of your covered dependents is to receive a medical service that the health plan has determined requires "pre-certification". Failure to pre-certify a service will result in a penalty, or more out-of-pocket expenses for the participant. Please refer to your health plan materials for details.

per member per month (PM/PM): a unit of measure used by HMOs (Health Management Organizations), usually related to costs. "Member" refers to the subscriber, as well as his or her dependents.

physician hospital organization (PHO): a health care delivery system with one or more hospitals entering a joint venture arrangement with one or more physician groups. The PHO serves the needs of its members for both inpatient and physician services.

point-of-service (POS) plan: a health plan that allows members the choice to receive a service from either a participating or non-participating provider. In a POS plan, copays and other out-of-pocket costs for members are generally lower and levels of coverage highest when you choose a participating (in-network) provider than when you use a non-participating (out-of-network) provider.

portability: under this requirement, a covered person who changes jobs is guaranteed continuous coverage with a new plan, without a waiting period or pre-existing illness limitation. The member's previous health plan issues a certificate of coverage to give to the new plan, making benefits coverage "portable."

pre-certification: the process of a member or provider verifying with Preferred Care that a health care service or a visit to a health care provider will be covered by the member's plan *before* the service is performed or the visit takes place. Before you see a specialist, for example, you or your Primary Care Physician (PCP) may need to call Preferred Care for a pre-certification. Also known as *pre-authorization*.

pre-existing condition: any medical condition that has been diagnosed or treated within a specified period of time before a member's effective date of health plan coverage.

preferred provider organization (PPO): a program in which a health plan establishes contracts with providers of medical care to form a network of preferred providers. Under a PPO plan, members usually receive significantly better benefits (lower copayments) for services received from these preferred providers. Benefits are provided for non-participating providers' services, but with higher copayments. Members of a PPO plan are not required to select a Primary Care Physician (PCP).

premium: a premium is the amount paid to a health plan (usually monthly) for providing coverage under a health plan contract. Premiums are typically set according to coverage classifications, such as individual, employee and spouse, employee and child, or family.

prepaid care: health care services provided to an HMO member in exchange for a fixed, monthly premium paid in advance of the delivery of medical care.

preventive care: preventive care is health care that emphasizes the prevention, early detection, and early treatment of conditions. Services generally include routine physical examinations, immunizations, laboratory tests, and radiological exams.

primary care: basic or general health care traditionally provided by family practice, general practice, pediatrics, and internal medicine physicians.

primary care physician (PCP): The physician responsible for managing and coordinating a member's health care services. For HMO plan members, a PCP is responsible for coordinating all medical care, including diagnosis, treatment, referrals to specialists, hospitalization, and follow-up care. He or she works with a team of health care professionals, which may include physician assistants and nurse practitioners, to provide your treatment. A PCP may be certified in internal medicine, family practice, general practice, or pediatrics. Women also may choose an obstetrician/gynecologist as their secondary PCP.

prior justification: the process of getting an "OK" from Preferred Care on a request or referral made by your Primary Care Physician or specialist for certain services or procedures to make sure they fit within the guidelines of your health plan, possibly involving a clinical review of these requests.

Prior justification assures that medically necessary, cost effective therapies have been considered for you by your doctor(s) and that patients meet certain clinical criteria for the service or procedure that the doctor is recommending.

privacy notice: a legal document that describes how medical information about you may be used or disclosed, as well as your rights and choices concerning this information. Also called a *privacy policy*.

provider: a physician, hospital, physical or occupational therapist, group practice, nursing home, pharmacy, or any individual or group of individuals that provide a health care service. Also called a *health professional*.

Q

quality assurance: a set of evaluations that assess and affect the quality of any health care service. Quality assurance evaluations also include corrective actions that need to be taken to solve problems that are identified in the quality of a health care provider's patient, administrative, and support services.

quality improvement: a continuous process that identifies problems in the delivery of health care to patients, tests solutions to those problems, and constantly monitors those solutions for possible improvement.

