M	
Maintenance Drug	A prescription drug prescribed for the control of a chronic disease or illness, or to alleviate the pain and discomfort associated with a chronic disease or illness.
Major Medical	Major medical benefits supplement the hospital and medical/surgical portions of basic coverages. The member shares in the cost of medical expenses through an annual deductible and coinsurance.
Managed Care	Managed care programs integrate the delivery and financing of medical care. The programs offer health care coverage through a network of contracting physicians who provide care to people who subscribe to the plan (called "members"). Managed care programs provide preventive coverage to members and use its network of physicians to assist in determining the appropriateness and the efficiency of the members' care in order to promote and maintain good health while conserving resources.
Maximum	The greatest amount of benefits that the health plan will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days, or number of services.
Medicaid	A federal entitlement program that provides health and long-term care coverage to certain categories of low income Americans. States design their own Medicaid programs within broad federal guidelines.
Medical Care and Reduction of Error Fund (MCARE Fund)	Medical doctors, doctors of osteopathy, and nurse midwives are all required by Pennsylvania law to participate in the Pennsylvania Medical Care and Reduction of Error Fund ("MCARE Fund"). By law, these providers must maintain primary medical malpractice insurance with liability limits of $500,000 per medical incident and $1.5 million in the annual aggregate in addition to the limits provided by the MCARE Fund of $500,000 per medical incident and $1.5 million in the annual aggregate (for a combined total of $1 million per incident and $3 million in annual aggregate).
Medical Policy	Medical policies are documents that provide medical necessity and coverage guidelines for all of our medical-surgical products, including managed care. These guidelines address hundreds of medical issues, including diagnostic and therapeutic procedures, injectable drugs, and durable medical equipment.
Medical Policy Update	Medical Policy Update is the monthly newsletter for most health care professionals (and office staff) and facilities who participate in Highmark's networks and submit claims to Highmark using the 837P HIPAA transaction or the CMS 1500 form, or the 837I HIPAA transaction. Medical Policy Update focuses only on medical policy and claims administration updates, including coding guidelines and procedure code revisions, and is the sole source for this information.

Medical Review Committee (MRC)	The Highmark Medical Review Committee investigates and resolves claim disputes arising out of the relationship between the Corporation and professional health care providers in Pennsylvania who render health services to Highmark members. In addition, appeals of credentialing decisions in Pennsylvania are directed to the Medical Review Committee.
Medically Necessary and Appropriate	The term "Medically Necessary," "Medical Necessity," or such other comparable term in any provider contract shall mean health care services (or such similar term as contained in the applicable benefit agreement or plan document to include, but not be limited to, "health services and supplies," "services and supplies," and/or "medications and supplies") that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: • In accordance with generally accepted standards of medical practice; • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; and • Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
Medically Underwritten	Health insurance benefit plans that base acceptance for enrollment on health status, determined by the answers given on a medical questionnaire.
Medicare	Medicare is health insurance for people age 65 or older, under age 65 with disabilities, and any age with permanent kidney failure (called "End-Stage Renal Disease"). Medicare has two parts: Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). You have two choices about how you get your Medicare coverage. Here are the two main options: • Original Medicare: Managed by the Federal government, it provides Medicare Part A and Part B coverage. You can choose to have either one or both parts. • Medicare Advantage Plans (called Part C): You must have both Part A and Part B to join one of these plans. They provide all of your Part A and Part B services and generally provide additional services. You usually pay a monthly premium, and copayments that will likely be less than the coinsurance and deductibles under Original Medicare. In most cases, these plans also offer Part D prescription drug coverage. These plans are offered by private insurance companies approved by Medicare. Costs and benefits vary by plan.

Medicare Administrative Contractor (MAC)	Medicare Administrative Contractors, or MACs, are private organizations that carry out the administrative responsibilities of Traditional Medicare (Parts A and B). They also handle durable medical equipment, home health, and hospice claims.
Medicare Advantage or Medicare Part C	In an effort to make broader and more cost-effective coverage options available to people eligible for Medicare, the Centers for Medicare & Medicaid Services (CMS) created "Medicare Part C." This term includes a wide variety of delivery models. All of these models are funded through a combination of payments from the Medicare program and the member's premium. Medicare Advantage products are available only to individuals who are entitled to Medicare Part A and enrolled in Medicare Part B and over the age of 65 and/or disabled.
Medicare Advantage Medical Savings Account Plan (MSA)	Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.
Medicare Overcharge Measure (MOM) Act	On Sept. 8, 1990, the Medicare Overcharge Measure (MOM) Act was passed. This prevents the majority of all health care providers in the state of Pennsylvania from billing Medicare beneficiaries any amount in excess of the Medicare reasonable charge.
Medicare Part D	Highmark offers Medicare Part D prescription drug coverage under many of its Medicare Advantage HMO and PPO plans, as well as through the Medicare-approved stand-alone *Blue Rx* Prescription Drug Plans. These plans provide coverage for prescription drugs that are covered under the Medicare Prescription Drug Benefit (Part D) and that are also on the Highmark Medicare-approved formulary for Medicare products.
Medigap Policies	Medigap coverage is health insurance that supplements Medicare's benefits by filling in some of the coverage gaps. These policies only work with the original Medicare Part B Plan. Medigap policies pay most of the coinsurance amounts for Medicare eligible services.
Member	A member is an individual who is enrolled in a health plan and who meets the eligibility requirements of the program.
Member Appeal	A member appeal is a request from a member or member's authorized representative to review an adverse benefit determination. This includes services related to coverage, which includes contract exclusions, non-covered benefits, and decisions related to the medical necessity and/or appropriateness of a health care service. This also includes full or partial adverse benefit determinations involving a requested health care service or claim.

Member Grievance (for managed care per PA Act 68)	In Pennsylvania, a member grievance is a process by which a member or member's authorized representative (or provider on behalf of a member) with the written consent of the member may file a written or verbal grievance regarding the denial of payment of a health care service on the basis of medical necessity and appropriateness. A grievance may be filed regarding a decision that: 1) disapproves full or partial payment for a requested health care service; or 2) approves the provision of a requested health care service for a lesser scope or duration than expected; or 3) disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.
Moderate Sedation or Conscious Sedation	Moderate sedation, also known as conscious sedation, induces an altered state of consciousness that minimizes pain and discomfort through the use of pain relievers and sedatives. Patients who receive moderate sedation usually are able to speak and respond throughout the procedure.
Modifier	A modifier is a two-character code – numeric, alphabetical, or alpha-numeric – that is placed after the usual procedure code. A modifier permits a provider to indicate whether a service or procedure has been altered by specific circumstances, but not changed its definition or code.
Motor Vehicle Financial Responsibility Law	The Motor Vehicle Financial Responsibility Law requires anyone who registers a motor vehicle in Pennsylvania to provide for specific levels of medical insurance coverage. • The law mandates a minimum of $5,000 in medical benefit coverage must be available for each accident victim. • The victim's motor vehicle accident insurance is always the primary payer for the treatment of injuries sustained in an automobile accident. • Highmark may pay for covered services after the automobile insurance benefits are exhausted.
MyCare NavigatorSM	MyCare Navigator is a telephone-based support service available to most Highmark members to help them make informed decisions and get the care that they need. The service is free and can be accessed 24 hours a day, seven days a week, 365 days a year.