Medicare Insurance Terms

Activities of Daily Living (ADL): Activities in which most people take part on a daily basis. Eating, bathing, dressing, toileting and moving from one place to another are some examples.

Acute Illness: A disease or condition that comes on rapidly and severely, but that can—with proper treatment—be cured, such as pneumonia or a broken bone.

Administrative Law Judge (ALJ): A hearing officer who presides over appeals to Medicare by people with Medicare or their providers. The ALJ level follows the reconsideration level for all appeals for Medicare coverage.

Advance Beneficiary Notice (ABN): Also known as a "waiver of liability." A notice health care providers and suppliers are required to give a person with Original Medicare when they believe that Medicare will not cover their services or items and the person has no reason to know that Medicare will not cover these services or items. If your provider does not give you an ABN to sign and you have no reason to know the procedure is not covered, then you do not have to pay. If you sign an ABN before you get the service or item and Medicare does not pay for it, you generally pay for it (although there are a few exceptions). Providers are not required to give you an ABN for services or items Medicare never covers.

Advance Coverage Decision: A Private Fee-For-Service (PFFS) plan's determination about whether or not it will pay for a certain service. Note: this is completely unrelated to an advance beneficiary notice (ABN), which only applies to people with Original Medicare.

Advance Directive: A legal document that outlines how you want medical and financial decisions made if you can no longer communicate your wishes. A health care advance directive may include a health care proxy, living will and a health care power of attorney.

Advanced Illness: A serious disease or condition that has progressed too far to be cured, such as cancer that has spread throughout the body.

Affordable Care Act (also known as the Health Care Law): Signed by President Obama on March 23, 2010, the Affordable Care Act (ACA) includes provisions to expand health coverage to eligible Americans, control health care costs and improve the health care delivery system. The ACA closes the Medicare Part D doughnut hole/coverage gap and expands coverage of preventive services for people with Medicare. The Act also creates state-specific Marketplaces, where individuals can go to purchase health insurance. Generally, those with Medicare should not buy health insurance in the Marketplace.

ALS/Lou Gehrig's Disease: A disease that affects the motor nerve cells of the spinal cord and causes their degeneration. Patients with this disease can qualify for Medicare coverage regardless of age.

Ambulette: A wheelchair-accessible van that provides non-emergency transportation for people with disabilities.

Annual Coordinated Election Period (ACEP): See Fall Open Enrollment

Annual Wellness Visit: This is a once a year visit covered by Medicare in which you can meet with your doctor to develop a prevention plan based on your needs. It will give you an opportunity to create and update a medical history a list of your medications and a list of your current providers and suppliers. During this visit your provider will record your weight, height, blood pressure and BMI, as well as screen for cognitive issues and depression and your ability to function safely at home. The provider should give you a 5 to 10 year screening schedule or checklist and health advice and referrals to health education or preventive counseling services or programs aimed at reducing identified risk factors and at promoting wellness.

Annual Notice of Change (ANOC): The notice you receive from your Medicare Advantage or Part D plan in late September. This notice gives a summary of any changes in the plan's cost and coverage that will take effect January 1 of the next year. Review this notice to see if your plan will continue to meet your health care needs in the following year. If you do not receive an ANOC from your plan, you should contact your plan. The ANOC is typically mailed with the plan's Evidence of Coverage (EOC), which is a more comprehensive list of the plan's cost and benefits for the upcoming year.

Appeal: A formal request for review of an official decision made by a Medicare private health plan (Part C), a Medicare private drug plan (Part D), or Original Medicare regarding payment for or coverage of health care. Federal regulations and law specify appeals deadlines, processes for handling cases, decision notification requirements, and multiple levels of review in the appeals process.

Approved Amount: The fee that a health insurance plan sets as as the amount a provider or supplier should be paid for a particular service or item. Original Medicare calls this “assignment.” See also, Take Assignment, Participating Provider and Non-Participating Provider.

Area Agency on Aging (AAA): Agencies that coordinate and offer services such as Meals-on-Wheels, homemaker assistance, and similar programs that help older adults remain independent in their home and community.

