Term	Definition
Benchmark	The normative groups against which your cost and utilization are being compared. This is based on the populations of similar size, geographic location and type of business using North American Industry Classification System (NAICS) codes.
Capitation	Dollars paid to a provider for care of a member on a per member per month basis.
Chronic Condition	An industry standard classification of non-acute disease states. Includes Coronary Artery Disease (CAD), Congestive Heart Failure (CHF)
Coinsurance	A percentage of the claim cost for which a member is responsible.
Co-morbidities	The simultaneous presence of two or more chronic diseases or conditions.
Contract Tier	
Coordination of Benefits (COB)	Determination of primary payor when more than one insurance coverage exists.
Copayment	A specific dollar amount of a claim for which a member is responsible.
Deductible	A specific dollar amount for which the member is responsible prior to the benefits being applied.
Diagnostic Related Group (DRG)	Industry standard method to group inpatient diagnoses and services for payment.
Discounted Allowable Charge	The total amount of a medical claim that is considered eligible for payment after provider discounts, before **Coordination of Benefits (COB)** and **member liability** are applied.
Drug Net Payment	The sum of all payments made for prescription drug services by the plan.
Emergent Visit	An Emergency Room visit that, based on the ER admitting diagnosis code, may be considered life-threatening.
Engaged	An individual that was outreached for Care Management and had at least one meaningful conversation with a health coach.
Free-Standing Lab	A laboratory that is not associated with a hospital.
Gap in Care Percentage	The ratio of members that did not receive a preventive screening or service, but were eligible based on nationally recognized criteria (HEDIS). Note: Members who received these services prior to enrollment with the plan may appear to have a gap.
High Cost Claimant (HCC)	A member whose total net payments exceed a user defined threshold.
In Network	The doctors, hospitals, labs, and other health care providers who contract with the plan to deliver services to members.
Inpatient	Any medical services that require an admission into a hospital. Inpatient payments include amount paid to inpatient facility and for professional services delivered in inpatient setting.
Medical Net Payment	The sum of all payments made for medical services by the plan.
Member Liability	The sum of all payments made by a member. This includes coinsurance, copayment, and deductible.
Network expenses	Payments associated with processing claims incurred out of the plan service area.
Non-Emergent Visit	An Emergency Room visit that, based on the ER admitting diagnosis code, is not considered life-threatening.
Out of Network	The doctors, hospitals, labs, and other health care providers who do not contract with the plan to deliver services to members.
Outpatient	Any medical service provided at a medical facility that does not require an admission into a hospital.
Outpatient Lab	A laboratory that is associated with a hospital.
Outreach (Digital or Health Coach)	Contacts with members via email, text, IBXWire, IVR, mailings, or phone. May be unique at the member level or at the program level.
PCP	Primary Care Physician - The doctor you see for most of your health care needs. HMO plans require you to choose a PCP, who will refer you to a specialist when needed. PPOs do not require that you choose a primary care physician.
Per thousand	Method of measuring units/ admits/ days/ services/ visits/ scripts that allows for accurate comparison from period to period and to other populations.
Pharmacy Net Payment	The sum of all payments made for pharmacy services by the plan.
PMPM (Per Member Per Month)	Method of measuring costs that allows for accurate comparison from period to period and to other populations.
Prevalence	Percent of unique members with a condition.
Preventive Services	Routine services recommended to maintain optimal health.
Professional	Non-facility services including physician office visits, therapies and durable medical equipment.
Quality Incentive Payment System (QIPS)	Program to reward providers for high quality care to attributed members.
Retail Clinic	Clinics located in retail stores, supermarkets and pharmacies that treat minor illnesses and provide preventive health care services.
Risk Score	Assigns a numerical value to a members potential health status.
Targeted	Identified as a candidate for a care management program.
Urgent Care Center	Free-standing facility that is not located at a hospital and delivers non-emergent, non-routine care.