GLOSSARY

ABMS - Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Accreditation - An evaluative process in which a health care organization undergoes an examination of its policies and procedures to determine whether the procedures meet designated criteria as defined by the accrediting body, and to ensure that the organization meets a specified level of quality.

Action - An activity of EmblemHealth or its subcontractor that results in:

- Denial or limited authorization of a service authorization request, including the type or level of service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure of EmblemHealth to act within the time frames for resolution and notification of determinations regarding complaints, action appeals and complaint appeals

Action Appeal - Oral or written request for EmblemHealth to review or reconsider an action by EmblemHealth or its subcontractor.

Actual Charge - The amount a physician or other practitioner actually bills a patient for a medical service or procedure.

Acute Illness - A physical condition or illness that begins abruptly and requires medical care or restricted activity for a short period of time (usually three months or less).

Adjudication - The process by which a claim is paid or denied based on eligibility and contract determination.

Admission - Formal acceptance as an inpatient by an institution, hospital or health care facility.

Admitting Physician - The physician responsible for admission of a patient to a hospital or other inpatient health facility.

Adverse Determination - A determination by EmblemHealth or its agents that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, is not medically necessary.

Allowed Charge - The amount EmblemHealth will reimburse for covered services rendered by out-of-network providers.
Ambulatory Care - All types of health services provided on an outpatient basis.

Ambulatory Care Facility - A medical care center that provides a wide range of health care services, including preventive care, acute care, surgery and outpatient care in a centralized facility.

Ambulatory Surgery - Surgical procedures that do not require an overnight hospital stay. Procedures can be performed in a hospital or a licensed surgical center. Also called Outpatient Surgery.

American Board of Medical Specialties - Organized originally in 1933 as the Advisory Board of Medical Specialties, the ABMS (1970), in collaboration with the American Medical Association (AMA), is the recognized certifying agent for establishing and maintaining standards of medical specialization and pattern of training.

Ancillary Services - Auxiliary or supplemental services (i.e., diagnostic services, physical therapy and medications) used to support diagnosis and treatment of a patient's condition.

Appeal - Oral or written request from a member or their designee for EmblemHealth to review or reconsider a decision made by the plan.

Assignment - An agreement in which a patient assigns to another party, usually a physician or hospital, the right to receive payment from a public or private insurance program for the service the patient has received.

Attending Physician - The physician primarily responsible for the care of a patient during hospitalization. The physician is licensed, board-certified or board-eligible and qualified to practice in the area appropriate to treat the member's life-threatening or disabling condition or disease. The attending physician must be a network provider with EmblemHealth or one to which EmblemHealth has referred the member.

Authorization - Services that have been approved for payment based on a review of EmblemHealth's policies.

Authorized - Services that have been approved for payment based on a review of EmblemHealth's policies.

Balance Billing- Billing a member or other responsible party for the difference between the insurer's payment and the actual charge.

Beacon Health Options - Provides managed mental health and substance abuse (MHSA) programs, workplace services, employee assistance programs (EAP), psychiatric disability management, Medicaid behavioral health management and child welfare programs for over 23

million lives. Visit the Beacon Health Options website at **https://www.beaconhealthoptions.com/**.

Behavioral Health - Conditions that affect thinking and the ability to figure things out that affect perception, mood and behavior.

Benefit Plan – A health insurance product offered by a health plan company that is defined by the benefit contract and represents a set of covered services. Also called a health benefit plan.

Benefit Program - Any HMO (with or without primary care physician referral requirements), POS, Medicaid, Child Health Plus, Medicare Advantage, ASO or other line of business offered by the EmblemHealth plans.

Benefits - Services available to a member as defined in his or her contract. Benefit design includes the types of benefits offered, limits (e.g., number of visits, percentage paid or dollar maximums applied) and subscriber responsibility (cost sharing components).

Benefits Exhausted - When the maximum number of visits for a specific service is reached, further benefits will not be considered.

Board Certification - A process by which a physician who has been tested for proficiency in a medical specialty or subspecialty, by a medical specialty board, has passed those tests and been certified as proficient in that medical specialty.

Brand Name Drug - A prescription drug that has been patented and is only available through one manufacturer.

Carrier - An insurance company that either administers insurance or self-insures.

Case Management - A program that assists the patient in determining the most appropriate and cost effective treatment plan, including coordinating and monitoring care with the ultimate goal of achieving the optimum health care outcome.

Centers for Medicare & Medicaid Services - The government agency responsible for administering the Medicare and Medicaid programs.

Certificate of Insurance - The member's Certificate of Insurance is evidence of coverage under the Group Contract between EmblemHealth and the member's group. The Certificate of Insurance typically consists of a booklet along with an Attachment (the "Certificate Attachment" and any applicable riders or amendments). Together these documents describe the health insurance benefits available to the member from EmblemHealth as well as other important applicable information to the member's coverage.

Certification- A process in which an individual, institution or educational program is evaluated and recognized as meeting certain predetermined standards. Certification usually applies to

individuals; accreditation to institutions.

Chemical Dependency - The use of one or more drugs for purposes other than those for which they are prescribed or recommended.

