Medicare Glossary

A

- **Accreditation** - The process when organizations review a medical facility to ensure they meet a predetermined set of criteria.
- **Advance Beneficiary Notice of Noncoverage (ABN)** - A notice that a medical provider or supplier gives a Medicare beneficiary if the medical providers or supplier believes that Medicare may deny payment for a given service.
- **Advance coverage decision** - A notice your Medicare Advantage plan provides before a particular medical service stating whether it is covered or not.
- **Amyotrophic Lateral Sclerosis (ALS)** - A degenerative disease that harms nerve cells in the spinal cord and brain and often leads to muscular weakness or atrophy. It's also called Lou Gehrig's disease.
- **Ambulatory Surgical Center** - A surgical medical facility where patients aren't expected to need more than 24 hours of post-surgical care.
- **Appeal** - The action you take if you disagree with a particular coverage or payment decision made by your Medicare plan.
- **Assignment** - An agreement by your medical provider or supplier to accept the Medicare-approved amount as payment in full for a particular service.

B

- **Beneficiary** - A person who received health insurance through the Medicare program.
- **Benefit period** - A set time for your Medicare Part A hospital or skilled nursing facility services. It begins the day you're admitted as an inpatient and ends when you haven't received that care for 60 days in a row.
- **Benefits** - The medical services covered under a particular health insurance plan.

C

- **Catastrophic coverage** - An insurance plan that helps protect you from paying very high out-of-pocket costs by capping certain costs once you reach a set yearly limit. Original Medicare doesn't have this type of coverage, but Medicare Part D prescription drug plans and certain Medicare Advantage plans do.
- **Centers for Medicare and Medicaid Services (CMS)** - The federal agency that manages Medicare, Medicaid and the Children's Health Insurance Program.
- **Claim** - A payment request that you submit to Medicare when you get services that you believe are covered.
- **Coinsurance** - A charge that you may have to pay for a medical service, typically after you meet your deductible. It's usually a percentage, such as 20%.

- **Coordination of benefits** - A way to figure out payment for a service when 2 or more health insurance plans are responsible.
- **Copayment** - A charge that you may have to pay for a medical service, doctor visit or prescription drug. It's usually a flat fee.
- **Cost sharing** - Your portion of the bill that you may have to pay for a medical service, doctor visit or prescription drug as outlined by your insurance plan. This may include deductibles, copayments and coinsurance.
- **Coverage determination** - The decision your Medicare Part D prescription drug plan makes about your drug benefits such as if a particular drug is covered and how much you have to pay.
- **Coverage gap** - A time period where you pay a higher rate of cost sharing for prescription drugs until you qualify for catastrophic coverage. It's also called the donut hole.
- **Creditable coverage** - Insurance coverage from a previous insurance plan that fits the new insurance plan's basic requirements.
- **Custodial care** - A broad term for certain types of non-skilled care such as help with eating, bathing or dressing.

D

- **Deductible** - The amount you pay for certain health coverage before your insurance plan pays for anything.
- **Demonstrations** - Projects that test specific ways to improve the Medicare program.
- **Dental coverage** - Insurance benefits that help cover dental treatments such as teeth cleaning, fillings and X-rays.
- **Department of Health and Human Services (HHS)** - The federal agency that oversees the Centers for Medicare and Medicaid Services (CMS).
- **Drug list** - A list of prescription drugs that a specific insurance plan covers. It's also called a formulary.
- **Durable medical equipment** - Special equipment, such as wheelchairs or hospital beds that is prescribed by your medical provider.
- **Durable power of attorney** - The legal document that names another person who can make health care decisions on your behalf.

E

- **Employer or union retiree plans** - Insurance plans that employers or unions provide for certain people after they retire from a workplace.
- **End-Stage Renal Disease (ESRD)** - A medical condition that is marked by permanent kidney failure.
- **Exception** - A prescription drug plan decision, in response to your formal request, to either cover a prescription drug that is not on the formulary or to charge a lower amount for a specific prescription drug that you need.

- **Excess charges** - The amount a medical provider can legally charge you over what the Medicare-approved amount is in Original Medicare.
- **Extra help** - The Medicare program that helps people with limited incomes cover costs such as deductibles, premiums and coinsurance.

F

- **Federally qualified health center** - Nonprofit medical clinics or centers that help serve medically underserved areas.
- **Formulary** - A list of prescription drugs that a specific insurance plan covers. It's also called a drug list.

