Glossary of Terms

Appeal: A request by or on behalf of a member (with authorization) for a new review of an organization determination, as a result of an adverse benefit determination.

Care Coordinator: provides Care Management and, working with a member and care team, establishes a Care Plan for the member.

Care Management: is a program designed to assist Members in gaining access to services, including medical, social, educational, and other services, regardless of the funding source for the services. Care Management is a collaborative process that is designed to assist Members and their providers to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet the Member's needs across the continuum of care.

Carelon: BCBSIL has contracted with Carelon to manage benefit preauthorization requests for certain specialized clinical services for BCBSIL (Commercial) Members. Carelon is an independent company that has contracted with BCBSIL to provide utilization management services for members with coverage through BCBSIL.

Care Plan: A care plan is a Member-centered, goal-oriented, culturally relevant, and logical written plan of care with a service plan component, if necessary, that is designed to assist the Member to obtain access, to the extent applicable, medical, medically related, social, behavioral, and necessary covered services, including long-term services and supports, in a supportive, effective, efficient, timely manner that emphasizes prevention and continuity of care.

Centers for Medicare & Medicaid Services (CMS): CMS is the federal agency responsible for administering Medicare.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Beneficiary survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of beneficiary experiences with health care.

Contracted Facility: Any independently contracted health facility, hospital, laboratory, or other institution licensed and/or certified by the State of Illinois and Medicaid to deliver or furnish health care services and which has a written agreement to provide services directly or indirectly to Members pursuant to the terms of the Agreement for facility services.

Contracted Provider: Any independently contracted physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, and any other Provider of medical services, licensed and/or certified by the State of Illinois and Medicaid to deliver or furnish health care services and who has a written agreement to provide services directly or indirectly to Members pursuant to terms of their agreement with BCBSIL.

Covered Services: Those benefits, services or supplies that are covered and approved for a Member set forth in the respective plan document.

Cultural Competence: Generally considered to be the understanding of those values, beliefs and needs that are associated with age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds of Members receiving health care services. Cultural competence also includes a set of competencies, which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.

Delegated Activities: Delegation occurs when an organization gives another entity the authority to carry out a function that it would otherwise perform. Delegation or Subcontracting is the process by which an organization contracts with or otherwise arranges for another entity to perform functions and to assume responsibilities on behalf of the health plan, while the health plan retains final authority to provide oversight to the delegate.

Emergency Services: Covered inpatient or outpatient services that are furnished by a Provider qualified and appropriately licensed to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition.

Enrollment: The processes by which an individual who is eligible for a plan is registered in the plan, including transfers from one participating BCBSIL plan to another.

eviCore® healthcare (eviCore): BCBSIL has contracted with eviCore to manage benefit prior preauthorization requests for certain specialized clinical services for BCBSIL (Government Programs) Members. eviCore is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

Facility: Hospital and ancillary providers, which include, but are not limited to: Durable Medical Equipment (DME) suppliers and Skilled Nursing Facilities (SNFs).

Grievance (applies only to Government networks): Expression of dissatisfaction by a Member, including complaints regarding healthcare services and about any matter other than an organization determination.

HEDIS® (Healthcare Effectiveness Data and Information Set): A tool developed and maintained by the National Committee for Quality Assurance and its successor organization that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality. Ensures that Members will receive optimal preventive and quality care. Annually, the Quality Improvement Department collects, analyzes, and evaluates performance measures. The results are used to evaluate our adherence to practice guidelines and improve Member outcomes. The results are reported to Healthcare and Family Services in June

Hospice: An organization or agency, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital: A certified institution licensed in the State of Illinois, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Laws: Any and all applicable laws, rules, regulations, statutes, orders, and standards of the United States of

America, the states or any department or agency thereof with jurisdiction over any or all of the Parties, as such laws, rules, regulations, statutes, orders, and standards are adopted, amended, or issued from time to time

Medicaid: The program of medical assistance benefits under Title XIX of the Social Security Act and various demonstrations and waivers thereof.

Medically Necessary Service: A service, supply or medicine that is reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, for the prevention of future disease, to assist in the Member's ability to attain, maintain, or regain functional capacity or to achieve age- appropriate growth, or otherwise medically necessary and meets the standards of good medical practice in the medical community, as determined by the Contracted Provider in accordance with BCBSIL guidelines, policies or procedures.

Medicare: Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities and people with End State Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Medicare Advantage (MA) Plan: A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit plan in the same service area.

Medicare Part D: the prescription drug coverage program offered by Medicare Member/Enrollee: The beneficiary, entitled to receive covered services, who has voluntarily elected to enroll in a plan. Member shall include the guardian where the Member is an adult for whom a guardian has been named; provided, however, that the plan is not obligated to cover services for a guardian who is not otherwise eligible as a Member.

Member Handbook: A document that describes the health care benefits covered by the plan. It provides the member with some form of documentation of what that insurance covers and how it works.

Non-Contracted Provider or Facility: Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the State of Illinois or Medicaid to deliver or furnish health care services and also being neither employed, owned, operated by, nor under contract with BCBSIL to deliver covered services to Members.

Participating IPA: Any duly organized Independent Practice Association (IPA), Independent Physician Association, organized Medical Group, Physician Hospital Organization or other legal entity organized to arrange for the provision of professional medical service which has in force a contract or agreement with BCBSIL to provide professional and ancillary services to Members enrolled in BCBSIL as outlined in BCBSIL Provider Manual and according to the Member's plan of benefits outlined in his or her member handbook, coverage agreement, plan document, and/or benefit booklet.

Primary Care Physician (PCP): Any physician, who, within his or her scope of practice; is responsible for providing all preventive and primary care services to his or her assigned Members.

Provider: Any contracted physician or practitioner, to include, but not limited to, a physician, physical therapist, psychologist, hospital facility, health care facility, laboratory, and any other provider of medical services, licensed in accordance with all applicable Laws.

Quality Improvement Organization (QIO) Organizations: comprising practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, SNFs, HHAs, Medicare health plans and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Quality of Care Issue: A quality-of-care complaint may be filed through the grievance process and/or a Quality Improvement Organization (QIO). A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration: A Member's first step in the appeal process after an adverse organization determination. BCBSIL or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative: An individual appointed by a Member or other party, or authorized under state or other applicable law, to act on behalf of the Member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of the Member or party in obtaining an organization determination, filing a grievance or in dealing with any of the levels of the appeal process, subject to the applicable rules described at 42 CFR Part 405.

Service Area: A geographic area approved by HFS within which an eligible individual may enroll in a participating BCBSIL plan.

Skilled Nursing Facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services. Temporary residence for patients undergoing medically necessary rehabilitative treatment outside of a hospital. Skilled nursing care is provided 24/7 by trained registered nurses in a medical setting under a doctor's supervision.

Timely Filing: refers to the period within which healthcare providers must submit claims to BCBSIL for services rendered. The specific timely filing requirements can vary among different plans.

The above information is provided as a general resource. This list is not all-inclusive. Participating providers should refer to their provider agreement for additional information.

eviCore healthcare (eviCore) is an independent company that has contracted with BCBSIL to provide prior authorization for expanded outpatient and specialty utilization management for members with coverage through BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products or services they offer.