Definitions, Terms and Abbreviations

These definitions, terms and abbreviations are useful in understanding the structure, organization and language of Blue Cross and Blue Shield of Nebraska (BCBSNE) benefit plans and administrative functions.

Admission Review: Admission Review is the review of the Medical Necessity and appropriateness of non-elective or emergency hospital admissions. The review takes place within 24 hours of admission or the next working day.

Affiliate: A corporation at least 51% owned by BCBSNE, which is entitled to the rights and bound by the obligations of this Agreement.

Agreement: A contract document, all attachments, exhibits and reimbursement schedules. All provider Newsletter Updates and the Policies and Procedures Manual are considered extensions of the agreement. The Agreement must be signed by the Network Provider, or authorized reprehensive, and BCBSNE which outlines each party's terms.

Alcoholism or Drug Treatment Center (Treatment Center): A facility licensed by the Department of Health and Human Services Regulation and Licensure, whose program is certified by the Division of Alcohol, Drug Abuse, and Addiction Services (or equivalent state agency), accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not licensed as a hospital, but provides inpatient or outpatient care, treatment, services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of dependency or addiction to alcohol or drugs.

Allowable Charge: Payment is based on the Allowable Charge **for Covered Services**.

Provider Type	Allowable Charge
Contracting Professional and other Non-Institutional Preferred Providers	The lesser of the Preferred Fee Schedule Amount or the billed charge. The Allowable Charge for Covered Services in another Service Area is the amount agreed upon by the Onsite Plan and its Participating Providers.

Ambulatory Surgical Center (ASC): A certified facility that provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be licensed as a health clinic as defined by state statutes but shall not include the offices of private physicians or dentists, whether for individual or group practice.

Approved Provider: A licensed practitioner of the healing arts who provides Covered Services within the scope of their license or a licensed or certified facility or other health care provider, payable according to the terms of the member/subscriber contract, Nebraska law or the direction of the Board of Directors of BCBSNE.

Auxiliary Provider: A certified physician assistant, nurse practitioner, nurse midwife, social worker, psychiatric registered nurse or other approved provider who is performing services within their scope of practice and who is supervised by a qualified physician or licensed psychologist, or as otherwise permitted by state law. Certified master social workers or certified professional counselors performing mental health services who are not licensed mental health practitioners are included in this definition.

BCBSNE: Blue Cross and Blue Shield of Nebraska.

Benefit Maximum: Amount of total dollars or total days of care beyond which a policy will no longer pay benefits. When a service is billed after a benefit max has been met, the provider can collect the billed charge. However, if there is a service in which an amount is remaining after a benefit max is applied, then the provider can only collect up to the allowed amount for the service.

BlueCard Access® 1.800. 810.BLUE: A toll-free 800 number for you and members to use to locate health care providers in another Blue Plan's area. This number is useful when referring the patient to a physician or health care facility in another location.

BlueCard Eligibility® 800-676-BLUE (2583): A toll-free 800 number for you to verify membership and coverage information and obtain pre-certification on patients from other Blue Plans.

BlueCard PPO: A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO Member: Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard® Program: This Blue Cross and Blue Shield Association ("BCBSA") out-of-area or reciprocal programs allowing claims to be covered by another Licensed Blue Cross and Blue Shield Plan ("Blue Plan") to permit the submission of claims for payment to BCBSNE for BCBSNE's coordination with the appropriate Blue Plan in adjudicating the claim according to the covered person's Contract. The provisions of this agreement shall apply, including provisions related to charges for Covered Services, under the Blue Cross and Blue Shield out-of-area and reciprocal programs. Provider shall accept reimbursement by BCBSNE as payment in full for Covered Services provided to such covered

persons except to the extent of Deductibles, Coinsurance, Copayments, and/or Charges associated with noncovered services.

BlueCard Worldwide®: A program that allows Blue members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from health care providers worldwide. The program also allows members of foreign Blue Cross and/or Blue Plans to access domestic (United States) Blue provider networks.

Blue Cross and Blue Shield Association: National Association of Independent Blue Cross and Blue Shield Plans; the organization which works to coordinate the efforts of onsite Blue Cross and Blue Shield Plans at the national level.

CMS: Centers for Medicare and Medicaid Services are a branch of the Department of Health and Human Services that issues rules and regulations for the Medicare program.

CMS 1500: The standard paper claim form to bill Medicare fee-for-service providers. The electronic version is the 837P. BCBSNE requires this standard format to file a professional claim.