G

- **Generic drug** - A prescription drug that has the same active ingredients as a brand name prescription drug.
- **Grievance** - A formal complaint about how your Medicare health or prescription drug plan is treating you, such as the plan's customer service.
- **Group health plan** - A health insurance plan provided by your employer.
- **Guaranteed issue rights** - An outlined set of rights and protections you have when purchasing a Medicare Supplement Insurance plan (Medigap).
- **Guaranteed renewable policy** - An insurance plan that can't be canceled unless you lie to the insurance company, commit fraud or don't pay your premiums on time.

H

- **Health care provider** - A person or organization that is licensed to provide medical care, such as doctors, nurses or hospitals.
- **Health coverage** - A legal agreement made by a health insurance company to pay or reimburse you for an outlined part of your health care costs in exchange for a premium.
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** - A law that assures your health information is protected.
- **High-deductible Medigap policy** - A type of Medigap plan (Medicare Supplement Insurance) that has a high deductible you must meet before the plan pays for any covered services.
- **Homebound** - A person who is either confined to their home, or has trouble leaving their home without assistance, due to an injury or illness.
- **Home health agency** - A medical organization that provides health care in your home.
- **Home health care** - Medical services and supplies a doctor deems necessary for you to receive in your home.
- **Hospice** - Specialized medical care for people who have been deemed terminally ill.
- **Hospital outpatient setting** - The area of a hospital where outpatient services are provided, such as a surgery center or an observation unit.

- **Hospital-related medical condition** - A health condition that is treated during a qualifying 3-day inpatient hospital stay, as outlined by Medicare's rules.

I

- **Independent reviewer** - An organization, unrelated to your Medicare plan that reviews your appeal case.
- **Initial coverage limit** - Your prescription drug plan's first limit you hit before entering the coverage gap, or "donut hole."
- **In-network** - The group of doctors, hospitals, pharmacies and other medical providers that agree to provide medical care to a certain insurance plan's members for a reduced price.
- **Inpatient care** - Medical care that is provided when you're admitted to a medical facility.
- **Inpatient rehabilitation facility** - A hospital that provides rehabilitation programs to people who are inpatients at the hospital.

L

- **Large group health plan** - An employee health plan for a company with at least 100 employees.
- **Lifetime reserve days** - The additional days of care that Original Medicare will cover when you're in a hospital for more than 90 days. You get a total of 60 lifetime days.
- **Limiting charge** - The largest amount you can be charged for a covered service in Original Medicare when you visit a medical provider that doesn't accept assignment.
- **Living will** - A legal document that details what medical treatments you do and don't want if you can't decide for yourself.
- **Long-term care** - Medical and non-medical care, provided in the home or in a medical facility, for people who need help with daily activities such as dressing, eating or taking medications.
- **Long-term care hospital** - A specific hospital that provides medical care for patients who need extensive treatment.

M

- **Medicaid** - A federal and state insurance program that helps provide medical care for people with limited income and resources.
- **Medical emergency** - An injury or illness that requires immediate, and possibly intensive, medical attention.
- **Medically necessary** - When a medical professional says a service or supply is required to treat a specific illness, condition, injury or disease.

