

Glossary of Terms

The following is a list of definitions either frequently used in this manual or commonly used in the business of providing health care coverage.

ACCREDITATION - the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined standards. The recognition is called accreditation. Similar assessment of individuals is called certification. Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited program or institution. The Joint Commission on the Accreditation of Health Care Organizations is one such organization. In some instances, public governments recognize accreditation as the basis of licensure. Public or private payment programs often require accreditation as a condition of payment for covered services.

ACCREDITED GENERAL HOSPITAL - a general hospital fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

ACTUARY - a person trained in statistics, accounting and mathematics who determines contract rates, reserves and dividends by making assumptions about each of the risk factors involved (such as the frequency of occurrence of the peril, the average benefit that will be payable, the rate of investment earnings, if any, expenses and persistency rates), and who endeavors to secure valid statistics on which to base these assumptions.

ACUPUNCTURIST - a health practitioner who follows a system of health care used in China for more than 2,500 years. The goal of treatment is to balance the "chi" or energy in the body. To perform acupuncture, an acupuncturist stimulates points on the body's surface using very fine needles, pressure or heat. In order to be licensed, an acupuncturist must have completed three years of training, including western science, and passed a national certification exam.

ADJUDICATION - determination of payment allowed on a claim.

ADMINISTRATIVE SERVICES CONTRACT (ASC) - an arrangement under which an insurance carrier, a health care service contractor or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

ADVANCED REGISTERED NURSE PRACTITIONER (ARNP) - any licensed registered nurse who, after satisfactory completion of an advanced formal education, is board-certified to practice specialized and advanced nursing.

ADVERSE SELECTION - disproportionate insurance of risks that are more prone to suffer loss or make claims than the average risk. It may result from the tendency for poorer risks or less desirable insured (sick people) to seek or continue insurance to a greater extent than do better risks (healthy people), or from the tendency for the insured to take advantage of favorable options in insurance contracts.

AGENT -

1 - (legal definition) - an insurance solicitor, licensed by the state, who places group/individual business with one or many healthcare service contractors. An agent represents the seller of insurance rather than the buyer and is paid commission by the healthcare service contractor.

2 - (common usage, as in this document) - often referred to as a broker. Often these terms are used interchangeably (as is the case in this document), although there is a distinct legal difference.

AGGREGATE - the combined out-of-pocket expenses among all family members equal to the pre-determined total out-of-pocket or deductible maximum.

ALTERNATIVE DELIVERY SYSTEM --a means of offering choices or options in modes of health care, often reducing costs but not quality of care. An example of an alternative delivery system is a health maintenance organization.

ALTERNATIVE MEDICINE - techniques of medicine not widely taught in U.S. medical schools and not generally available in U.S. hospitals. In 1995, Washington state enacted a law that requires health plans to "permit every category of health care provider to provide health services or care for conditions included in the Basic Health Plan services." In compliance with that law, Regence BlueShield has contracted with four provider types: acupuncturists, massage therapy practitioners, naturopaths and nutritionists. Regence BlueShield views techniques practiced by these providers as complementary to, rather than a substitute for, conventional medical practices.

AMBULATORY CARE - outpatient health care provided to patients who do not need to occupy a hospital bed.

AMERICAN MEDICAL ASSOCIATION (AMA) - a public service organization composed of 53 state and territorial medical societies and component county medical societies. The Association is dedicated to the advancement of science and medicine and the betterment of the public health and welfare.

ANCILLARY SERVICES - common hospital terminology meaning services other than bed, board and nursing care (e.g.; drugs, dressings, operating room services, and special diets).

ANNIVERSARY DATE -- the annual date when a contract is to renew; usually, but not always, the annual return of an effective date.

APPLICATION - a statement of facts requested by Regence BlueShield. This becomes part of the health contract when it is issued.

ASSIGNED CLAIM - a claim submitted by a provider where payment is made directly to the provider.

ASSIGNMENT - payment for covered services that are made directly to the provider.

ASURIS NORTHWEST HEALTH – the non-BlueShield subsidiary of Regence BlueShield. Provides health care coverage to people in Adams, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties where Regence BlueShield does not have approval from the Blue Cross and Blue Shield Association to use the Blue Shield brand and logo.

AT RISK - the state of being subject to some uncertain loss or difficulty. In the financial sense, this refers to an individual, organization or insurance company assuming the chance of loss -- through running the risk of having to provide or pay for more services than paid for through rates. A second use of the term relates to the special vulnerability of certain populations to certain diseases or conditions; (i.e., workers in coalmines at risk for black lung disease).

BASIC BENEFITS or BASIC CONTRACT - a contract or schedule of benefits that requires no front-end deductible before benefits are payable.

BILLING - an itemized account of member or group rates owed to Regence BlueShield by the member or group.