CPT - Current Procedural Terminology: Current Procedural Terminology (CPT) is a book published and updated by the American Medical Association. This book lists descriptive terms and identifying codes for reporting medical services. The procedure code that best describes the services provided is required on claims.

Cardiac Rehabilitation: Use of various modalities of treatment to improve cardiac function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

Care Transition: A collaborative process that helps coordination and continuity of health care during a movement from one healthcare setting to home, while promoting quality and cost-effective outcomes.

Case Management: A collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet a covered member's and their family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Certification (Certified): Successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be complying when they are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the Contract provisions or state law.

Charges: The amount per service or supply regularly established by the Provider which is billed to the general patient population.

Clean Claim: A claim for payment of health care services provided to a covered person by a Provider on a UB04 or CMS 1500 (or successor forms) or an equivalent electronic form that is submitted in compliance with BCBSNE's Policies and Procedures, with all required fields completed and with all information necessary to adjudicate the claim. If the claim must be returned for any reason, it is NOT considered a clean claim.

Cognitive Training: A rehabilitative intervention aimed at retraining or facilitating the recovery of mental and information processing skills, including perception, problem-solving, memory storage and retrieval, language organization and expression.

Coinsurance: The percentage of the allowable charge which the covered person must pay after the deductible has been satisfied and based on the applicable contract.

Concurrent Review: Utilization management conducted during a patient's ongoing course of treatment in an inpatient facility to assure that it remains the most appropriate setting for the care being rendered. NEtwork BLUE hospitals obtain extensions in benefits beyond precertification of the initial admission through the Utilization Management program. If we have been notified of the admission, we will contact the hospital, treatment center or the physician to determine the treatment plan and obtain clinical information needed to complete the review.

Congenital Abnormality: A condition existing at birth which is outside the broad range of normal, such as cleft palate, birthmarks, webbed fingers or toes. Normal variations in size and shape of the organ, such as protruding ears, are not considered a congenital abnormality.

Consultations: Physician services by providers with different specialties or subspecialties for a patient in need of specialized care requested by the attending physician who does not have that expertise or knowledge.

Content of Service: Refers to specific services and/or procedures, supplies and materials that are considered by BCBSNE to be an integral part of previous or concomitant services or procedures, or all inclusive, to the extent that separate reimbursement is not recognized by BCBSNE.

Charges denied as "content of service" are the participating physician's liability and may not be billed to the member. The charges for any line item denied previously as "content of service" by BCBSNE should not be added to the billed amount on another line item in a corrected claim.

Contract: An insurance contract or administrative services agreement outlining the covered services, benefits allowed for those covered services, and other related topics. The contract includes any endorsements, the master group application, subgroup applications, addenda and

individual enrollment forms of subscribers, the summary plan description and amendments, and any health plan documents designated or qualified as such under applicable federal or state law.

Contracted Amount: The payment mutually agreed to by BCBSNE and provider for services and supplies received by a covered person.

Coordination of Benefits (COB): Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Copayment: The fixed dollar amounts payable by the covered person for the Covered Services identified in the applicable Contract, Master Group Application or Summary Plan Description.

Cosmetic: Any services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Charge: The part of a charge for which benefits would be provided under the terms of the Contract except for any Coinsurance and Deductible amount.

Covered Person: Any person entitled to benefits at the time services are rendered for Covered Services pursuant to a Contract underwritten or administered by BCBSNE.

Covered Services: Any single service or combination of services, provided to covered persons for which benefits are payable under the terms of a benefit contract, pursuant to all applicable state and federal law.

Custodial Care: The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Care given to a patient who:

- Is mentally or physically disabled; and
- Needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home; and
- Is not under active and specific medical, surgical or psychiatric treatment which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance, within a reasonable time, which will not exceed one year in any event.

A custodial care determination may still be made if the care is ordered by a physician or services are being administered by a registered or licensed practical nurse.

Deductible: An amount which the covered person must pay each calendar year for Covered Services before benefits are payable based on the applicable Contract.

Diagnosis Code: Specific description for the reason a person is seeking medical care. ICD-10CM is the appropriate coding method to describe the reason for the encounter.

Discharge Planning: The process of assessing a covered person's need for medically appropriate and timely discharge. The hospital and the attending physician have major responsibility for this function. Blue Cross and Blue Shield Case Management promotes and assists the hospital discharge planners.