- **Medical underwriting** - A process where an insurance company uses your medical history and other information to decide if you will be accepted by a specific insurance plan, if you will have a waiting period and how much you will pay.
- **Medicare** - A federal health insurance program for people 65 and older or younger people with qualifying disabilities or diseases.
- **Medicare Administrative Contractor (MAC)** - A company that processes Medicare claims.
- **Medicare Advantage Plan (Medicare Part C)** - A Medicare health plan, offered by a private insurance company, that provides your Medicare Part A and Part B benefits and may include other benefits.
- **Medicare-approved amount** - The amount that a medical provider can be paid if the provider accepts Medicare assignment.
- **Medicare-approved supplier** - A person, agency or company that Medicare has certified to provide certain medical items or services.
- **Medicare-certified provider** - A medical provider that Medicare has approved.
- **Medicare Cost Plan** - A type of Medicare health plan that has specific network rules stating that if you get medical care outside of the plan's network without a referral, your covered services will be paid for by Original Medicare.
- **Medicare Health Maintenance Organization (HMO) Plan** - A type of Medicare Advantage plan that requires you to use the plan's network of providers in most instances and may require referrals.
- **Medicare health plan** - A private medical plan that is contracted by the Medicare program, to provide plan enrollees with their Medicare Part A and Part B benefits.
- **Medicare Medical Savings Account (MSA) Plan** - A plan that combines a Medicare Advantage plan and a bank account where you can use the money to help pay for your approved health care costs.
- **Medicare Part A** - The hospital insurance part of Original Medicare that covers inpatient hospital stays, skilled nursing facility care, hospice care and certain home health care.
- **Medicare Part B** - The medical insurance part of Original Medicare that covers certain doctors' services, preventative services, medical supplies and outpatient care.
- **Medicare plan** - A medical plan other than Original Medicare, such as Medicare health plans or Medicare prescription drug plans.
- **Medicare Preferred Provider Organization (PPO) Plan** - A type of Medicare Advantage plan that offers lower costs if you use the plan's network, but allows you to use providers outside of the network for an added cost.
- **Medicare Prescription Drug Plan (Medicare Part D)** - A type of Medicare plan, provided by private insurance companies, that offers prescription drug coverage for Medicare beneficiaries.
- **Medicare Private Fee-for-Service (PFFS) Plan** - A type of Medicare Advantage plan that generally allows you to go to any medical provider or facility that accepts Medicare assignment, but has a different cost structure than Original Medicare.
- **Medicare Savings Program** - A Medicaid program that helps people with limited incomes pay for certain Medicare out-of-pocket costs.

- **Medicare SELECT** - A type of Medigap (or Medicare Supplement Insurance) plan that requires you to use a certain network and/or doctors to qualify for plan benefits.
- **Medicare Special Needs Plan (SNP)** - A type of Medicare Advantage plan that provides specialized medical care for certain groups of people, such as those with certain health conditions.
- **Medicare Summary Notice (MSN)** - A notice you receive after a medical appointment that outlines what Medicare paid for the service and what you owe.
- **Medicare Supplement Insurance (Medigap)** - A private insurance plan that helps pay for Medicare out-of-pocket costs such as certain deductibles, copayments and coinsurance.
- **Medigap (Medicare Supplement Insurance)** - A private insurance plan that helps pay for Medicare out-of-pocket costs such as certain deductibles, copayments and coinsurance.
- **Medigap basic benefits** - The set of benefits that all Medigap plans must cover.
- **Medigap Open Enrollment Period** - A 6-month enrollment period when you can enroll in a Medigap plan with added protections.
- **Multi-employer plan** - A health insurance plan that's provided by 2 or more employers.

N

- **Network** - The set of medical facilities, providers and suppliers that your health insurance plan contracted with to provide your care.
- **Network pharmacies** - Pharmacies that your health insurance plan contracted with to provide your prescription drugs at a reduced cost.
- **Non-preferred pharmacy**- A pharmacy that's part of your health insurance plan's network, but doesn't offer reduced costs like a network pharmacy.

O

- **Occupational therapy** - Treatments that help you return to your regular life and work after a medical illness.
- **Optional supplemental benefits** - Extra services that a Medicare health plan may offer that aren't included in Original Medicare.
- **Original Medicare** - A fee-for-service health insurance plan that has 2 parts: Part A and Part B.
- **Out-of-network** - A benefit offered by some Medicare Advantage plans that gives you the freedom to get certain medical services outside of the plan's network, potentially for a higher cost.
- **Out-of-pocket costs** - Any health or prescription drug costs that you have to pay on your own that aren't covered by your health insurance plan.
- **Outpatient hospital care** - Medical care you receive in a hospital setting when your medical provider didn't admit you to the hospital as an inpatient, such as for observation services, outpatient surgery or X-rays.