Assets: Resources such as savings and checking accounts, stocks, bonds, mutual funds, retirement accounts, and real estate.

Assignment: Medicare's approved amount for a service or item. Original Medicare will cover 80 percent of this amount (or 55 percent for most mental health services) and you (or your supplemental insurance) are responsible for the remaining coinsurance. See also, Take Assignment, Participating Provider and Non-Participating Provider.

Assisted Living Facility: Also known as a “group home.” Facilities designed to assist people with activities of daily living who can otherwise take care of themselves. They are different from nursing homes, which also provide skilled care. Medicare does not cover a stay in an assisted living facility.

Assistive Technology: Any item, piece of equipment, or system that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities. For example, Closed Circuit Television is an assistive technology that Medicare will cover if medically necessary. Simple items like “grabbers” and “reachers” are not covered by Medicare.

Balance Billing: When doctors and hospitals charge you more than the approved amount for the service.

Benchmark: See Extra Help Premium Amount.

Beneficiary: A person who receives benefits. (If you are a member of a health plan, like a group health plan, Original Medicare, or Medicaid, and receive benefits from that plan, you are a health plan beneficiary).

Benefit Period: The amount of time during which Medicare pays for hospital and skilled nursing facility (SNF) services. A benefit period begins the first day you enter the hospital or SNF and ends when you no longer receive hospital care or skilled care in a SNF for 60 days in a row. With each new benefit period, you pay a new deductible. Your coinsurance is determined by the number of days you have been in the facility during each benefit period.

Bereavement Services: A hospice service that provides counseling for the family up to a year after the patient passes away.

Brand-Name Drug: A drug marketed under a proprietary, trademark-protected name. (Definition from the U.S. Food and Drug Administration)

Calendar Quarters: A three-month period of time ending with March 31, June 30, September 30, or December 31. Social Security counts each calendar quarter that you work and pay into Social Security and Medicare taxes toward your eligibility for premium-free Part A.

Capped Rental Item: Durable medical equipment (DME) (such as a wheelchair) that Medicare covers initially for rental, rather than for purchase, often because of its high cost. Medicare pays the rental fees for these items in monthly installments. You can keep a capped rental item as long as it is medically necessary and elect to buy it. After you rent for 13 months, ownership will automatically transfer to you. (Note: If you have been renting an item of DME since before January 1, 2006, you can continue to rent that item without purchasing if you choose.)

Caregiver: Anyone who provides help and support to someone who is either temporarily or permanently unable to function or someone who can function but not optimally. Most caregivers are unpaid, and are often a family member, friend or neighbor. Formal caregivers are paid care providers or volunteers associated with a service system.

Care Manager: A nurse or specially trained educator or doctor who will assess your needs and advise you on how to best manage your health conditions.

Carrier: A private company that has a contract with Medicare to process Part B claims.

Catastrophic Coverage: Insurance designed to protect you from having to pay very high out-of-pocket costs. Catastrophic coverage usually begins after you have spent a pre-determined amount on your health care. Original Medicare Part A and Part B do not offer catastrophic coverage. They always pay the same amount regardless of how much you have spent. The Medicare prescription drug benefit (Part D) does offer catastrophic coverage. After you have spent a certain amount out-of-pocket, you will only pay five percent of the cost of each prescription drug (in addition to your monthly plan premium). Medicare private plans, like regional PPOs (Prefered Provider Organizations), may also have catastrophic coverage or caps on out-of-pocket costs, but these caps may exclude certain high cost services. Also, Medicare Medical Savings Accounts (MSAs) must pay all or most of your Medicare Part A and B costs after you have met your deductible.

Catastrophic Limit: The highest amount of money you have to pay out-of-pocket during a given period of time for certain services. After you have reached the catastrophic limit of your insurance plan, a higher level of coverage begins.

Center for Health Dispute Resolution (CHDR): See Maximus.

Centers for Medicare & Medicaid Services (CMS): Formerly known as the “Health Care Financing Administration (HCFA).” The United States government agency responsible for administering Medicare, Medicaid, SCHIP (State Children's Health Insurance), HIPPA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs.