Chemotherapy - Treatment of malignant disease by chemical or biological antineoplastic agents.

Chiropractic Care - An alternative medicine therapy administered by a licensed chiropractor. Chiropractors specialize in the relief, correction, and prevention of musculoskeletal problems of the spine, peripheral joints and related areas through manipulation.

Chronic Care - A pattern of medical care that focuses on long-term care of chronic diseases or conditions.

Claim - An itemized statement of health care services and their costs provided by a hospital, physician's office or other health care facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.

Claim Form - An application for payment of benefits under a health care plan.

Clinical Decision - A decision about the patient's medical treatment.

Clinical Issue - Information relating to the patient's health.

Clinical Peer Reviewer - A physician who possesses a current and valid license to practice medicine or a health care professional other than a licensed physician who:

- Where applicable possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body to the profession
- Is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care service or treatment under review

Clinical Professional – A doctor, nurse or other health care professional.

Clinical Rationale - A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the patient's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review – Occurs when a clinical professional reviews information about a patient's health.

Clinical Review Criteria - The written screens, decision rules, medical protocols or guidelines

used by the utilization management agent as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures and services under the auspices of the applicable health benefit plan.

CMS - The government agency responsible for administering the Medicare and Medicaid programs.

COB - When a member is covered by more than one benefit plan, with both providing similar benefits, EmblemHealth coordinates with the other carrier to ensure appropriate reimbursement. Also called Coordination of Benefits.

COBRA - A federal act that requires an eligible group's health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment. Also called the Consolidated Omnibus Budget Reconciliation Act.

Coinsurance - A percentage of the allowed charge that is payable by the member, not EmblemHealth, for covered services rendered by an out-of-network provider. After the member has met his or her deductible, EmblemHealth will pay a percentage of the allowed charge for those covered services in accordance with the member's benefit program. The member is responsible to pay the remaining percentage of the allowed charge. This remaining percentage is the coinsurance charge.

Community-based Long-Term Services and Supports - A range of medical, habilitation, rehabilitation, home care or social services a person needs over months or years to improve or maintain function or health that are provided in the person's home or a community-based setting such as an assisted-living facility. These home and community-based services are designed to meet an individual's needs as an alternative to long-term nursing facility care and to enable a person to live as independently as possible. Also called community-based LTSS.

Complaint - Initial oral or written communication from a member or their designee or provider that expresses discontent with any aspect of their care or coverage with EmblemHealth. Specifically, it is dissatisfaction with:

- A determination made by the plan, other than a determination of medical necessity or a determination that a service is considered experimental or investigational
- Treatment experienced through the plan, its providers or contractors
- Any concern with the plan, its benefits, employees or providers.

Consolidated Omnibus Budget Reconciliation Act - A federal act that requires an eligible group's health plan to allow employees and certain dependents to continue their group coverage for a stated period of time following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment. Also called COBRA.

Consultation - Services rendered by a physician whose opinion or advice is requested by another physician for further evaluation or management of the patient.

Consumer - An individual person who is the direct or indirect recipient of the services of the organization. Depending on the context, consumers may be identified by different names, such as "member," "enrollee," "beneficiary," or "patient." A consumer relationship may exist even in cases where there is not a direct relationship between the consumer and the organization. For example, if an individual is a member of a health plan that relies on the services of a utilization management organization, then the individual is a consumer of the utilization management organization.

Continuing Care Services Program - Utilization review activities performed by a utilization management agent that include evaluation of requests for prior approval where necessary for covered services.

Contraception - The process by which pregnancy is prevented by either barring conception of an embryo or the implantation of an embryo in the uterine wall.

Contract - A legal agreement between an individual member or an employer group and a health plan that describes the benefits and limitations of the coverage.

Contract Holder - The individual in whose name a contract is issued or the employee covered under an employer's group health contract. The contract holder can enroll dependents under family coverage.

Contractor - A business entity that performs delegated functions on behalf of the insurer or managed care organization.

Coordinated Care - The evaluation of the medical necessity, appropriateness and efficiency of the use of health care services, procedures and facilities under the provisions of the applicable health benefit plan. It is sometimes called utilization review or utilization management.

Coordination of Benefits - When a member is covered by more than one benefit plan, with both providing similar benefits, EmblemHealth coordinates with the other carrier to ensure appropriate reimbursement. Also called COB.

Copay - The fixed dollar amount members must pay for certain covered services. It is generally paid to a network provider at the time the service is rendered.

Copayment - The fixed dollar amount members must pay for certain covered services. It is generally paid to a network provider at the time the service is rendered.

Cost Sharing - A general term for the deductible, copayment and coinsurance provisions in the member's plan.

Covered Service – A medically necessary service for which a member is entitled to receive partial or complete coverage under the terms and conditions of the benefit program, is within the scope of the practitioner's practice and the practitioner is authorized to render pursuant to the terms of the agreement.

Covering Physician - A licensed doctor of medicine or osteopathy who has an agreement with a network provider to provide covered services to members when the network provider is not available.