P

- **Penalty** - A monthly amount added to your Medicare Part B or Part D premium if you don't join a plan when you're first eligible.
- **Pharmacy network** - A group of pharmacies that agree to provide the enrollees of a specific Medicare plan with discounted prescription drug prices.
- **Physical therapy** - A method of treating a disease or injury through methods such as exercise or massage.
- **Pilot programs** - Projects that test specific ways to improve the Medicare program.
- **Point-of-service option** - The option to use a non-network medical provider or facility outside of a HMO plan for an added cost.
- **Power of attorney** - A document that lets you name someone to make your medical decisions.
- **Pre-existing condition** - A medical problem you had before you enrolled in a new health insurance plan.
- **Preferred pharmacy** - A pharmacy that's in a prescription drug plan's network.
- **Premium** - A payment to a health insurance company or Medicare.
- **Preventative services** - Medical care that may help prevent or detect an illness.
- **Primary care doctor** - The medical provider you see for the majority of your health visits.
- **Prior authorization** - A formal approval from your Medicare prescription drug plan that you get before filling a prescription stating it's covered by the plan.
- **Programs of All-inclusive Care for the Elderly (PACE)** - A type of health plan, specifically created for older adults who need nursing home care but can live at home, that combines Medicare and Medicaid services, plus other services the person needs as determined by a team.

Q

- **Qualified Disabled and Working Individuals (QDWI) Program** - A state program that helps people with limited incomes pay for Medicare Part A premiums.
- **Qualified Individual (QI) Program** - A state program that helps people with limited incomes pay for Medicare Part B premiums.
- **Qualified Medicare Beneficiary (QMB) Program** - A state program that helps people with limited incomes pay for Medicare Part A premiums, Part B premiums and other out-of-pocket costs such as deductibles, copayments and coinsurance.

R

- **Referral** - A written order from your primary care doctor to see a specialist for a specific medical treatment.

- **Rehabilitation services** - Health care services that help you regain the skills you need for everyday living after an injury or illness.
- **Religious nonmedical health care institution** - A facility that offers nonmedical services to people who need medical care, but can't because of their religious beliefs.
- **Respite care** - Temporary care for a patient, provided in a hospital, hospice inpatient facility or nursing home, so the patient's caregiver can take a break.
- **Rural health clinic** - A federally qualified health center that provides medical care in rural areas of the country.

S

- **Secondary payer** - The insurance plan or program that pays second on a medical claim.
- **Service area** - A specific geographic area that a health insurance plan will accept new members from based on where the people live.
- **Skilled nursing care** - Medical care that can only be provided by a registered nurse or doctor.
- **Skilled nursing facility (SNF)** - A nursing facility that provides skilled nursing care and other medical services.
- **Skilled nursing facility care** - Medical care received in a skilled nursing facility such as physical therapy or IV injections.
- **Specified Low-Income Medicare Beneficiary (SLMB) Program** - A state program that helps people with limited incomes and resources pay Medicare Part B premiums.
- **Speech-language therapy** - Treatment that helps you improve or regain talking or swallowing.
- **State Health Insurance Assistance Programs (SHIP)** - A state program, funded by the federal government that provides free health insurance counseling to Medicare beneficiaries.
- **State Insurance Department** - A state agency that regulates insurance and educates the public about insurance products available in the state.
- **State Medical Assistance (Medicaid) office** - A state or local agency that helps educate the public about Medicaid programs.
- **State Pharmaceutical Assistance Program (SPAP)** - A state program that helps certain people pay for prescription drug costs.
- **State Survey Agency** - A state agency that inspects and oversees medical facilities that participate in the Medicare and Medicaid programs.
- **Step therapy** - A prescription drug plan coverage rule that requires you to use a similar and cheaper prescription drug to treat your medical condition before the plan will cover the more expensive prescription drug that your doctor prescribed.
- **Supplemental Security Income (SSI)** - A monthly benefit provided by Social Security to help certain people with limited incomes who are either 65 years or older, disabled or blind.
- **Supplier** - A company, person or agency that provides a medical service or item outside of an inpatient hospital or skilled nursing facility setting.

T

- **Telemedicine** - Medical services given to a patient through technology, such as on the phone or online, by a medical provider that is in a different location than the patient.
- **Tiers** - A system in a prescription drug plan that groups certain prescription drugs together and charges a different rate for each group.
- **TRICARE** - A federal health insurance program for active-duty and retired military members and their families.
- **TRICARE FOR LIFE (TFL)** - Medical coverage for uniformed service members and their family members who are Medicare-eligible.
- **TTY** - A communication device, also called a teletypewriter that is used by people who are deaf, have a speech impairment or have difficulty hearing.

U

- **Urgent care** - Medical care you receive outside of your normal health insurance plan's service area to help treat an illness or injury that isn't life threatening.

W

- **Waiting period** - A time period between when you enroll in a health insurance plan and when the coverage begins.
- **Worker's compensation** - An employer insurance plan that covers employees who get injured or sick on the job.

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