



Glossary of Terms and Acronyms – Revised: 8/8/2011

These terms are defined for general information purposes only; certain terms may have varying definitions based on state law.

A

Aggregate Deductible.

The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. If You have single coverage (self only), the single Deductible is the amount You must pay. If You have family coverage (two or more covered family members), the family Deductible is the total amount any one or more covered family members must pay.

Allowable Expense(s)

Any Medically Necessary health expense, part or all of which is covered under any of the plans covering the Member for whom claim is made. A health care service or expense including deductibles, coinsurance or Copayments that is covered in full or in part by any of the plans covering the Member. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an **Allowable Expense**. Plan documents will show examples of expenses or services that are or are not allowable.

Adjudication

The process used by health plans to determine the availability of benefits for a claim.

Ambulatory Surgery

Surgical procedures performed that do not require an overnight hospital stay. Also see Outpatient Surgery.

Appeals

A process used by a member to request the health plan re-consider a previous authorization or claim decision.

Authorization

See Preauthorization/Pre-certification

B

Benefit

Payment received for covered services under the terms of the policy.

Benefit Period

The maximum length of time for which benefits will be paid.

Brand Name Drug

A prescription drug that is protected by trademark registration.

C

Capitation

A method of paying medical providers through a pre-paid, flat monthly fee for each covered person. The payment is independent of the number of services received or the costs incurred by a provider in furnishing those services.

Case Management

A process of identifying individuals at high risk for problems associated with complex health care needs and assessing opportunities to coordinate care to optimize the outcome.

Certification

See Preauthorization/Pre-certification

Chemotherapy

Treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic Care

An alternative medicine therapy administered by a licensed Chiropractor. The Chiropractor adjusts the spine and joints to treat pain and improve general health.

Claim

A request for payment of benefits for health care services provided to a member.

Coinsurance

The portion of covered expenses that a member is responsible for paying, after first meeting any applicable deductible amount.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA, requires group health plans with 20 or more employees to offer continued health coverage for you and your dependents for 18 months after you leave your job. Longer durations of continuance are available under certain circumstances. If you opt to continue coverage, you must pay the entire premium, plus a two percent administration charge.

Contract

A legal agreement between an individual subscriber or an employer group ("Contract holder"), and, a health plan that describes the benefits and limitations of the coverage. Also known as a Benefit Certificate or Policy.

Conversion Option

An option to purchase individual coverage at a negotiated rate by a person who is leaving an employee group.

Coordination of Benefits (COB)

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their benefits and provides the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision; it does not have to pay its benefits first. Plan documents include a description of the COB provision.

Copayment

The specified dollar amount or percentage required to be paid by or on behalf of a Member in connection with benefits.

Covered Benefits or Covered Services

Those medically necessary services and supplies which are covered in whole or in part under the plan, subject to all the terms and conditions of the group agreement or group insurance policy

Custodial Care

Any type of care where the primary purpose of the type of care provided is to attend to the Member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the Member, general maintenance care of colostomy or ileostomy.

Credentialing

A systematic approach to assessing a provider's qualifications and record on issues relating to professional competence and conduct. This includes a review of relevant training, academic background, experience, licensure, certification, etc..

Customary and Reasonable

The amount customarily charged for the service by other providers in the same geographic area (often defined as a specific percentile of all charges in the community), and the reasonable cost of services for a given patient. **Also called "Usual, Customary, and Reasonable"(UCR).**

D

Day Treatment Center

An outpatient psychiatric facility that is licensed to provide outpatient care and treatment of mental and nervous disorders or substance abuse under the supervision of physicians.

Deductible

An amount that a Member must pay for Covered Services in a specified time period in accordance with the Member's Plan before the Plan will pay benefits.

Dependent

A person who is eligible to be enrolled for coverage by the subscriber as determined by the employer and agreed upon with the plan. Examples would be a subscriber's spouse or child.

Diagnostic Tests

Tests and procedures ordered by a provider to determine if a patient has a specific condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include, but are not limited to, radiology, ultrasound, nuclear medicine, and laboratory and pathology services or tests.

Durable Medical Equipment (DME)

Equipment which is a) made for and mainly used in the treatment of a disease or injury; b) made to withstand prolonged use; c) suited for use while not confined as an inpatient in the Hospital; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

Drug Formulary

A listing of prescription drugs established by the health plan, which includes both Brand Name Prescription Drugs, and Generic Prescription Drugs. This list is subject to periodic review and modification by the health plan.

E

Effective Date

The date on which the coverage under a member's plan goes into effect at 12:01a.m.

Embedded Deductible.