BLUE CROSS and BLUE SHIELD ASSOCIATION (BCBSA) - a nonprofit corporation formed by Blue Cross and Blue Shield Plans to act as the national coordinating agency for independent licensees of the BCBSA. The office is located in Chicago, Illinois.

BLUECARD - see Interplan Teleprocessing Service.

BLUE SHIELD - the words and identification symbol used by a medical care corporation approved by the national Blue Cross and Blue Shield Association. The words are registered by the Blue Cross and BlueShield Association under the Federal Trademark Act.

BROKER-

1 - (legal definition) – an insurance solicitor, licensed by the state, who places business with a variety of insurance companies. A broker represents the buyer of insurance rather than the insurance company, but is paid commission by the insurance company.

2 - (common usage, as in this document) – refers to a broker or an agent. Often these terms are used interchangeably (as is the case in this document), although there is a distinct legal difference.

CAPITAL BENCHMARK – a formula used by the Blue Cross and Blue Shield Association to determine the balance between a Plan's capital and its risk. It's intended to gauge the financial health of member Plans.

CAPITATION – a provider financing arrangement whereby the patient selects the provider for a period of treatment and the provider is paid a flat amount per month for each patient who has selected him or her, regardless of the services provided.

CARE MANAGEMENT – a program under which a health plan's medical staff identifies patients with high-cost conditions or specific illnesses, assesses treatment methods and manages health care benefits to promote positive treatment outcomes and maximize use of the patient's benefits.

CARRIER – any organization offering insurance benefits. Also, organizations with which the Medicare Part B program contracts for local program administration.

CARVE-OUT – coverage that is offered to members of a group who are 65 years of age or older and who are covered by Medicare as primary. The coverage assures the employees over age 65 that their health care benefits are equal to the health care benefits received by employees of the same group who are under age 65. For this coverage, Regence BlueShield pays group plan benefits minus any amounts paid by Medicare.

CASE MANAGEMENT – see Care Management.

CATASTROPHIC COVERAGE – benefits included in certain insurance plans to protect insured individuals from extraordinary expense incurred as a result of serious or prolonged illnesses or injuries. Many plans with catastrophic coverage also place ceilings on how much the plan will pay for insured individuals' covered expenses during their lifetimes.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) – a division of the federal Department of Health and Human Services that is responsible for the administration of the Medicare and Medicaid contracts.

CERTIFICATE – page attached to an Individual contract that includes the name(s) of the member(s) to be covered, the effective date of the contract, and the rate.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) – the federal health care program for military dependents and retirees.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) – portions of the federal law that affect continuation of employer-based health benefit coverage beyond the point when termination would normally occur.

COINSURANCE – The member's percentage share for any benefits provided at less than 100 percent.

COMMERCIAL INSURANCE CARRIER – a company governed under the insurance laws of the state, usually for profit.

COMMUNITY-RATED – an approach for determining the rates for groups of a certain size. Rates are based on the average estimated costs (or experience) of medical claims for groups of the same general size.

COMPLEMENTARY BENEFITS – a plan for coverage that is designed to extend benefits of another health care program, such as a program to cover Medicare deductibles and coinsurance.

COMPOSITE RATE – one rate per subscriber regardless of the number of dependents covered.

CONCURRENT REVIEW – the review of inpatient hospitalization to assure it remains the most appropriate setting for the care being rendered.

CONTRACT – the legal agreement between a group or an Individual Plan member and Regence BlueShield.

CONTROL PLAN – a local Blue Cross and/or Blue Shield Plan that serves as headquarters for a national or statewide group account. A control plan determines rates, consolidates multi-plan bills and, in some cases, reimburses Plans that serve members of that group account.

CONVERSION – a method by which members who are no longer covered under a group plan may pay rates directly to Regence BlueShield and continue coverage under a Regence BlueShield plan. Benefits and rates will be different from the group plan.

COORDINATED CARE – see Managed Care.

COORDINATION OF BENEFITS (COB) – a provision designed to avoid duplicate payments or payments in excess of charges for benefits covered under more than one Individual or group contract.

COPAY – the amount, in addition to the rate, that the member is required to pay for certain services and supplies provided under the contract. The member is responsible for the payment of any copay directly to the provider of the service or supply.

COST SHARING – provisions of a health insurance contract that require the covered individual to pay some portion of covered medical expenses. Forms of cost sharing are deductibles, coinsurance and copays. In addition to being used to reduce rates, cost sharing is used to manage utilization of covered services (for example, by requiring a large copay for a service that is likely to be overused)

COST SHIFTING – usually, the practice of reducing federal government health care expenditures (i.e., Medicare), not by reducing actual cost, but by moving the responsibility for the costs, or a greater share thereof, to the states or the private sector.

CPT (Current Procedural Terminology) – the American Medical Association’s current procedure and terminology five-digit coding system that describes the service rendered by providers in terms of current medical practices.

CPT-4 CODES – the most recent edition of CPT codes. Participating providers must use these codes when billing Regence BlueShield.