Cultural Competence - Understanding the values, beliefs and needs associated with an individual's age, gender identity, sexual orientation, and/or racial, ethnic or religious background. Cultural competence also includes a set of competencies required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Custodial Care - Maintenance care of a patient that is designed to assist the patient in daily living and not primarily provided for the treatment of an illness, disease or condition. Custodial care includes but is not limited to help in walking, bathing and feeding.

Customary Charge - The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and the reasonable cost of services for a given patient after medical review of the case. Also called customary and reasonable (C&R) and usual, customary and reasonable (UCR).

Date of Service - The date a service was rendered.

Deductible - A portion of eligible expenses that an individual or family must pay during a calendar year before EmblemHealth will begin to pay benefits for covered services.

Delegate – An entity contracted with EmblemHealth to perform various services including utilization review, credentialing and claims processing. Also called managing entities and carve outs.

Delegation - The process by which the organization permits another entity to perform functions and assume responsibilities covered under these standards on behalf of the organization, while the organization retains final authority to provide oversight to the delegate.

Denial of Benefits -A rejection of an entire claim or part of a claim.

Dental Care - The treatment of the oral cavity.

Department of Health and Human Services - The US government's principal agency for protecting the health of all Americans and providing essential human services. Also called the DHHS.

Dependent - An individual other than the subscriber who is eligible to receive health care

services under the member's Certificate of Insurance. Generally, dependents are limited to the subscriber's spouse and eligible children.

Designee - A person authorized by the insured to assist in obtaining access to, or payment to, the insured for health care services. If the insured has already received health care services and has no liability for payment of services, a designee will not be authorized for the purpose of requesting an external appeal.

DHHS - The US government's principal agency for protecting the health of all Americans and providing essential human services. Also called the Department of Health and Human Services.

Diagnostic Test - A test or procedure ordered by a physician to determine if the patient has a certain condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include radiology, ultrasound, nuclear medicine, laboratory or pathology services.

Direct Payment - Individual subscribers who are billed and pay premiums directly to the insurer or managed care organization.

Disabling Condition - Any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months and renders the member unable to engage in any substantial gainful activities.

Disabling Disease - Any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months and renders the member unable to engage in any substantial gainful activities.

Discharge Date - Date the patient left the hospital.

Disease Management - A coordinated system of preventive, diagnostic and therapeutic measures intended to provide cost-effective, quality health care for a patient population who have or are at risk for a specific chronic illness or medical condition.

DME - Medical equipment, goods, implements and prosthetics that are prescribed for patient care, usually in an outpatient setting. Examples of such equipment include hospital beds, wheelchairs and walkers.

Durable Medical Equipment - Medical equipment, goods, implements and prosthetics that are prescribed for patient care, usually in an outpatient setting. Examples of such equipment include hospital beds, wheelchairs and walkers.

Effective Date - The date on which the coverage of an insurance policy goes into effect at 12:01 am.

Elective Surgery - Surgery for a condition not considered an emergency.

Eligibility - A determination of whether or not a person meets the requirements to participate in the plan and receive coverage under the plan.

Eligible Expense - The total dollar amount allowed by EmblemHealth for a covered service. Eligible expenses are set forth in EmblemHealth's Schedule of Allowances.

Emergency Care (Emergent) - See **Emergency Condition**.

Emergency Condition - Means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Emergency Medical Condition - See **Emergency Condition**.

Emergency Medical Services and Surprise Bills Law - means legislation (passed in the 2014-2015 New York State budget) which provides for greater transparency of out-of-network charges and network participation as well as safeguards against “surprise bills” from out of network providers. Also called Out-of-Network Law.

Enrollee - An individual enrolled and eligible for coverage under a health plan contract. Also called a member.

EOB - A form sent to the enrollee after a claim for payment has been processed by the health plan. The form explains the action taken on that claim. This explanation usually includes the amount paid, the benefits available, reasons for denying payment and the claims appeal process. Also called Explanation of Benefits.

EPO - A health care benefit arrangement that is similar to a preferred provider organization in administration, structure and operation but does not cover out-of-network care. Also called an Exclusive Provider Organization.

Exclusion - Specific conditions or circumstances not covered under the benefit agreement or Certificate of Insurance. It is very important to consult the benefit contract to understand what services are not covered benefits.

Exclusive Provider Organization - A health care benefit arrangement that is similar to a preferred provider organization in administration, structure and operation but does not cover out-of-network care. Also called an EPO.

Expedited Appeal - Oral or written request to review or reconsider an initial adverse determination when waiting for a standard decision could seriously harm the enrollee's life, health or ability to regain maximum function. For pre-service expedited requests, the practitioner may act on behalf of the member. Also called a fast track appeal.

Experimental and Investigational - Treatment, procedure, drug, biological product or medical device that has not been of proven benefit for the particular diagnosis or treatment of the particular condition or is not generally recognized by the medical community, as reflected in the published peer-reviewed medical literature, as effective or appropriate for the particular diagnosis or treatment of the particular condition.

Expiration Date - The date indicated in an insurance contract as the date coverage expires at 12 midnight.

Explanation of Benefits - A form sent to the enrollee after a claim for payment has been processed by the health plan. The form explains the action taken on that claim. This explanation usually includes the amount paid, the benefits available, reasons for denying payment and the claims appeal process. Also called an EOB.