The amount You and Your Dependents must pay for Covered Services including Prescription Drugs within a calendar year, before any benefits will be paid by the Plan. The single Deductible is the amount each Covered Person must pay. The family Deductible is the total amount any **two** or more covered family members must pay.

Emergency

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. **Also called Medical Emergency.**

Enrollee

See Member

Exclusions

Specific conditions or circumstances that are not covered for benefits under the Plan.

Explanation of Benefits

For certain PreferredChoices® plans, an Explanation of Benefits form is provided to members to explain how the payment amount for a health benefit claim was calculated. Among other things, the Explanation of Benefits may explain the claims appeal process.

F

Flexible Spending Account (FSA)

A Flexible Spending Account is an account funded by employee salary deferral elections and, in some cases, employer contributions, for the purpose of reimbursing expenses on a pre-tax basis. Most plans offer two types of accounts: Medical (also called Health Care) for reimbursement of eligible medical, dental, vision, prescription and over-the-counter drug expenses; and Dependent Care for reimbursement of day care expenses.

Flexible Spending Account, Limited (Limited FSA)

A Flexible Spending account that is limited to dental, vision or preventive care only. Can be used in conjunction with an HRA or HSA.

Formulary

See Drug Formulary

G

Generic Drug

A prescription drug, which is not protected by, trademark registration, but is produced and sold under the chemical formulation name.

H

Health Benefit Plan

The health insurance or HMO product offered by a licensed health benefits company that is defined by the benefit contract and represents a set of covered services or expenses accessible through a provider network, if applicable, or direct access to licensed providers and facilities.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is a federal law enacted in 1996. It was designated to improve availability and portability of health coverage by:

- limiting exclusions for pre-existing conditions;
- providing credit for prior health coverage;
- allowing transmittal of the coverage information (i.e., covered family members and coverage period) to a new insurer;
- providing new rights to allow individuals to enroll for health coverage when they lose their health coverage or have a new dependent;
- prohibiting discrimination in enrollment/premiums
- guaranteeing availability of health insurance coverage for small employers.

HIPAA's Administrative Simplification and Privacy (AS&P) Act final rules took effect in April 2001. The purpose of these rules is to improve the efficiency of the health care system by standardizing the electronic exchange of health information and protecting the security and privacy of member-identifiable health information.

Health Maintenance Organization (HMO)

A third party legal entity which arranges payment for the provision of basic and supplemental health services to its members from a network of independently contracted providers and facilities on a prepaid or reduced fee basis. For most plans, members are required to select a network primary care physician to provide routine care and provide referrals for hospital services when appropriate. Some Paramount HMO plans do not require the member to select a PCP or obtain referrals and members can self refer for covered services within the network. Some PreferredChoices® plans provide coverage for services from out-of-network providers.

Health Reimbursement Account (HRA)

A Health Reimbursement Account (HRA) is an employer-sponsored benefit program under which employees may receive reimbursement for medical expenses. An HRA may be offered in conjunction with a high-deductible OR other type of health plan - an HDHP is not required. Under an HRA plan, the employer reimburses the employee for qualified medical care expenses. The HRA provides reimbursement up to the maximum dollar amount established by the employer group for the coverage period and any unused portion may be carried forward to the next coverage period – as defined by the employer.

Health Risk Appraisal/Assessment (HRA – now known as HRiskA)

A Health Risk Assessment (HRiskA) is a tool used to evaluate the health of a given member.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a special tax-sheltered savings account that is similar to a traditional Individual Retirement Account (IRA), but designated for medical expenses. An HSA allows you to pay for current health expenses and save for future qualified medical and retiree health care expenses on a tax-free basis. Contributions, earnings, and qualified distributions all are exempt from federal income and Social Security (FICA) taxes.

Home Health Care

Skilled nursing and other therapeutic services provided by a home health care agency in a home setting as an alternative to confinement in a hospital or skilled nursing facility.

Home Infusion Therapy

The administration of intravenous drug therapy in the home.

Hospice Care

This is palliative and supportive care, either on an inpatient or outpatient basis, given to a terminally ill person and to his or her family. The focus of hospice programs is to enable terminally ill patients to remain, for as long as they can, in the familiar surroundings of their home.

Hospital

An institution rendering inpatient and outpatient services, accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, or as otherwise determined by Paramount as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

I-L

ID Card

Your PreferredChoices® member ID card provides proof of your PreferredChoices® coverage. An ID card is sent to you after we accept your enrollment form. As of your effective date, your copy of the enrollment form may be used as a temporary membership card until you receive your permanent card. Your PreferredChoices® ID card includes your member identification number, as well as your toll-free phone number to contact PreferredChoices® Member Services. If you need to **request a new ID card**, you may do so through our Member Services page.