CUSTODIAL CARE – care that, as determined by Regence BlueShield, is designed primarily to assist the patient in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial care includes, but is not limited to help with walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered.

CUSTOMARY CHARGE – the prevailing charge for the service or supply in the area by providers with similar professional standing.

D.D.S – Doctor of Dental Science, Doctor of Dental Surgery (oral surgeon).

DEDUCTIBLE – a member’s stated portion of the cost of care before certain contractual benefits are paid.

DEPENDENT – the subscriber’s lawful spouse; a natural child, adoptive child or a child legally placed for adoption, stepchild or legally designated minor ward of the subscriber who is primarily dependent on the subscriber, spouse or non-covered legal parent for support. Dependent children of or over a certain age (this age depends on the contractual agreement) can be excluded from coverage, unless they are incapacitated.

DIAGNOSIS – the statement of a medical condition or disease, the cause of which may not be determined.

DIRECT PAYMENT - payment made by Regence BlueShield directly to a participating provider for services rendered to a member. Also, the method by which members are billed and pay rates directly to Regence BlueShield.

DISPENSING FEE - a fee predetermined by Regence BlueShield paid to pharmacies for dispensing drugs.

D.M.D (Doctor of Dental Medicine) – a dentist who is not an oral surgeon.

D.O. (Doctor of Osteopathy) – a doctor practicing in the branch of medicine based on the theory that diseases are due chiefly to loss of structural integrity, which can be restored by manipulation of the parts and therapeutic measures (surgical or medicinal).

D.P.M. (Doctor of Podiatry Medicine) – a doctor practicing in the branch of medicine dealing with ailments of the foot. Podiatry is also called chiropody.

DRG (Diagnostic Related Group) – a method for reimbursing services based on diagnosis rather than actual services performed.

DRUG CARD PROGRAM – a prescription drug program in which the member shows an ID card to a participating pharmacy and pays a copay at the counter. The pharmacy then bills the carrier for the balance of the cost.

DSHS – standard abbreviation for Department of Social and Health Services in Washington state.

DUAL OPTION – an employee choice between two health insurance plans or health programs, usually a traditional health insurance program, HMO, or PPO.

ELECTRONIC DATA INTERCHANGE (EDI) – the process of submitting claims via magnetic tape, diskette, or telecommunication. A service available to Regence BlueShield providers as an alternative to paper claim submission.

ELIGIBLE OUT-OF-POCKET EXPENSES – a member's share of payment for benefits covered by a plan that is used for the accumulation of a stoploss provision.

EMERGENCY – the sudden and unexpected onset of a condition or the exacerbation of an existing condition requiring medically necessary care to safeguard the patient's life or limb immediately after the onset of the emergency. For the purpose of benefit determination, consideration will be given by Regence BlueShield to the symptoms of the condition and to the actions that would have been taken by a prudent person under such circumstances.

ENROLLMENT – the act of becoming covered under a contract; also, the total number of members covered under a contract.

EOB (Explanation of Benefits)– notification that is sent to members for each claim incurred.

ERISA (Employee Retirement Income Security Act of 1974) – a federal law primarily enacted to effect pension equality, ERISA also contains provisions to protect the interests of group insurance plan participants and beneficiaries. It requires, among other things, that insurance plans be established pursuant to a written instrument that describes the benefits provided under the plan, names the persons responsible for the operation of the plan, and spells out the arrangements for funding and amending the plan.

EXCLUSIONS – provisions in the contract stating situations, services or conditions for which benefits are not provided.

EXCLUSIVE PROVIDER ORGANIZATION – a type of plan that requires the member to use only designated providers or sacrifice reimbursement altogether. Other plans encourage members to use selected plan providers through more generous reimbursement, but will still reimburse for other plan providers.

EXPERIENCE – the extent that plan benefits are used by its members.

EXPERIENCE-RATED – the determination by Regence BlueShield of the group's rates wholly on the basis of the experience of that group (usually 150 or more subscribers).

EXTRAS (ANCILLARY SERVICES) – common hospital terminology meaning services other than bed, board and nursing care (e.g., drugs, dressings, operating services, special diets, etc.).

FEE SCHEDULE – a listing of accepted charges or established allowances for specified procedures. It represents a provider's or third party's standard or maximum charges for the listed procedures.

FIRST-DOLLAR COVERAGE – insurance that pays virtually all of the full cost of covered services, with little or no cost sharing (deductible, coinsurance or copay) by the member.

FORMULARY (Preferred Medication List)– a comprehensive list of generic and brand name-preferred drugs covered under a health plan's prescription drug benefit. The Regence BlueShield drug formulary was developed by leading providers and pharmacists on the basis of relative effectiveness and value and is intended to promote high-quality drug therapy while keeping prescription drug costs low. If two drugs are equivalent in effectiveness, then only the most cost-effective drugs are included in the formulary. The formulary is used for the Prescription Drug Card Program.