External Appeal - Written request for an independent entity that has been certified by the State to conduct a review of a denial of coverage, based on lack of medical necessity or that the service requested is experimental and investigational.

Facility - A hospital, ambulatory surgical facility, birthing center, dialysis center, rehabilitation facility, skilled nursing facility or other provider certified under New York Public Health Law. A hospice is a facility. An institutional provider of mental health substance abuse treatment operating under New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services is a facility.

Facility-based Long-Term Services and Supports - A range of medical, social or rehabilitation services a person needs over months or years to improve or maintain function or health that are provided in a long-term care facility such as a nursing home (not including assisted-living residences). Also called facility-based LTSS.

Fee-For-Service - A payment method in which the insurer reimburses the member or provider directly for each covered medical expense.

Fee Schedule - The fee determined by the insurer to be acceptable for a procedure or service that the physician agrees to accept as payment in full.

FIDA Demonstration - A Medicare-Medicaid alignment initiative developed to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees). Also called fully-integrated duals advantage demonstration.

FIDA Plan - A managed care plan under contract with the Centers for Medicare & Medicaid

Services and the State to provide the fully-integrated Medicare and Medicaid benefits under the FIDA demonstration. Also called fully-integrated duals advantage plan.

Final Adverse Determination - Final determination made on a first level utilization review appeal, where an initial adverse determination has been upheld.

First Tier Entity - Any party that enters into a written arrangement, acceptable to the Centers for Medicare & Medicaid Services, with a Medicare Advantage organization or applicant to provide administrative services or health care services for a Medicare-eligible individual under the Medicare Advantage program.

Formulary - A list of preferred pharmaceutical products that health plans, working with pharmacists and physicians, have developed to encourage greater efficiency in the dispensing of prescription drugs without sacrificing quality. Also called a Drug Formulary.

Full-Time Student - A dependent enrolled at an accredited institution of learning. The student's principal residence, when not away at school, must be the same as the parents.

Fully-Integrated Duals Advantage Demonstration - A Medicare-Medicaid alignment initiative developed to better serve individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees). Also called FIDA demonstration.

Fully-Integrated Duals Advantage Plan - A managed care plan under contract with the Centers for Medicare & Medicaid Services and the State to provide the fully-integrated Medicare and Medicaid benefits under the FIDA demonstration. Also called FIDA plan.

Generic Drug - A drug that is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug.

Grievance - A request to change an adverse determination that was based on administrative policies, procedures or guidelines.

Grievance Procedure - A complaint process whereby the member or the member's duly authorized representative may seek review of benefit determinations or other determinations made by EmblemHealth or a delegate relating to the member's health plan.

Group Contract - The Agreement EmblemHealth has with the member's group to provide health insurance.

Group Number - This number identifies the subscriber's employer or Union Benefits Fund.

Health Care Provider - A professionally licensed individual, facility or entity giving health-related care to patients. Physicians, hospitals, skilled nursing facilities, pharmacies, chiropractors, nurses, nurse-midwives, physical therapists, speech pathologist, laboratories are providers. All network providers are health care providers, but not all providers are network

providers.

Health Insurance Portability and Accountability Act - A federal act that protects people who change jobs, are self-employed or have pre-existing medical conditions. The act standardizes an approach to the continuation of health care benefits for individuals and members of small group health plans and establishes parity between the benefits extended to these individuals and those offered to employees in large group plans. The act also contains provisions to ensure that prospective or current enrollees in a group health plan are not discriminated against based on health status and protects the confidentiality of protected health information of members. Also known as HIPAA.

Health Maintenance Organization - An organization that provides comprehensive health care coverage to its members through a network of doctors, hospitals and other health care providers. Also called an HMO.

Health Professional - An individual who: (1) has undergone formal training in a health care field; (2) holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and (3) has professional experience in providing direct patient care.

HIPAA - A federal act that protects people who change jobs, are self-employed or have pre-existing medical conditions. The act standardizes an approach to the continuation of health care benefits for individuals and members of small group health plans and establishes parity between the benefits extended to these individuals and those offered to employees in large group plans. The act also contains provisions to ensure that prospective or current enrollees in a group health plan are not discriminated against based on health status and protects the confidentiality of protected health information of members. Also known as the Health Insurance Portability and Accountability Act.

HMO - An organization that provides comprehensive health care coverage to its members through a network of doctors, hospitals and other health care providers. Also called a Health Maintenance Organization.

Hold Harmless – when a practitioner/provider renders services to an EmblemHealth Member under the participating network agreement, Hold Harmless means that he/she/it will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from an EmblemHealth Member, or persons acting on a Member's behalf (other than the Payor), for such services. Such Hold Harmless agreement includes but is not limited to, non-payment by or insolvency of the Payor, as well as breach of the participating network agreement by the Payor. This provision does not prohibit the practitioner/provider from: (1) collecting copayments, coinsurance or deductibles as specifically provided in the Member's benefit plan; (2) fees for Non-Covered Services delivered on a fee-for-service basis to Members; and (3) continuing services solely at the expense of the Member, provided the practitioner/provider has informed the Member in advance, and in writing, that the Payor will not cover or continue to cover such specified services and the Member has agreed, in writing, to be financially responsible for such

continuation services.

