

## Glossary of Terms

### A

**Allowed Amount:** The maximum amount to be reimbursed to a provider as negotiated and defined in the provider contract.

### B

**Benefit Period:** The period of time during which charges for covered services provided to a member must be incurred in order to be eligible for payment.

**Brand-Name Drug:** A drug product which has the established name, active ingredient and strength initially protected by a patent when brought onto the market. The brand-name drug may or may not be copied by other pharmaceutical companies in the form of generic drugs upon expiration of the patent.

### C

**Claim:** A request for retrospective payment by a subscriber or, on his/her behalf, by the provider for services or supplies rendered by a provider or supplier of medical supplies and equipment.

**Copayment:** A cost-sharing arrangement in which a member pays a specified charge for a specific service (e.g., \$10 for office visit).

**Coinsurance:** A form of cost-sharing in which the member must pay a specified percentage of all remaining eligible medical expenses after the deductible has been paid.

**Coinsurance Maximum:** The total amount of coinsurance that a member is obligated to pay for covered services per benefit period. This amount excludes any deductibles, copayments, prescription drug charges, and non-covered services.

## D

**Deductible:** The amount of loss or expense for covered services that must be incurred by a member before an insurer will assume any liability for all or part of the remaining cost of covered services.

**Dependent:** An individual who is eligible for health insurance through a spouse's, parent's or other family member's policy.

## E

**Effective Date:** Date on which the initial membership, coverage, or rate begins under a certificate.

**Explanation of Benefits:** (EOB) A statement for the subscriber that explains how and why benefit payments were or were not made on each claim.

## F

**Family Deductible:** The dollar amount a family must incur for covered services in a benefit period before benefits are payable under the plan.

**Formulary:** The list of covered prescription drugs that is available to members within their prescription drug benefits. The BCBSNC formulary can be located [here](#).

**Formulary Tier:** A classification of each drug in a formulary that determines the amount of coverage and copayment/coinsurance each requires.

## G

**Generic Drug:** A drug product which has the same chemical name, active ingredient, strength, and dosage form, and which is therapeutically equivalent to the brand drug product identified in the prescription.

## H

**Health Insurance Portability and Accountability Act:** (HIPAA) Federal regulations that safeguard the privacy and security of health information. A member may give written authorization to disclose protected health information (PHI) to another person or entity. To authorize a person or entity to receive PHI, the member must complete the [Member Authorization Form](#).

**Hospital Comparison Tool:** An interactive web-based tool that provides members with hospital-specific information to assist them in making more informed health care decisions. Available for members on the [bcbsnc.com](http://bcbsnc.com) web site, the tool provides both quantitative and qualitative hospital-specific information from a variety of sources. It allows members to draw on this data, sort the hospitals according to their own customized set of criteria, and find the hospitals that may best fit their needs.

## I

**Identification Card:** (ID) A card issued by a health insurer to a subscriber as evidence of membership in a health plan.



**In-Network Provider:** Providers who are under contract with BCBSNC to provide health care services to its members. In-network providers can be located using the [provider search tool](#).

**Inpatient:** (IP) Pertaining to services received when a member is admitted to a hospital or nonhospital facility as a registered bed patient for whom a room and board charge is made.

## L

**Length of Stay:** (LOS) Number of inpatient days.

**Lifetime Maximum:** A specified amount of covered services, usually expressed in dollars, that is the extent of the plan's liability per lifetime per member under the certificate.

## M

**Medical Evacuation:** The transportation of a member in the event of an unforeseen injury or illness where emergency evacuation is determined to be medically necessary for the member to be transported under medical supervision to the nearest hospital or treatment facility for treatment, or to be returned to the member's place of residence for treatment.

**Member:** An individual for whom the plan has a contractual obligation to provide or arrange for the provision of health services. Members are comprised of the subscriber and his/her covered dependents.

**Member Services:** A free internet-based subscriber access portal for updating membership information and making inquiries. Customers can request ID cards, verify eligibility and benefits, and check claim status. Members can create an account on [Member Services](#) in order to gain access to a personalized online account.

## O

**Out-of-Network Provider:** Providers who have not signed a contract with the member's health plan to be part of a provider network. Services are available at a reduced or no benefit from the health plan.

**Over-The-Counter:** (OTC) Any medication that can be purchased without a prescription.

## P

**Patient:** An individual under or awaiting medical care and treatment.

**Plan:** BCBSNC or other Blue Cross and Blue Shield organization.

**Pre-Existing Condition:** Conditions for which medical advice or treatment was received, recommended or medically documented within a specified period immediately preceding the effective date of health insurance coverage.

**Preferred Provider Organization:** (PPO) PPOs are health plans that contract with various physicians and hospitals. Enrollees are offered a financial incentive to use providers on a preferred list, but may use out-of-network providers as well.

**Premium:** The amount paid to keep an insurance policy active.

**Prescription:** (Rx) A written order, especially by a physician, for the preparation and administration of a medicine or other treatment.

**Prescription Drug:** A drug that has been approved by the U.S. Food and Drug Administration (FDA) and is required, prior to being dispensed or delivered, to be labeled "Caution federal law prohibits dispensing without a prescription," or labeled in a similar manner and is appropriate to be administered without the presence of a medical supervisor.

**Preventive Care:** Covered services provided for health maintenance such as routine health assessments and well baby and well child care, including urinalysis, immunizations, and screening tests such as Pap smears, mammograms, prostate-specific antigen (PSA) tests, and cholesterol. The frequency of these services is determined based on a member's age and gender and as determined to be medically necessary by the health insurer.

**Primary Care:** Medical practice based on direct contact with the patient. Such practice is undertaken by doctors trained in various ways including pediatricians, obstetricians, general internists, family practitioners and general practitioners.

**Primary Care Physician:** (PCP) A physician, usually a general or family practitioner, who serves as a member's "personal physician" and with whom the health insurer has an agreement to provide primary care services for in-network benefits.

**Prior Plan Approval:** The approval of specific medical services, prescription drugs, and/or supplies for BCBSNC members. Procedures included in the Prior Plan Approval list include high-cost and/or potentially abused services and medications. Services are evaluated against the severity of an illness and intensity of service requirements for approval.

**Protected Health Information:** (PHI) Information subject to privacy and security protections under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). PHI is individually identifiable information including name, birth date, address, social security number, and any other unique identifier.

**Provider:** A hospital, doctor or other licensed, certified, or accredited professional or facility rendering health services within the scope of license or certification.

## R

**Referral:** The recommendation by a primary care physician for a member to receive care from a participating specialist or facility.

**Repatriation of Mortal Remains:** The return of the remains of a member to the country or state of residence in the event of an injury or illness resulting in death.

## S

**Subscriber:** The person whose name appears on the identification card and who is enrolled according to the records of the plan.

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## U

**Urgent Care:** Services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that in the absence of immediate care the member could reasonably be expected to suffer chronic illness, prolonged impairment, or the need for more hazardous treatment. Fever, earache, most fractures, sprains, most lacerations, repeated kidney stones, and dizziness are examples of conditions that would be considered urgent.

## W

**Waiting Period:** The amount of time that must pass before a member is eligible to be covered for benefits under the terms of the plan.

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