GENERAL NURSING SERVICE – all hospital nursing care other than that provided by private duty nurses.

GENERAL PRACTITIONER (GP) – a licensed physician who is engaged in general practice including surgery, medicine and obstetrics, but who does not specialize in a particular branch of medicine.

GRACE PERIOD – a specified period following the due date during which payment of the member rates may be made without penalty or suspension of coverage.

GROUP – a body of members enrolled through an employer, association or other organization that has complied with the applicable enrollment regulations.

GROUP ADMINISTRATOR – the person who has been designated by the group to act as its group's agent for benefit negotiations and for relaying information between Regence BlueShield and the group.

GROUP NUMBER – a six-digit number assigned by Regence BlueShield to identify a particular firm, group, or segment within a group.

HEALTH CARE AUTHORITY (HCA) – a state agency responsible for the administration of state employee health care benefits and Basic Health.

HEALTHCARE MANAGEMENT ADMINISTRATORS (HMA) – a subsidiary of Regence BlueShield. HMA is one of the largest locally owned third-party administrators in Washington state. The office is located in Bellevue, Washington.

HEALTH CARE SERVICE CONTRACTOR – a company similar to an insurance company, but formed under special laws and registered as such by the state insurance commissioner, that has participating providers who furnish medical services. Regence BlueShield is a health care service contractor.

HEALTH MAINTENANCE ORGANIZATION (HMO) – an organized private or public legal entity providing comprehensive hospital and medical services to individuals, families or groups for a fixed periodic rate, through either staff providers and owned facilities, or through participating agreements with providers. The HMO concept concentrates on preventive medicine and provides needed medical services on a continuing basis.

HEALTH RISK APPRAISAL – a survey used by employers to determine the likelihood of an insured experiencing illness or injury in the future. It helps employers decide whether wellness and other preventive care programs are advisable.

HOME HEALTH CARE – noncustodial care provided in a patient's home in lieu of medically necessary hospitalization.

HOSPICE CARE – care provided to a terminally ill patient during the last months of life, usually at home, but sometimes in a section of a hospital approved for hospice care.

ICDA (INTERNATIONAL CLASSIFICATION OF DISEASES) – a standard diagnosis coding system adapted for use in the United States.

ICD-9 CODES – the most recent edition of ICDA codes. Participating providers must use these codes when billing Regence BlueShield.

IDENTIFICATION CARD – the ID card presented to providers by Regence BlueShield members to establish positive coverage identification. It does not give authorization for services nor is it a guarantee of payment.

INCAPACITATED CHILD – under Regence BlueShield contracts, a natural child, adopted child or stepchild incapable of self-support because of developmental disability or physical handicap.

INDEMNITY – a fixed dollar payment for a specified health care service.

INDEMNITY BENEFIT – an allowance for benefits available to a maximum dollar limit.

INDEMNITY SCHEDULE – a predetermined allowance for each medical and surgical procedure in a given set of procedures.

INDEPENDENT BLUE SHIELD PLAN – a Plan that holds the license to operate as a Blue Shield Plan and belongs to the Blue Cross and Blue Shield Association. Each Plan in the Association is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which permits Plans to use the service mark in their respective service areas.

INDEPENDENT PRACTICE ASSOCIATION (IPA) – association of private practitioners, clinics and/or hospitals that provides medical services for a health plan.

INPATIENT – a person confined overnight in a hospital or other facility as a regularly admitted bed patient to whom a charge for room and board is made in accordance with the hospital's or facility's standard practice.

INSURANCE POOL –

(a) an organization of insurers or reinsurers through which particular types of risks are shared or pooled. The risk of high loss by any particular insurance company is transferred to the group as a whole (the insurance pool) with rates, losses and expenses shared in agreed amounts. The advantage of a pool is that the size of expected losses can be predicted for the pool with much more certainty than for any individual party in it. Pooling arrangements are often used for catastrophic coverage or for certain high-risk populations. Pooling may also be done within a single company by pooling the risks insured under various policies so that high losses incurred by one policy are shared with others;

(b) a group of insured individuals, usually with some common characteristics, who form a generic group large enough to serve as a base for actuarial evaluation and risk analysis.

INTEGRATED DELIVERY SYSTEM (IDS) – a system of organizations, practice groups and professionals that assumes the responsibility for the delivery and financing of a complete array of health services. It includes strategic partnerships of payers, providers and hospitals.

INTENSIVE CARE UNIT (ICU) – the area of a hospital that provides specialized, constant care for patients with critical conditions.

INTERMEDIARY – an organization that has an agreement with the Health Care Financing Administration to handle claims for and make payment to participating providers on behalf of Part A of Medicare.

INTERPLAN TELEPROCESSING SERVICES (ITS) – a system created by Blue Cross and Blue Shield Plans that allows Plans to use a common format for exchanging data electronically and sharing provider discount arrangements. Also referred to as the BlueCard program.