Home Health Care - Health care services rendered to a member in their home in lieu of confinement in a hospital or skilled nursing facility. Care must be under the supervision of a registered professional nurse. This type of care may include physical, occupational or speech therapy, medical supplies and medication prescribed by a doctor.

Home Infusion Therapy - The administration of intravenous drug therapy in the home. Home infusion therapy includes the following services: solutions and pharmaceutical additives; pharmacy compounding and dispensing services; durable medical equipment; ancillary medical supplies; and nursing services.

Hospice - A facility or service that provides care for the terminally ill patient and support to the family. The care, primarily for pain control and symptom relief, can be provided in the home or in an inpatient setting.

Hospital - An institution that provides inpatient services under the supervision of a physician, and meets the following requirements:

- Provides diagnostic and therapeutic services for medical diagnosis, treatment and care of injured and sick persons and has, as a minimum, laboratory and radiology services and organized departments of medicine and surgery
- Has an organized medical staff which may include, in addition to doctors of medicine, doctors of osteopathy and dentistry
- Has bylaws, rules and regulations pertaining to standards of medical care and service rendered by its medical staff
- Maintains medical records for all patients
- Has a requirement that every patient be under the care of a member of the medical staff;
- Provides 24-hour patient services
- Has in effect agreements with a home health agency for referral and transfer of patients to home health agency care when such service is appropriate to meet the patient's requirements

ID Card - A card that allows the subscriber to identify himself or his covered dependents to a provider for health care services.

ID Number - A unique number that identifies the member's enrollment with EmblemHealth. EmblemHealth's claims are processed by this number. Also known as Member ID Number.

Identification Card - A card that allows the subscriber to identify himself or his covered dependents to a provider for health care services.

Identification Number - A unique number that identifies the member's enrollment with EmblemHealth. EmblemHealth's claims are processed by this number. Also known as Member ID Number.

IDT - The group of individuals who provide person-centered care coordination and care

management to participants in a FIDA plan. Each participant will have an interdisciplinary team (IDT). Each IDT will be comprised, first and foremost, of the participant and/or his or her designee, and the participant's designated care manager, primary care physician, behavioral health professional, home care aide, and other providers either as requested by the participant or his or her designee or as recommended by the care manager or primary care physician and approved by the participant and/or his or her designee. The IDT facilitates timely and thorough coordination between a FIDA plan and the IDT, primary care physician and other providers. The IDT makes coverage determinations. Accordingly, the IDT's decisions serve as service authorizations, may not be modified by a FIDA plan outside of the IDT, and are appealable by the participant, their providers and their representatives. IDT service planning, coverage determinations, care coordination and care management are delineated in the participant's person-centered service plan and are based on the assessed needs and articulated preferences of the participant.

Independent Practice Association - An organization comprised of individual physicians or physicians in group practices that contracts with the managed care organization on behalf of its member physicians to provide health care services. Also called an IPA.

Initial Adverse Determination - Initial determination made by a utilization management agent for a denial of a service authorization request on the basis that the requested service is not medically necessary or an approval of a service authorization in a amount, duration or scope less than requested.

Infertility - The inability to conceive or an inability to carry a pregnancy to a live birth after a year or more of regular sexual relations without the use of contraception.

Infusion Therapy - Treatment accomplished by placing therapeutic agents into the vein, including intravenous feeding. Such therapy also includes enteral nutrition that delivers nutrients into the gastrointestinal tract by tube.

In-Network – The use of providers who participate in the health plan's provider network. Many benefit plans encourage enrollees to use network providers to reduce the enrollee's out-of-pocket expense.

Inpatient - Service provided after the patient is admitted to the hospital. Inpatient stays are those lasting 24 hours or more.

Inpatient Care - Treatment provided to a patient who stays overnight (24 hours or more) in a hospital or other facility.

Interdisciplinary Team - The group of individuals who provide person-centered care coordination and care management to participants in a FIDA plan. Each participant will have an interdisciplinary team (IDT). Each IDT will be comprised, first and foremost, of the participant and/or his or her designee, and the participant's designated care manager, primary care physician, behavioral health professional, home care aide, and other providers either as

requested by the participant or his or her designee or as recommended by the care manager or primary care physician and approved by the participant and/or his or her designee. The IDT facilitates timely and thorough coordination between a FIDA plan and the IDT, primary care physician and other providers. The IDT makes coverage determinations. Accordingly, the IDT's decisions serve as service authorizations, may not be modified by a FIDA plan outside of the IDT, and are appealable by the participant, their providers and their representatives. IDT service planning, coverage determinations, care coordination and care management are delineated in the participant's person-centered service plan and are based on the assessed needs and articulated preferences of the participant.

IPA - An organization comprised of individual physicians or physicians in group practices that contracts with the managed care organization on behalf of its member physicians to provide health care services. Also called an Independent Practice Association.

Itemized Bill - A bill from a provider that itemizes all charges for services rendered needed to process for payment.