R

referral: the recommendation by a physician and/or health plan for a covered person to receive health care from a different physician or facility.

reimbursement: payments to health care providers for costs or charges that have been incurred.

rider: a document that modifies coverage within a health plan contract, either by expanding or diminishing benefits. Preferred Care, for example, offers eyewear and prescription "riders" for selected health plans.

S

section 125 plan: a term used to refer to flexible benefit plans, in which employees are presented annually with a number of benefit options, allowing them to tailor health benefits to their specific needs. The reference is to the section of the IRS code that defines flexible benefit plans and states that your contributions to such plans may be made with pre-tax dollars.

self-funding, self-insurance: a health care program in which employers assume complete financial responsibility for employee health insurance. Self-funded plans may be administered by the employer, or the employer may contract with a health plan like Preferred Administrative Services for an "administrative services only" (ASO) arrangement.

skilled nursing facility (SNF): a place that provides skilled nursing or skilled rehabilitation services to help members recover after a hospital stay. It can be a separate facility, or part of a hospital or other health care facility. The term "skilled nursing facility" does not include places that

mainly provide custodial care (help with bathing, dressing, eating and other daily activities), such as convalescent nursing homes or rest homes.

specialist: a health care professional certified to practice in a specific field of medicine (for example, a cardiologist). In New York, your primary care physician (PCP) may, under certain circumstances, be a specialist.

staff model HMO: a health care model in which an HMO employs physicians as part of its staff to provide health care to its members. Preferred Care is NOT a staff-model HMO.

subscriber: a subscriber is an individual who has elected to contract for, or participate in (subscribe to), a health plan for himself or herself and dependents, if any. Also called a *contract holder*.

I

Tax Equity and Fiscal Responsibility Act (TEFRA): although this law involved many things, for HMO and insurance purposes it included rules about when Medicare coverage (such as Preferred Care Gold and GoldAnywhere) is primary and when it is secondary.

termination date: the date that an employer group contract with a health plan expires; or, the date that a member stops being eligible for health plan coverage.

third party administrator (TPA): a service company that is hired by an employer to provide administration services for its group benefit plan. The TPA's functions may include premium accounting, claims review and payment, utilization reviews and other services. Third party administrators are most commonly employed by self-funded groups. See also *self-funding*.

total enrollment: the total number of covered persons in a health plan.

treatment plan: documenting the services to be provided to improve a member's health – such as rehabilitation services.

triage: a method of classifying patients according to how severely injured or sick they are, to help medical and nursing staff work more efficiently.

U

underwriter: in insurance, underwriting is the process of selecting, classifying, evaluating and assuming risks according to their insurability. Its fundamental purpose is to make sure that the group insured. An underwriter is an individual or company that specializes in underwriting.

urgent care center: a medical facility where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate, non-emergency care. The urgent care center may be open 24 hours a day; patients calling an HMO after hours with urgent, but not emergency problems are often referred to these facilities because they are less expensive than an emergency room (ER).

urgent services: non-emergency services that are required in order to prevent a serious decline to a member's health as a result of sudden illness or injury.

usual, customary, and reasonable (UCR): health benefit plans will pay a physician's full charge for a service, provided that the charge (1) does not exceed his or her "usual" fee, (2) does not exceed the amount "customarily" charged for the same service in that geographic area, and (3) is otherwise considered "reasonable." Also called *U&C* (usual and customary) or *R&C* (reasonable and customary).

utilization: the extent to which the members of a health plan use a program and obtain a particular medical service or category of medical procedures over a period of time.

utilization review: an evaluation of the necessity and appropriateness of medical or institutional services to patients.

V

No current listings.

W

waiting period: there are two types of waiting periods:

- 1) the time between when a person is hired by a company and when he or she becomes eligible for benefits, such as health benefits, and
- 2) a waiting period is frequently required when a member enrolls with a pre-existing condition (a medical condition that has been diagnosed or treated before a person enrolls in a health plan).

workers' compensation: coverage available from federal or state compensation acts for medical expenses resulting from a job-related illness or injury.

XYZ

No current listings.