JOINT COMMISSION FOR THE ACCREDITATION OF HEALTH CARE

ORGANIZATIONS (JCAHO) – a private nonprofit organization that evaluates and accredits hospitals and other health care organizations in the areas of home care, mental health, ambulatory care and long-term care.

KING COUNTY MEDICAL SOCIETY – county organization of physicians established to advance the standards of medical education and practice and to promote the health and welfare of our community. It is not directly associated with Regence BlueShield.

LEGEND DRUG – a medical substance whose original packaging label under the federal Food, Drug and Cosmetic Act is required to bear the legend, “Caution: federal law prohibits dispensing without prescription.”

LICENSED PHYSICAL THERAPIST (LPT) – a licensed person engaged in physical therapy, which is the treatment of disability, injury and disease by external physical means, such as massage, exercise, heat, light, etc.

LINE OF BUSINESS – a classification or grouping of revenue, claims and administrative expenses by market segments to measure underwriting results.

LONG-TERM CARE – a program of coverage that provides skilled or custodial care to the elderly or to individuals who are chronically ill. Usually includes nursing home care and care in the home. Offered by Regence Life & Health.

LOSS RATIO – the relationship between case cost and member dues for the same period and on the same accounting basis (e.g., incurred in the calendar year and paid in the calendar year).

MAJOR MEDICAL – a coverage plan designed to pay or copay all or most medical expenses above certain deductible amount(s) and up to maximum amount(s). Coverage may supplement a basic plan.

MAJOR MEDICAL CONTRACT – a contract that requires satisfaction of a front-end deductible before any benefits are available.

MANAGED CARE – an integrated system of insurance, financing and health care delivery functions that:

- a) assumes financial risk for delivery of health services and uses a defined network of providers; or
- b) assumes financial risk for delivery of health services and promotes the efficient delivery of health services through provider assumption of some financial risk including capitation, prospective payment, resource-based relative value scales, fee schedules or similar method of limiting payments to health care providers. Managed care is sometimes referred to as “coordinated care.”

MANDATED BENEFIT – a benefit required by either state or federal law to be included in health care contracts.

MASSAGE THERAPY PRACTITIONER – a health practitioner who uses various hands-on techniques involving heavy or light stroking or deep pressure to promote healing. To be licensed, a therapist must have completed an approved training program and passed an exam.

MAXIMUM AMOUNT – total dollar amount allowed under a contract.

M.D. (Doctor of Medicine) – a doctor practicing in general medicine.

MEDICAID – state programs of public assistance to persons whose income and resources are insufficient to pay for health care. Title XIX of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

MEDICAL-SURGICAL BENEFITS – services performed and billed by a physician or other covered provider.

MEDICALLY NECESSARY – a service or supply that is required to diagnose or treat the condition; is consistent with the symptoms or diagnosis and treatment of the condition; is the most appropriate supply or level of service that is essential to the need; when applied to an inpatient, it cannot safely be provided on an outpatient basis, including diagnostic studies; is not an investigational service or supply; is not primarily for the convenience of the patient or provider. Medical necessity is determined by Regence BlueShield.

MEDICARE (TITLE XVIII OF THE SOCIAL SECURITY ACT) – the portion of the Social Security Act that provides health care benefits to citizens age 65 and older and to citizens who are disabled.

MEDICARE PART A – the part of Medicare law that provides hospitalization.

MEDICARE PART B – the part of Medicare law that provides medical and surgical benefits, as a supplementary program to Part A.

MEDICARE BENEFICIARY – an individual who has attained the age of 65, is a resident of the United States and is either a citizen or an alien lawfully admitted as a permanent resident who has resided in the United States continuously during the five years immediately preceding the month in which he or she applies for enrollment under Medicare. The individual must also be eligible to enroll in the insurance program established by Medicare, and be entitled to hospital insurance benefits of the Medicare Program. May also be a disabled individual under age 65.

MEDICARE CARVE-OUT – see Carve-Out.

MEDICARE SUPPLEMENT – a plan of benefits that generally covers some or all of the coinsurance and deductibles not covered by Medicare.

MEMBER – a person covered by a Regence BlueShield plan.

MESSAGE CODE – the code on a provider's payment voucher and/or a member's Explanation of Benefits that explains how a procedure was processed.

MINIMUM "PREMIUM" PLAN – a funding method to improve cash flow, whereby the employer assumes responsibility for funding most benefits and the insurer assumes liability for benefits above a predetermined level.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) – the association of insurance commissioners of various states formed to promote national uniformity in the regulation of insurance.

NATIONAL MANAGEMENT INFORMATION SYSTEM (NMIS) – a reporting system used by the Blue Cross and Blue Shield Association. Each Plan belonging to the Association is required to submit quarterly reports and undergo a triennial onsite audit to determine that performance standards are being met.