Distant Site: The site where the provider rendering the professional service is located.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of enough severity, including, but not limited to, 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 persons or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious impairment of any bodily organ or part of such person; or
- Serious disfigurement of such person.

EPO: An Exclusive Provider Organization, or EPO, is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

Exclusion: A provision in the covered person's Contract stating situations or conditions for which there is no coverage.

Explanation of Benefits (EOB): The document provided to members showing a breakdown of how the claim was adjudicated. The EOB breakdown of charges includes:

- Total billed
- BCBSNE payment
- Covered person's liability
- Coinsurance
- Deductible
- Non-covered amounts
- Provider write off

Explanation of Medicare Benefits (EOMB): A notice sent to the Medicare beneficiary explaining the Medicare payment.

Federal Employee Health Benefit Program (FEHBP): The largest nationally underwritten group covering employees of the federal government and their dependents. FEHBP members have an identification number that starts with the single alpha prefix "R."

GABBI (Greater Access to Blue Cross and Blue Shield of Nebraska): The voice response service for health care professionals who need to obtain benefit eligibility information or claim status. Call 800- 635-0579. You will need your NPI, cardholder's name and ID number, the patient's date of birth and the dates of service.

HCFA (Health Care Financing Administration): Health Care Financing Administration is a branch of the Department of Health and Human Services that issues rules and regulations for the Medicare program.

HCPCS (Health care Common Procedure Coding System): Medicare's National Level II codes – the Health Care Common Procedure Coding System is a 5-digit alpha-numeric code. This system of coding is an expansion of the CPT coding structure and includes coding for ambulance, home medical equipment, injectables, etc., which are not available with CPT coding.

Health Maintenance Organization (HMO): An entity or organized system of health care that provides, offers or arranges for coverage of designated health care services to a voluntarily enrolled population in a geographic area for a fixed, prepaid premium.

Hold Harmless: An agreement with a health care provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the health care provider has contractually agreed on with a Blue Plan as full payment for these services.

Home Health Aide Services: Medically necessary personal care services provided by a licensed or Medicare-certified home health agency to a covered person that relate to the treatment of his or her medical condition. Such services must be ordered by a physician and performed under the supervision of a registered nurse. Such services include, but are not limited to, bathing, feeding and performing household cleaning duties directly related to the covered person.

Home Infusion Therapy: Medically Necessary Covered Services and supplies required for administration of a Home Infusion Therapy regimen when ordered by a physician.

Home Medical Equipment (HME) (Durable Medical Equipment-DME): Equipment and supplies medically necessary to treat an Illness or Injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Home medical equipment includes such items as prosthetic

devices, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

Homebound: An individual will be essentially homebound if he or she has a condition due to an illness or injury which considerably restricts the ability to leave his or her residence without the aid of supportive devices, the use of special transportation or the assistance of another person. The patient who does leave the residence may still be considered homebound if the absences from the place of residence are infrequent or for periods of relatively short duration and attributable to the need to receive medical treatment that cannot be provided in the home.

Hospice: Hospice care is a program of care for person diagnosed as terminally ill, and their families.

Hospice services include:

- Home Health Aide Services;
- Hospice Nursing Services provided in the home;
- Respite Care;
- Medical Social Services;
- Crisis Care; and
- Bereavement Counseling.

Hospital: An institution or facility duly licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and/or treatment services with 24-hour per day nursing services to two or more nonrelated persons with an illness, injury, or pregnancy, under the supervision of a staff of physicians licensed to practice medicine and surgery.

Illness: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way and is manifested by a characteristic set of signs or symptoms.

Injury: Physical harm or damage inflicted to the body from an external force.

Inlier Rate: Base reimbursement amount for a DRG. When Covered Charges are less than Inlier Rate, the reimbursement is the Inlier Rate.

Inpatient: Admission to a hospital or other institutional facility for bed occupancy to receive acute care services. Services must consist of active medical and nursing care to treat the condition(s). The condition(s) must require continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting. The stay must encompass two midnights.

Inpatient Days: Inpatient hospital, acute care, acute rehabilitation facility, mental health facility, Alcoholism or Drug Treatment Center or Skilled Nursing Facility days. The day of admission shall be counted, but the day of discharge shall not be counted.

(Exception: When the patient is discharged on the same day as admitted or is transferred to another acute care facility on the same day as admitted.)