LDSS – A city or county social services district as constituted by Section 61 of the New York State Social Services Law (SSL). Also called a Local Department of Social Services.

License - A permit (or equivalent) to practice medicine or a health profession that is: 1) issued by any state or jurisdiction in the United States and 2) required for the performance of job functions.

Life-threatening Condition or Disease - A condition or disease that has a high probability of death, according to the current diagnosis of the attending physician.

Limitation - Specific circumstances or services listed in the contract for which benefits will be limited.

Local Department of Social Services - A city or county social services district as constituted by Section 61 of the New York State Social Services Law (SSL). Also called a LDSS.

MA - Acronym for Medicare Advantage. An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

MA Organization - A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by the Centers for Medicare & Medicaid Services as meeting the Medicare Advantage contract requirements. Also called Medicare Advantage organization.

Mail Order Pharmacy Program - A program that offers drugs ordered and delivered through the mail to plan members.

Mailing Address - The address designated by the member for all correspondence.

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 prior approval of certain services.

Medicaid - A jointly funded federal and state program that provides hospital and medical coverage to the low-income population and certain aged and disabled individuals.

Medical Care - Professional services rendered by a physician for the treatment or diagnosis of an illness or injury.

Medical Director - A doctor of medicine or doctor of osteopathic medicine who is duly licensed to practice medicine and is an employee of, or party to a contract with, a utilization management organization, and has responsibility for clinical oversight of the utilization management organization's utilization management, credentialing, quality management and other clinical functions.

Medical Emergency - A medical or behavioral condition with a sudden onset that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Medically Necessary - Health care that is rendered by a hospital or a licensed or certified provider and is determined by EmblemHealth to meet all of the criteria listed below:

- It is provided for the diagnosis or direct care or treatment of the condition, illness, disease, injury or ailment.
- It is consistent with the symptoms or proper diagnosis and treatment of the medical condition, disease, injury or ailment.
- It is in accordance with accepted standards of good medical practice in the community.
- It is furnished in a setting commensurate with the member's medical needs and condition.
- It cannot be omitted under the standards referenced above.
- It is not in excess of the care indicated by generally accepted standards of good medical practice in the community.
- It is not furnished primarily for the convenience of the member, the member's family or the provider.
- In the case of a hospitalization, the care cannot be rendered safely or adequately on an outpatient basis or in a less intensive treatment setting and, therefore, requires the member receive acute care as a bed patient.

The fact that a provider has prescribed a service or supplies care does not automatically mean the service or supply will qualify for reimbursement under the EmblemHealth plan. To be eligible for reimbursement by EmblemHealth, all covered services must meet EmblemHealth's medical necessity criteria, described above.

Medically necessary with respect to Medicaid members means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such a person's capacity for normal activity or threaten some significant handicap. For children and youth, medically necessary means health care and services that are necessary to promote normal growth and development and prevent, diagnose, treat, ameliorate or palliate the effects of a physical, mental, behavioral, genetic, or congenital condition, injury or disability.

Medicare - A nationwide insurance program for the disabled and people age 65 and over, created by the 1965 amendments to the Social Security Act and operated under the provisions of the Act. It consists of two separate but coordinated programs, Part A and Part B.

Medicare Advantage - An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program. Also known as MA.

Medicare Advantage Organization - A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by the Centers for Medicare & Medicaid Services as meeting the Medicare Advantage contract requirements. Also called MA organization.

Medicare Part A - This part of Medicare provides benefits for hospitalization, extended care and nursing home care to Medicare beneficiaries with no premium payment for qualified individuals.

Medicare Part B - This part of Medicare provides medical surgical benefits for Medicare beneficiaries for a modest premium.

Member - An individual and each of his or her eligible dependents, including Medicare beneficiaries who are enrolled or participate in a benefit program and who are entitled to receive covered services from the practitioner pursuant to such benefit program and the terms of the practitioner's agreement.

Member ID Number - A unique number that identifies the member's enrollment with EmblemHealth. EmblemHealth's claims are processed by this number. Also known as ID Number.

Member Services - The department responsible for helping members with problems and questions.

Mental Health - Conditions that affect thinking and the ability to figure things out that affect perception, mood and behavior.

Mental Health Care - The provision of mental health and substance abuse services.

National Committee for Quality Assurance - A nonprofit organization that performs quality-oriented accreditation reviews of HMOs and similar types of managed care plans. Also called NCQA.

NCQA - A nonprofit organization that performs quality-oriented accreditation reviews of HMOs and similar types of managed care plans. Also called the National Committee for Quality Assurance.

Network - The group of physicians, hospital and other medical care providers that a specific plan has contracted with to deliver medical services to its members.

Network Facility - A facility that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. Sometimes, network facilities are referred to as participating facilities.

Network Hospital - A hospital that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. Sometimes, network hospitals are referred to as participating hospitals.

Network Provider - A physician, hospital or other provider who has signed an agreement to covered services to EmblemHealth plan members. A network provider is a member of the EmblemHealth network of network providers applicable to the member's certificate. Therefore, they are sometimes referred to as participating providers. Payment is made directly to a network provider. Please consult the EmblemHealth Directory or go online to search for network providers.