NATUROPATH – a health professional licensed by the state of Washington who follows a health care system based on supporting and maintaining the body's ability to heal itself. A naturopath's practice includes physical exams, diagnosis, and interpretation of laboratory tests, prescription of certain medications, herbal treatments and nutritional counseling. It also emphasizes prevention and non-invasive therapies. Naturopaths are trained to act as primary care providers or may engage in specialty practice. To be licensed they must have completed four years of training and passed a licensing exam. Under Regence BlueShield managed care plans, a participating naturopath can serve as a PCP.

NCQA (NATIONAL COMMITTEE FOR QUALITY ASSURANCE) – an independent nonprofit organization that sets standards and reviews managed care organizations. Its mission is to promote improvements in the quality of service provided through managed care health plans and their contracted providers.

NETWORK DATA EXPRESS (NDEX) – a subsidiary of Regence BlueShield that provides computer-to-computer electronic data interchange functions to the Northwest health care community, reducing administrative costs and speeding access to information for patient care.

NON-ASSIGNED CLAIM – a claim submitted by either the provider or the member in which payment is made to the member.

NON-LEGEND DRUG – an “over-the-counter” drug, which may be purchased without prescription.

NOT-FOR-PROFIT– a tax-exempt institution incorporated under the state not-for-profit enabling law. Not necessarily a charitable organization.

NUTRITIONIST– a health practitioner who provides nutritional counseling to individuals. A nutritionist may have identical training to a dietitian or may have completed a master’s or doctoral degree in nutrition from an accredited school and needs to be certified by the state. Under Regence BlueShield managed care plans; any service that is currently covered when provided by a dietitian will be covered when provided by a nutritionist.

OFF-LABEL – the prescribed use of a drug that is other than that stated in its FDA-approved labeling.

OFFICE OF THE INSURANCE COMMISSIONER (OIC) – in Washington state, an independent, elective office charged with enforcing the insurance code. The commissioner may make rules and regulations governing activities under the insurance code, conduct investigations to determine whether any person has violated any provision, take action against an insurance company or a health care service contractor by revocation or suspension of its certificate of authority, fine carriers, and revoke or suspend the licenses of insurance agents or fine them. The commissioner may go to court to stop an activity conducted by an individual licensed by the OIC office. The commissioner may also issue a cease and desist order.

OPEN ENROLLMENT PERIOD – the period once each year (usually 30 days prior to the group’s anniversary date) when employees can enroll for coverage or add dependents to their coverage. Coverage is usually effective on the anniversary date of the group’s contract.

ORAL SURGEON (D.D.S.) – same as a dentist, but also separately licensed for all surgery in and around the mouth.

OUT-OF-AREA PROVIDER – a provider outside the service area, acting within the scope of that provider’s license who belongs to a category of providers whose services or supplies would be covered if furnished in the service area. The out-of-area provider must have qualifications and license or certification equivalent to the qualifications and license of certification required for comparable provider category inside the service area. Outside Washington, an approved home health agency or hospice agency must be certified as such by Medicare.

OUTPATIENT – a patient who is not officially admitted as an inpatient, but who receives hospital care without occupying a hospital bed overnight.

PACKAGE NUMBER – a five-digit number assigned by Regence BlueShield to identify a specific set of benefits and rates for a given contract.

PACKAGES, BENEFITS, RATES SYSTEM (PBR) – Regence BlueShield system to define benefit codes and their rates and assign benefits to groups, forming benefit packages.

PARTICIPATING PROVIDER – a provider who entered into a current participating agreement with Regence BlueShield and whose name is included on the current list of participating providers for that contract as prepared by Regence BlueShield.

PEER REVIEW – evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review and claims review are all aspects of peer review.

PERSONAL CARE PROVIDER – (PCP) a Regence BlueShield participating provider who has entered into a current personal care provider agreement with Regence BlueShield and whose name is included in the current list of personal care providers for that contract as prepared by Regence BlueShield and provided to the group. Sometimes called a “Primary Care Provider.”

POS (POINT OF SERVICE) – a product similar to a PPO, except with fewer providers in the panel and more managed care features. For the highest level of benefits, the primary care physician is responsible for providing all care or referring the patient to an in-network specialist. Lesser coverage may be provided if the patient self-refers or uses a provider outside the panel.

PPO (PREFERRED PROVIDER ORGANIZATION) – an organization that contracts with a group of medical care providers who furnish services at discounted fees in return for prompt payment and a certain volume of patients.

PREADMISSION REVIEW – the process whereby a written or telephoned request is submitted to the Regence BlueShield Health Care Services Division to determine if hospital admission is medically necessary. Each approved hospital stay is assigned an appropriate length of stay. If preadmission approval is not obtained, benefits may be significantly reduced. This applies only outside Regence BlueShield service area for most groups.