Indemnity Plan

A traditional indemnity plan allows members flexibility in their choice of recognized health care providers for covered expenses. Members are responsible for seeking care, initiating pre-certification, paying for services rendered, and submitting claims for reimbursement of covered services. Indemnity plans traditionally have out of pocket expenses such as deductibles and coinsurance which the member must pay before any expenses are paid under the plan. Benefit maximums and lifetime maximums also apply to the plan.

Independent Practice Association (IPA)

A legal entity or other group of providers that contract with managed care plans while maintaining their separate practice. A member who selects an IPA-affiliated primary care office generally will be referred to specialists and hospitals affiliated with the IPA, unless the member's medical needs extend beyond the capability of these providers.

In-Network

Refers to the use of providers who participate in the health plan's provider network.

Infusion Therapy

Treatment accomplished by placing therapeutic agents into the vein, including intravenous feeding. Such therapy also includes enteral nutrition which is the delivery of nutrients into the gastrointestinal tract by tube.

Inpatient Care

Service provided after the patient is admitted to the hospital. Inpatient care lasts 24 hours or more.

Lifetime Limit

A cap on the benefits paid under a policy. Many policies have a lifetime limit of \$1 million, which means that the insurer agrees to cover up to \$1 million in covered services over the life of the policy.

M

Managed Care

Any form of health plan that uses selective provider contracting to have patients seen by a network of contracted providers and that requires pre-authorization of certain services.

Medical Emergency

See Emergency

Medically Necessary

See Necessary

Member

A subscriber or dependent who is enrolled in and covered by a health care plan. Also called **Enrollee**.

Member Services

The PreferredChoices® Member Services department assists members with questions about plan benefits and exclusions and, if applicable to your plan, selecting or changing a primary care physician (PCP). Calling the toll-free number on your ID card will connect you with your plan's PreferredChoices® Member Services office. If you do not have your ID card yet, contact your employer's benefits office for your Member Services toll-free number.

Mental Disorder

A dysfunctional manifestation in the individual that may be physical, psychological or behavioral, and for which treatment is generally provided by under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker.

N

National Committee for Quality Assurance (NCQA)

The National Committee for Quality Assurance (NCQA) is an independent, not-for-profit organization that evaluates managed care plans. The NCQA accreditation process is nationally recognized and evaluates how well a health plan manages all aspects of its medical delivery system and the extent to which it continuously improves health care for its members.

Necessary, Medically Necessary, Medically Necessary Services, or Medical Necessity

Services or supplies that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section of the plan documents. **Medical Necessity**, when used in relation to services, shall

have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by the Plan of whether health care services are covered benefits under the plan. All services are subject to the exclusions and limitations described in the plan documents. **Network**

Physicians, hospitals and other health care providers who contract with Paramount to participate in health benefits plans. For certain PreferredChoices® plans, a member must access care through the network to receive the maximum level of benefits. Also called **Provider Network**.

Non-Participating Provider

This term is generally used to mean providers who have not contracted with a health plan to provide services at reduced fees. **Also called Non-Preferred Care Provider.**

O

Occupational Therapy

Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, and bathing.

Out-of-Network

The use of health care providers who have not contracted with the health plan to provide services. Members enrolled in preferred provider organizations (PPO) and point-of-service (POS) coverages can go out-of-network for covered expenses, but will pay additional costs in the form of deductibles and coinsurance and will be subject to benefit and lifetime maximums. Because reduced fees are not negotiated with out-of-network providers, Paramount will calculate reimbursement based on the usual, customary and reasonable charge, (see *definition*). Members are responsible for all charges above UCR in addition to any deductible and coinsurance provisions.

Out-of-Pocket Maximum

The maximum out of pocket amount that an enrollee will have to pay for expenses covered under the health plan. The maximum may be a coinsurance maximum or a copayment maximum. Generally the out of pocket maximum is calculated by the sum of all paid deductible and copayment or coinsurance amounts. Some POS plans may have two types of out of pocket maximums, and the member is required to meet both maximums before the plan pays expenses 100%. Once member reaches the out of pocket maximum(s), the plan pays 100% of expenses for covered services.

Outpatient Care

Care provided in a clinic, emergency room, hospital or non-hospital surgical facility ("SurgiCenter") without admission to the hospital or facility.

Outpatient Surgery

Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center, or physician office. Also see Ambulatory Surgery.

P-Q

Participating Provider

Any physician, hospital, skilled nursing facility, or other individual or entity involved in the delivery of health care or ancillary services which contracts to provide Covered Services to Members for a negotiated charge. **Also called Preferred Care Provider.**

PCP

See Primary Care Physician

Physical Therapy

Treatment involving physical movement to relieve pain, restore function and prevent disability following disease, injury, or loss of limb.