Inpatient Stay: The period from entry (admission) into an acute care hospital, acute rehabilitation, mental health facility, skilled nursing facility, or alcoholism or drug treatment center until discharge from that facility. The stay must encompass two midnights.

International Classification of Diseases, 10th Revision, Clinical Modification (ICD- 10-CM): ICD- 10-CM is a comprehensive list of diagnosis codes and narrative. ICD- 10-CM is based on the International Classification of Diseases, 10th Revision Clinical Modification codes and instructions; as well as Medicare regulations and manuals issued by the Centers for Medicare and Medicaid Services (CMS) and by the Health Care Financing Administration (HCFA). Diagnosis is required on claims submitted to BCBSNE.

Investigative: A technology, a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been scientifically validated.
BCBSNE, or the applicable Blue Plan, will determine whether a technology is investigative or not scientifically validated.

Licensure: Permission to engage in a health profession that would otherwise be unlawful in the state where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

Managed Care: A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving access to quality, cost-effective health care.

Medicaid: A jointly funded, Federal-State health insurance program for low-income and people in need. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments

Medicare: Health insurance for the aged and disabled, Title XVIII of the Social Security Act, as amended.

Medicare Advantage: "Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare." MA offers Medicare beneficiaries several product options (like those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

Medicare Crossover: The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Supplemental: Pays for expenses not covered by Medicare. Medicare Supplement plans help pay some of the health care costs that the Original Medicare Plan does not cover.
For more information go to the Medicare Supplement tab of Medicare.gov.

Member: A person that is covered by a BCBSNE benefit plan.

Mental Health Services: Assessment, treatment and supportive maintenance, activities delivered within a program that has as its primary mission the delivery of care for mental illness. These services are designed for persons with a diagnosis classified in the Diagnostic and Statistical Manual of Mental Disorders other than individuals with solely mental retardation or substance abuse diagnosis.

Mental Health Services Provider: A qualified physician, licensed psychologist, licensed special psychologist, and licensed mental health practitioners who are payable providers under the covered person's contract. A mental health practitioner may also be called a licensed professional counselor or a licensed social worker who is a duly certified/licensed professional acting within the scope of his or her practice according to state law. It also includes, for purposes of the contract, auxiliary providers; who are working under supervision and billed for by a professional as permitted by state law. All mental health services must be provided under appropriate supervision and consultation requirements as set forth by state law.

- Licensed clinical psychologist - Psychologist shall mean a person licensed to engage in the practice of psychology in this or another jurisdiction. The terms certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.

- Licensed special psychologist - A person who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association, but who is not certified in psychology. Such person shall be issued a special license to practice psychology that continues existing requirements for supervision by a licensed psychologist or qualified physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health services without supervision.

- Licensed mental health practitioner - A person licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for referral or consultation to a qualified physician or a licensed psychologist.

Mental Illness: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy. Also referred to as ssychiatric (mental llness, drug abuse and alcoholism).

Maternity: Includes obstetrics, abortions, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies or other conditions or complications caused by Pregnancy. A complication caused by pregnancy is a condition that occurs prior to the end of the pregnancy, distinct from the pregnancy, but caused or adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of pregnancy as that terminology is used in the contract.

Modifier: A means by which the reporting physician can indicate that a service or procedure performed has been altered by some specific circumstance, but not changed in its definition or code.

Network Provider: Practitioner, institution or other health care entity that has entered into an agreement with BCBSNE, has met all BCBSNE credentialing standards, and has been approved as a network provider by BCBSNE. This includes provisional practitioners when they are being supervised by a network provider.

Noncovered Person: A person who is not covered under the contract and for whom benefits are not available.

Noncovered Services: Services for which benefits are not provided under the covered person's contract.

Observation Period: The period of treatment when the physician is evaluating the patient's medical condition to determine whether the patient can be released from the outpatient department or admitted to the facility as an inpatient; or the period of treatment following an outpatient procedure when the physician is evaluating the patient's medical condition to determine whether the patient can be released from the outpatient department.

Other Payer/Party Liability (OPL): Cost containment programs that ensure that Blue Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, workers' compensation, subrogation, and no-fault auto insurance.

Outlier Threshold: The defined point at which covered charges exceed the expected charges for a DRG category, and additional reimbursement is added to the base reimbursement (inlier rate).

When Covered Charges are less than the outlier threshold, the reimbursement is the inlier rate. When covered charges exceed the outlier threshold, the reimbursement is the total of the inlier rate plus a percentage of the amount above the defined outlier threshold.