PREADMISSION TESTING – routine laboratory tests and examinations performed in the hospital on an outpatient basis before admission for surgical care as an inpatient.

PREEXISTING CONDITION – under Regence BlueShield contracts, a condition for which medical advice was given or for which a health care provider recommended or provided treatment within three months before the effective date of coverage.

PREFERRED PLAN PROVIDER – a provider who has signed a current PPO agreement with Regence BlueShield and whose name is included on the current list of PPO providers for that contract as prepared by Regence BlueShield.

PREMIUMS – see Rates.

PREPAYMENT - method whereby a Blue Shield Plan provides benefits for members in any given month, upon receipt of monthly subscription rates from the member.

PRESCRIPTION DRUG – any state or federal legend drug requiring a prescription and dispensed by a licensed pharmacist.

PREVAILING RANGE OF FEES – the range of usual charges made by providers of similar ability and experience for the same service within the same geographic area.

PRIMARY CARE – the point at which a person first seeks assistance from the medical care system for the care of simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and treatment of illness.

PROBATIONARY PERIOD – the period of time during which a new employee is not yet eligible for benefit programs.

PROFESSIONAL SERVICES – services performed and billed by a physician, nurse or other provider, as opposed to services billed by a facility, such as hospital services.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION – a program initiated in 1972 by the Social Security-Medicare-Medicaid Bill (Public Law 92-603), which created a national network of local physician groups to review the necessity, quality and appropriateness of institutional care provided under the Social Security Act.

PRO/FILEsm – a highly sophisticated data and information system that analyzes physicians' practice patterns in Regence BlueShield's service area and identifies those doctors who use health care resources most efficiently and effectively. Pro/File was the system used to select providers for the Selections network.

PROSPECTIVE RATING – a method to develop a rate that generates income to support probable future experience. A prospective group rating approach determines a rate based on a group's own past experience and projects that into the coming contract year.

PROVIDER – an individual, institution or organization qualified to provide medical care services or supplies (e.g., hospital, physician or skilled nursing facility).

PSYCHIATRIST – a licensed physician specializing in the study and treatment of mental disorders and diseases, particularly the cause and nature of such.

PSYCHOLOGIST – a person who specializes in the science that studies the functions of the mind such as sensation, perception, memory, thought, and, more broadly, the behavior of an individual in relationship to his or her environment. A psychologist is not a physician.

RATES – total monies to be paid to Regence BlueShield each month or each quarter as consideration for the benefits offered by a contract.

RATING – the process of determining rates, or the cost of insurance, for individuals, groups or classes of risks.

REASONABLE CHARGE – a fee that meets the customary and prevailing criteria or in the opinion of a duly constituted medical society committee or according to medical opinion, is justified under what is considered a complexity of treatment that merits special consideration.

RECOGNIZED PROVIDER – a provider in the service area who does not have a contract with Regence BlueShield, but whose services may be covered to some extent by a particular contract.

RECIPROCITY – a cooperative system among Blue Shield Plans to provide coverage for members who require the care of a physician in another Plan area.

REGENCE BLUECROSS BLUE SHIELD OF OREGON - One of four regional Blue Shield Plans that affiliated under The Regence Group in 1995. The office is located in Portland, Oregon.

REGENCE BLUECROSS BLUE SHIELD OF UTAH – One of the three regional Blue Shield Plans that affiliated under The Regence Group in 1995. The office is located in Salt Lake City, Utah.

REGENCE BLUE SHIELD – a health care service contractor in Washington state. Also, an affiliate of The Regence Group. It provides medical, surgical, hospital, prescription drug, vision and/or dental benefits on a prepaid basis to individuals and groups in Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom and Yakima counties. Corporate headquarters are located in Seattle, Washington.

REGENCE BLUE SHIELD OF IDAHO – One of three regional Blue Shield plans that affiliated under The Regence Group in 1995. The main office is located in Boise, Idaho.

THE REGENCE GROUP – The holding company that oversees the affiliation of Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah and Regence BlueShield.

REGENCE LIFE & HEALTH (RLH) – a wholly owned subsidiary of Regence BlueShield, organized to sell products other than medical coverage. RLH offers life, accident, disability, capitation dental care, long-term care and employee assistance coverages.

REGISTERED NURSE (RN) – a nurse who has passed the state board qualifying examination and who has been registered and legally licensed to practice by state authority.

RELATIVE VALUE SCALE OR SCHEDULE (RVS) – a coded listing of physician or other professional services using units that indicate the relative value of the various services performed, taking into account the time, skill and cost required for each service. Appropriate conversion factors are used to translate the units into dollar fees for each service.

REMITTANCE NOTICE – a form from Regence BlueShield that accompanies the provider's check. Also known as a "voucher," it lists the control numbers, patients' names and the amount paid on each claim.

RENEWAL – the period each year when benefits and/or rates may be adjusted for the next contract year. The renewal date is usually the same as the contract anniversary date.