Plan Documents

Plan documents include the Group Agreement, Group Policy, and Certificate or Evidence of Coverage (or Certificate of Insurance).

Point-of-Service Plan

A point of service plan provides benefits for covered services received from both participating and non-participating providers. When you enroll in a point-of-service plan, you choose a primary care physician (PCP) for yourself and each covered dependent. In order to minimize your out of pocket expenses, you must access care through your PCP, except for emergency care or direct access benefits. You are responsible for a copayment, or coinsurance. Participating/preferred providers will pre-certify all necessary services and may not balance bill you. Care received on a self-referred or non-preferred basis will subject you to higher out of pocket costs such as deductibles, coinsurance and balance billing. You are also responsible for obtaining pre-certification for services provided by non-network providers.

Preauthorization / Pre-certification (Also known as Authorization, Certification, or Prior Authorization)

Certain healthcare services, such as hospitalization or outpatient surgery, require pre-certification with Paramount to ensure coverage for those services. When a member is to obtain services requiring pre-certification through a participating provider, this provider should pre-certify those services prior to treatment. If your plan covers self-referred services to network providers or out-of-network benefits and you may self-refer for covered benefits, it is your responsibility to contact Paramount PreferredChoices® to pre-certify those services which require pre-certification to avoid a reduction in benefits paid for that service.

Pre-Existing Condition

A health condition (other than a pregnancy) or medical problem that was diagnosed or treated during a specified timeframe prior to enrollment in a new health plan. Some pre-existing conditions may be excluded from coverage during a specified timeframe after the effective date of coverage in a new health plan. Plan documents will provide specific information on pre-existing conditions.

Preferred Provider Organization (PreferredChoices®)

Paramount's preferred provider organization (PPO) plan is called PreferredChoices®. Members may choose any licensed health care providers for covered expenses; however, they will have lower out of pocket expenses when they utilize participating

providers. Members do not need to select a primary care physician to manage their care and can self-refer to providers either in or out-of-network.

Prescription

An order of a prescriber for a prescription drug. If it is an oral order, it must promptly be put in writing by the pharmacy.

Primary Care Physician (PCP)

A Participating Physician who supervises, coordinates and provides initial care and basic medical services as a general or family care practitioner, or in some cases, as an internist or a pediatrician to members, and maintains continuity of patient care.

Prior Authorization:

See Preauthorization

Prosthetic Devices

A device that replaces all or a portion of a part of the human body. These devices are necessary because a part of the body is permanently damaged, is absent, or is malfunctioning.

Provider

A licensed health care facility, program, agency, physician, or health professional that delivers health care services.

Provider Network:

See Network

R

Radiation Therapy

Treatment of a disease by x-ray, radium, cobalt, or high-energy particle sources.

Reasonable Charge

The charge for a covered benefit, which is determined by Paramount to be the prevailing charge level, made for the service or supply in the geographic area where it is furnished. Paramount may take into account factors such as the complexity, degree of skill needed, type or specialty of the Provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Reasonable Charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

Referral

Required when referring to a out of network specialists. May also be used for in-network hospital or other services, where appropriate. A referral may be written or electronic.

Respiratory Therapy

Treatment of illness or disease that is accomplished by introducing dry or moist gases into the lungs.

S

Second Opinion

The voluntary option or mandatory requirement to visit another physician or surgeon for an opinion regarding a diagnosis, course of treatment or having specific types of elective surgery performed.

Service Area

The geographic area the HMO or PPO is licensed to operate, where applicable, or when licensing is not required, the geographical area where an adequate network is established to provide the services covered under the benefit plan.

Skilled Nursing Facility (SNF)

An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by the health plan to meet the reasonable standards applied by any of the aforesaid authorities.

Speech Therapy

Treatment for the correction of a speech impairment that resulted from birth, or from disease, injury, or prior medical treatment.

Subscriber

The employee covered under an employer's group agreement or group insurance policy. The subscriber can enroll eligible dependents as determined by the contract holder under family coverage.

Specialist

A Physician who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

T

No entries for this letter.

U-V

Usual, Customary, Reasonable (UCR)

See Customary and Reasonable

Urgent Care

Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever.

W

Well Baby/Well Child Care

Generally, refers to routine care, testing, checkups and immunizations for a generally healthy child from birth through the age of eight.

Wellness Program

A health management program that incorporates the components of disease prevention, medical self-care, and health promotion. It utilizes proven health behavior techniques that focus on preventing illness and disability which respond positively to lifestyle related interventions.

X-Z

No entries for these letters