Outpatient: A person treated in the outpatient department or emergency room of an institutional facility, in an ancillary facility, in an ambulatory surgical center or a physician's office.

Outpatient Program: An organized set of resources and services for a substance abusive or mentally ill population, administered by a certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and outpatient programs that provide primary treatment for mental illness or substance abuse must be provided in a facility that is licensed by the Department of Health and Human Services Regulation and Licensure and whose program is certified by the Division of Alcoholism, Drug Abuse and Addiction Services (or

equivalent state agency) or accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

This definition does not include programs of co-dependency, family intervention, employee assistance, probation, prevention, educational or self-help programs, or programs that treat obesity, gambling, or nicotine addiction. It also does not include residential or day rehabilitation services for mental illness, or residential, halfway house or methadone maintenance programs for substance abuse. Benefits will not be provided for programs ordered by the court which are not medically necessary as determined by BCBSNE.

Originating Site: An originating site is the location where a patient gets physician or practitioner medical services through a telecommunications system. The patient must for to the originating site for the services located in either:

- Rural health clinic
- Critical access hospital

Outpatient Services: A variety of diagnostic and treatment services in a non-residential setting. These services may include preadmission screening; assessment; individual group and family therapy.

Participating Provider: Any licensed hospital, practitioner of the healing arts, or licensed and qualified provider of health care services, supplies, or home medical equipment who has contracted with BCBSNE or other plan through the BlueCard Program to provide Covered Services to covered persons.

Per Diem: An all-inclusive Contracted Amount for each Day of Inpatient Covered Services.

Physical Rehabilitation: The restoration of a person who was totally disabled as the result of an Injury or an acute physical impairment to a level of function which allows that person to live as independently as possible. A person is totally disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

Physician: Any person holding a license who is duly authorized to practice medicine, practice surgery and prescribe drugs.

Plan: An individual organization participating in the Blue Cross and Blue Shield Association.

Point of Service (POS): A plan which incorporates Managed Care through a primary care physician who coordinates care within a network of providers with the option to self-refer out of the network to a provider of choice at the time of treatment. Reimbursement levels vary based on the option selected.

Policies and Procedures Manuals: Manuals published by BCBSNE set forth the billing, payment, utilization management, certain medical policies and other administrative guidelines under the Agreement. These manuals are updated by BCBSNE from time to time by the Update Newsletter and, where applicable, under the Modification terms of the Agreement. The Policies and Procedures Manuals are incorporated as Attachment I of the Agreement.

Provider will follow all applicable BCBSNE policies and procedures and those applicable to the covered Person, and Provider agrees to provide appropriate information to provider employees, agents and representatives consistent with this commitment.

Preauthorization: Prior written approval of benefits. Preauthorization is based on the terms of the covered person's contract and is based on the information submitted to the applicable Blue Plan for review.

Preexisting Condition: A condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the first day of coverage, or if there is an eligibility waiting period, the first day of such waiting period. A preexisting condition does not include a pregnancy when coverage is subject to the Health Insurance Portability and Accountability Act of 1996.

Prefix: The three characters preceding the subscriber identification number on Blue Cross and/or Blue Shield Plan ID cards. The prefix identifies the member's Blue Cross and/or Blue Shield Plan or national account and is required for routing claims.

Principal Diagnosis: The condition which is determined to be the primary reason for admission.

Principal Procedure: The procedure performed for definitive treatment, rather than for diagnostic or exploratory purposes, or to resolve a complication. More than one procedure may meet this definition and may be listed on the claim.

RBRVS (Resource Based Relative Value Scale): RBRVS system assigns a value of each medical procedure or service based on the resources the physician or Provider used including physical or procedural resources, educational, mental or cognitive, and financial resources.

Remittance Advice (RA): The BCBSNE claim payment report for participating hospitals, physicians and other providers of health care services. The RA is a record of how payment was made: Total Charges, covered person's Liability, Provider Liability, and BCBSNE Payment.

Respite Care: Short-term Inpatient care which is necessary for the covered person to give temporary relief to the person who regularly assists with the care at home. Respite care may be provided in the hospice program's designated Inpatient unit that is affiliated with the Hospice that is providing services to the covered person, in an acute care setting in a hospital or in a skilled nursing facility.

RX Nebraska Information Network: This audio response system verifies a patient's prescription drug card eligibility copay amounts and effective dates.