RESERVE – the amount of the earnings of a health plan set aside to meet future losses or contingent liabilities (e.g., contingency reserve, operating reserves, etc.).

RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) – a provider payment methodology based on measurement of resources the physician uses in each specific procedure and service, from physical, intellectual and emotional effort to overhead and training.

RETENTION – the amount of administrative fees Regence BlueShield charges an employer group as the cost of doing business.

RETROSPECTIVE RATE CREDIT – a credit of unused rates made available to an employer group at the time of its rate renewal because of lower claims usage by its members than was projected in previous rates.

RIDER – a provision added to a contract whereby the benefits, rates or other provisions are revised or amended.

RISK – chance of gain or loss.

SECOND SURGICAL OPINION (SSO) – a provision that encourages patients to obtain a second opinion before undergoing non-emergency surgery

SELECTIONS[®] – a point-of-service plan offered by Regence BlueShield to individuals and employer groups. Primary care providers in Regence BlueShield's Selections network are known as Personal Care Providers (PCP).

SELECTIONS PLAN PROVIDER – a provider whose name is included on the current list of Selections providers for that contract as prepared by Regence BlueShield and provided to the group and who has signed a current Selections agreement with Regence BlueShield.

SELF-INSURANCE – the practice of an individual, group of individuals, employer or organization assuming complete responsibility for losses that might be insured against, such as health care expenses. In such cases, health care expenses would be financed out of current income, savings or a fund developed for the purpose.

SERVICE AREA – the geographic area in which Regence BlueShield has contracted providers.

SERVICE BENEFITS – hospital and/or medical and surgical services available to a member by participating providers.

SKILLED NURSING FACILITY – an institution primarily engaged in providing inpatient skilled nursing care or rehabilitation services for injured, disabled or sick persons. Also called an extended care facility.

STOPLOSS PROVISION – the dollar limit of coinsurance amounts that the member is responsible to pay during a calendar year; after the member has reached this limit, Regence BlueShield will pay most benefits at 100 percent of the allowed amount for the remainder of the calendar year. The member's annual deductible, any copays, any difference between the allowed amount and the provider's actual charge, any coinsurance required when the cost containment provisions are not satisfied, and any balance that remains after benefit limits have been expended do not count towards the stoploss. The contract may indicate that certain benefits are exempt from the stoploss provision, meaning they are paid at a given percentage regardless of stoploss.

SUBROGATION – the right of Regence BlueShield to reclaim payments for benefits paid by Regence for which a third party is legally liable.

SUBSCRIBER – the person whose application for coverage under a particular contract has been accepted by Regence and on whose behalf the rate for coverage is paid, or the person responsible for paying the rate for coverage.

SUPPLIER – an institution, business, or organization qualified to provide medical or surgical equipment (e.g., orthopedic or surgical supply companies, and pharmacies).

TACOMA AMBULATORY SURGERY CENTER (TASC) – Washington state's only multi-specialty, freestanding surgery center, accredited by the national Accreditation Association for Ambulatory Health Care. The facility is owned by Regence BlueShield and is located in Tacoma.

TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) – a federal law that amends the Age Discrimination in Employment Act of 1967 by requiring any company with 20 or more employees to offer the same health benefits to employees and spouses aged 65 and over that are provided to younger employees.

THIRD-PARTY ADMINISTRATOR – an organization that provides certain administrative services to group benefit plans, including premium accounting, claims review and payment, claims utilization review, maintenance of employee eligibility records and negotiations with insurers that provide stoploss protection for large claims.

TOTAL DISABILITY – a condition whereby a person is prevented, solely because of illness or accidental injury, from engaging in any occupation for which the person is reasonably qualified by education, training or experience; and is performing no work for compensation or, if not previously employed, is prevented from engaging in most of the normal activities of a person of like age and sex in good health.

TRICARE – Nationwide Department of Defense (DOD) managed care program, operated in partnership with civilian contractors, that is designed to ensure high-quality consistent health care benefits; preserve beneficiaries' choice of health care providers; improve access to care; and contain care costs. The program offers a choice of a health maintenance organization, a preferred provider organization, or a fee-for-service program (the former CHAMPUS program).

UNDERWRITING – the process of selecting, classifying, evaluating and assuming risks according to insurability.

UTILIZATION MANAGEMENT – evaluation of the efficient use of professional medical care, services, procedures and facilities. Activities include such things as preadmission review, admission review, concurrent review; benefits case management and provider profiling.

WAITING PERIOD – the period of time between the member's effective date of coverage and the date that Regence BlueShield will provide benefits for certain services.

WILLAMETTE DENTAL GROUP (WDG) – a group of dentists, affiliated with the Willamette Dental group in Oregon, with offices located in Washington state. Regence BlueShield contracts with WDG to provide dental coverage as a capitation plan under the Columbia Dental Plan for groups and individuals.