New York City Department of Health and Mental Hygiene - A public agency that works to control the spread of infectious diseases, monitor the health of New Yorkers and create an environment that protects and promotes health by using regulations, education and advocacy and providing direct health services. Also known as NYCDOHMH.

New York State Department of Health - The state regulatory agency that certifies reimbursement methods and rates to hospitals and reviews HMO activities in the state of New York. Also called NYSDOH.

No Fault- A law in several states including New York State requiring all registered motor vehicles to be covered by personal injury protection insurance. Under this law, a person's own motor vehicle insurance company pays for expenses relating to an accident regardless of who caused the accident.

Non-Certification - A determination by a utilization management organization that an admission, extension of stay or other health care service has been reviewed and, based on the

information provided, does not meet the clinical requirements for medical necessity, appropriateness, level of care or effectiveness under the auspices of the applicable health benefit plan.

Non-Participating Partner - A non-participating partner is a non-par individual practitioner that shares the same TIN# or NPI# and specialty and location as a participating (aka regular) partner (i.e., when a covering practitioner treats a member). These non-par partners sometimes see EmblemHealth patients as an advising or covering physician. These are also referred to as substitute physicians.

Non-Participating Provider- A health care provider, such as a physician, skilled nursing facility, home health agency or laboratory, that does not have an agreement with EmblemHealth plans to provide covered services to members. Also called an Out-of-Network Provider.

NYCDOHMH - A public agency that works to control the spread of infectious diseases, monitor the health of New Yorkers and create an environment that protects and promotes health by using regulations, education and advocacy and providing direct health services. Also known as the New York City Department of Health and Mental Hygiene.

NYSDOH - The state regulatory agency that certifies reimbursement methods and rates to hospitals and reviews HMO activities in the state of New York. Also called the New York State Department of Health.

Occupational Therapy - Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting and bathing (activities of daily living).

Ordering Physician - The physician or other provider who specifically prescribes the health care service being reviewed.

Out-of-Network - The use of health care providers who have not contracted with the health plan to provide services. Depending on the member's contract, out-of-network services may not be covered.

Out-of-Network Benefits - Reimbursement for covered services provided by out-of-network providers and suppliers. Out-of-network benefits are generally subject to a deductible and coinsurance and, therefore, have higher out-of-pocket costs. Depending on the member's contract, out-of-network services may not be covered.

Out-of-Network Facility – A facility that does not have a participation agreement with EmblemHealth or another EmblemHealth plan to provide facility services to persons covered under EmblemHealth.

Out-of-Network Hospital - A hospital that does not have a participation agreement with EmblemHealth or another EmblemHealth plan to provide hospital services to persons covered

under EmblemHealth.

Out-of-Network Law – See **Emergency Medical Services and Surprise Bills Law**.

Out-of-Network Provider - A health care provider, such as a physician, skilled nursing facility, home health agency or laboratory, that does not have an agreement with EmblemHealth plans to provide covered services to members. Also called a Non-Participating Provider.

Outpatient Care - Treatment provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

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

Participating Facility - A facility that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. More commonly referred to as a network facility.

Participating Hospital - A hospital that is part of EmblemHealth's provider network and has signed an agreement to provide covered services to its members. More commonly referred to as a network hospital.

Participating Provider - A physician, hospital or other provider who has signed an agreement to covered services to EmblemHealth plan members. A participating provider is a member of the EmblemHealth network of providers applicable to the member's certificate. Therefore, they are more commonly referred to as network providers. Payment is made directly to a participating provider. Please consult the EmblemHealth Directory or go online to search for participating providers.

PCP - A family physician, family practitioner, general practitioner, internist or pediatrician who is responsible for delivering or coordinating care. Also called a primary care physician.

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

POS - A type of health benefit plan that allows enrollees to go outside the health plan's provider network for care, but requires enrollees to pay higher out-of-pocket fees when they do. Also called Point of Service.

Postpartum Visit - During the postpartum visit, that must occur within 21 – 56 days following delivery, an assessment of the mother's blood pressure, weight, breasts, abdomen and a pelvic exam is conducted to determine the mothers physical health status and general well-being following childbirth.

PPO - A health plan that offers benefits in-network and out-of-network. In-network services

are available to enrollees at lower out-of-pocket cost than the services of non-network providers. In addition, PPO enrollees may self-refer to any network provider at any time. Also called a Preferred Provider Organization.

Pre-Existing Condition - A pre-existing condition is any disease, symptom or condition present on the first day of coverage and for which medical advice or treatment was recommended or received during the six-month period prior to the enrollment date.

Preferred Provider Organization - A health plan that offers benefits in-network and out-of-network. In-network services are available to enrollees at lower out-of-pocket cost than the services of non-network providers. In addition, enrollees may self-refer to any network provider at any time. Also called a PPO.

Premium - A prepaid payment or series of payments made to a health plan by purchasers and often plan members for health insurance coverage.

Prescription - A written order or refill notice issued by a licensed medical professional for drugs available only through a pharmacy.

Prescription Drugs - Drugs and medications required by law to be dispensed by written prescriptions from a licensed physician.