Scientifically Validated: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all the factors set forth below:

- Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine scientific validity.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

- The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition, there should be evidence based on established medical facts that such measurement or alteration improves the health outcomes.

- Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes but is not limited to Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.

- The technology must improve the net health outcome.

- The technology must improve the net health outcome as much as or more than established alternatives.

- The improvement must be attainable outside the investigational settings.

BCBSNE, or applicable Blue Plan, will determine whether a technology is not scientifically validated or investigative. BCBSNE shall post those technologies that it has previously determined to be not Scientifically Validated or Investigative and shall make such determinations available on its website. The absence of a medical policy shall not prohibit BCBSNE or the applicable Blue Plan from concluding that a matter is or is not scientifically validated or investigative.

Skilled Nursing Care or Service: Medically necessary inpatient skilled nursing services for the treatment of an illness or injury that must be ordered by a physician and performed under the supervision of a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.). The classification of a service as skilled is based on the technical or professional health training required to effectively perform the service. Services by other licensed professional providers within their scope of practice, and ordered by a physician, are included in Skilled Nursing Care.

A nursing service is not considered skilled merely because it is performed by an R.N. or L.P.N. The service cannot be regarded as Skilled Nursing when it can be safely and effectively performed by the average nonmedical person (or self-administered) without the direct supervision of a licensed nurse.

Subrogation: Subrogation is our right to recover benefits paid for Covered Services as the result of an Injury or Illness which was caused by a third party. We also assert a contractual right of recovery to collect proceeds recovered from a third party. Subrogation and the contractual right of recovery are prior liens against any proceeds recovered by the covered person.

Claims will be paid according to the covered person's Contract, then BCBSNE will seek reimbursement from the other party. The recovery amount will not exceed the amount we paid in benefits.

Substance Abuse: For purposes of the contract, this term is limited to alcoholism and drug abuse.

Supervision: The ready availability of the physician for consultation and direction of the activities of another provider who is providing health care services within his or her defined scope of practice.

Tax Identification Number (TIN): The TIN is the number you use to file income tax with the IRS.

Telehealth: The use of telecommunications technologies to exchange medical information from one site to another to improve a patient's clinical health status. Telehealth is a synchronous service rendered via real-time interactive audio and video telecommunications system between a provider and a patient or an Asynchronous service where information is uploaded to a provider from a patient.

Telemedicine: Two-way video communication between two or more providers with or without the patient present.

Telemonitoring: The remote monitoring of a patient's vital signs, biometric data, or other subjective data by a monitoring device which transmits such data electronically to a health care provider for analysis and storage.

Third-Party Payer: A company, organization, insurer or government agency that makes payments for health care services received by a patient. Blue Cross Blue Shield Plans, commercial insurance

companies, Medicare, Medicaid, HMOs and PPOs. The patient and the provider of service are the first two parties to the delivery of health care services; the insurer becomes the third party.

Transfer Per Diem: When a patient is transferred between two or more hospitals, and a Transfer Per Diem has been set for the applicable DRG, the transferring hospital will be reimbursed an all-inclusive contracted amount for each medically necessary inpatient day.

UB04: The Uniform Bill UB04 is intended to be used by the major Third-Party Payors, most hospitals and nursing homes. The data elements and design of the form are determined by the National Uniform Billing Committee. The NUBC has developed uniform definitions and procedures for completing the form. The procedural guidelines are designed to provide actual completion instructions for each payor.

Utilization Management (UM): Evaluation by BCBSNE or its designee of the medical necessity, appropriateness, and efficiency of the use of health, mental and dental care services, medical equipment and supplies, drugs, biologicals, procedures, and facilities based on the benefits available under the applicable health benefit plan. UM is sometimes called utilization review. Benefits may be excluded for services, procedures, supplies, drugs or home medical equipment found to be not Medically Necessary

Work-Hardening: Physical therapy or similar services provided primarily for strengthening an individual for purposes of his or her employment.

Workers' Compensation: The Nebraska Workers' Compensation laws are designed to provide certain benefits to employees who:

1. Sustain injury or contract occupational disease,
2. Arising out of and during their employment, and
3. Are not willfully negligent at the time of their injury.

The Nebraska Workers' Compensation Act (NWCA) applied to most employers in Nebraska; however, some exceptions include employers of farm or ranch laborers and domestic workers, independent contractors and non-incorporated business owners.