Preventive Care - Comprehensive care emphasizing prevention, early detection and early treatment of conditions, and generally including routine physical examinations and immunization.

Primary Care Physician - A family physician, family practitioner, general practitioner, internist or pediatrician who is responsible for delivering or coordinating care. Also called a PCP.

Prior Approval - The process of obtaining advanced approval of coverage for a health care service or medication. The request for services is reviewed to assess medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided. Also called pre-authorization or pre-certification or pre-determination.

Provider- A medical practitioner or covered facility recognized by EmblemHealth for reimbursement purposes. A provider may be any of the following, subject to the conditions listed in this paragraph:

- Doctor of medicine
- Doctor of osteopathy
- Dentist
- Chiropractor
- Doctor of podiatric medicine
- Physical therapist

- Nurse midwife
- Certified and registered psychologist
- Certified and qualified social worker
- Optometrist
- Nurse anesthetist
- Speech-language pathologist
- Audiologist
- Clinical laboratory
- Screening center
- General hospital
- Any other type of practitioner or facility specifically listed in the member's Certificate of Insurance as a practitioner or facility recognized by EmblemHealth for reimbursement purposes

A provider must be licensed or certified to render the covered service. The covered service must be within the scope of the Provider's license or certification.

Provider Network - A set of providers contracted with a health plan to provide services to the enrollees.

Provider Number - The seven-digit identification number issued to the provider by EmblemHealth. This is the tax identification number issued to the provider by the Internal Revenue Service.

Quality Improvement - The process to objectively and systematically monitor and evaluate the quality, timeliness and appropriateness of covered services, including both clinical and administrative functions, to pursue opportunities to improve health care and to resolve identified problems in any of these services.

Radiation Therapy- Treatment of disease by X-ray, radium, cobalt or high energy particle sources.

Reconsideration - A request for inpatient review, made while the member is still in the facility, of a case that was denied on the basis of medical necessity.

Referral - A recommendation by a physician that an enrollee receive care from a specialty physician or facility.

Retrospective Adverse Determination - A determination for which utilization review was initiated after health care services were provided. Retrospective adverse determination does not mean an initial determination involving continued or extended health care services or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider.

Retrospective Review - A review done after services are completed (usually as part of a claim or

appeal), that ensures the care given was medically necessary.

Rider - A provision added to a contract whereby the scope of its coverage is increased or decreased.

SDOH - The state regulatory agency that certifies reimbursement methods and rates to hospitals and reviews HMO activities in the state of New York.

Second Opinion - The voluntary option or mandatory requirement to visit another physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.

Service Area - The geographic area in which a health plan is prepared to deliver health care through a contracted network of participating providers.

Service Authorization Request - A request by the member or their provider (on the member's behalf) to have a service provided. This includes a:

- Request for referral
- Request for non-covered service
- Request for prior authorization for coverage of a new service
- Request for concurrent review for continued, extended or additional services than what is currently authorized.

Skilled Nursing Facility - A licensed institution (or distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services. Also called a SNF.

SNF - A licensed institution (or distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services. Also called a skilled nursing facility.

Specialist Physician - A physician who performs specialized services.

Specialized Services - Services provided by specialists, not by the PCP. For example, an allergist (who treats allergies) or a radiologist (who uses X-rays for diagnosis and treatment) are specialists.

Speech Therapy - Treatment of the correction of a speech impairment that resulted from birth, disease, injury or prior medical treatment

Subscriber - An active member enrolled under an EmblemHealth group Certificate or an individual enrolled under a direct payment contract. A "retiree" may also be a subscriber under a group Certificate.

Substance Abuse - The use of one or more drugs for purposes other than those for which they

are prescribed or recommended.

Surprise bill – means a bill for health care services, other than emergency services, received by: (1) an EmblemHealth Member for services rendered by a non-EmblemHealth participating physician at an EmblemHealth participating hospital or ambulatory surgical center, where a participating physician is unavailable or a non-participating physician renders services without the Member's knowledge, or unforeseen medical services arise at the time the services are rendered, or (2) an EmblemHealth Member for services rendered by a non-participating provider, where the services were referred by an EmblemHealth participating physician to such non-participating provider without the explicit written consent of the Member acknowledging that the participating physician is referring the Member to a non-participating provider and that the referral may result in costs not covered by the Plan.

A surprise bill does NOT mean a bill for services when a participating physician is available and the EmblemHealth Member opts to obtain services from a nonparticipating physician.

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.

Utilization Management - A review to determine whether covered services that have been provided or are proposed to be provided to a member, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. Also called Coordinated Care.

Utilization Management Agent – A person who performs utilization management under a contract with EmblemHealth on behalf of EmblemHealth (also known as a Delegate) and Emblem Health.

Utilization Review - A formal evaluation (prospective, concurrent or retrospective) of the coverage, medical necessity, efficiency or appropriateness of health services and treatment plans. Also called Coordinated Care.

Waiting Period - A period of time an individual must wait to become eligible for insurance coverage.

Workers' Compensation - Insurance carried by employers to cover occupation-related injuries or conditions incurred by the employees.