Certificate of Medical Necessity (CMN): Documentation from a doctor which Medicare requires before it will cover certain durable medical equipment (DME). The CMN states the patient’s diagnosis, prognosis, reason for the equipment, and estimated duration of need.

Chronic Illness: A disease or condition, such as diabetes or asthma, that lasts for a long period of time or is marked by frequent recurrence.

Claim: A bill that asks for payment for services or benefits you received. Medicare Part A claims are processed by fiscal intermediaries and Part B claims are processed by Medicare carriers. Medicare private health plan (Part C) and Medicare private drug plan (Part D) claims are processed by the plans. See also, Medicare Administrative Contractors (MACs) and DME MAC (Durable Medical Equipment Medicare Administrative Contractor).

COBRA (Consolidated Omnibus Budget Reconciliation Act): A federal law guaranteeing employees and their families at risk of losing health insurance—due to termination of employment, death, divorce, or other circumstances—the right to purchase continued coverage under the employer’s group health plan for limited periods of time.

Coinsurance: The portion of the cost of care you are required to pay after your health insurance pays. Usually, it is a percentage of an approved amount. In Original Medicare, the coinsurance is usually 20 percent of Medicare’s assignment.

Competitive Bidding: Competitive bidding is being phased in starting January 2011 in select locations. It will only allow you to get most of your durable medical equipment from certain Medicare-certified suppliers. The suppliers must accept the Medicare approved amount in full and can only bill you for 20 percent of the Medicare approved amount.

Comprehensive Outpatient Rehabilitation Facility (CORF): A medical facility that provides outpatient diagnostic, therapeutic and restorative services for the rehabilitation of an injury, disability or sickness.

Continuous Open Enrollment: A consumer's right to buy private insurance at any time, regardless of age or health status.

Conversion Policy: An employer-sponsored group health plan that can be converted to an individual policy with the same insurance company. These policies are usually very expensive.

Coordination of Benefits: The sharing of costs by two or more health plans, based on their respective financial responsibilities for medical claims. Your primary insurance and secondary insurance must coordinate benefits in order to pay claims.

Copayment: Also known as a "copay." A set amount you are required to pay for each medical service you receive (like $5 or $35).

Coordination Period, 30-Month: For people with End-Stage Renal Disease (ESRD), the period of time during which a group health plan pays first and Medicare pays second. Medicare may pay the remaining costs if your group health plan does not pay 100 percent of your health care bills during the coordination period.

Cost Plan: A private health plan sponsored by a Health Maintenance Organization (HMO), through which you can get your Medicare benefits. A cost plan is not a "Medicare Advantage" (Part C) plan. It allows you to go out of network to get care. If you get out-of-network care from a provider that accepts Medicare as payment, your costs will be covered by Original Medicare.

Cost Sharing: If you have health coverage, the portion of medical care that you pay yourself, such as a copayment, coinsurance or deductible. See also, Out-Of-Pocket Costs.

Cost Tiers: A system that Medicare private drug plans use to price prescription drugs. Generic drugs are generally on the first, least expensive tier (Tier 1), followed by brand-name drugs (Tier 2), and then specialty drugs (Tiers 3 and above), with each subsequent tier requiring higher out-of-pocket costs.

Coverage Gap: Also called the "Doughnut Hole." A gap in Medicare prescription drug coverage (Part D) during this coverage period your drug costs may increase. As a result of health reform, the coverage gap is gradually being phased out. It will be completely phased out in 2020 when you will pay no more than 25 percent of the cost of your drugs throughout the entire year.

Coverage Restrictions: Also called "Utilization Management Tools." Restrictions that a health or drug plan may place on certain covered services to restrict their usage. Coverage restrictions include prior authorization, quantity limits and step therapy.

Creditable Coverage: Any health insurance coverage you had within 63 days of securing a new insurance policy that can be used to shorten the waiting period for pre-existing conditions.Prescription drug coverage that is considered to be as good as or better than the Medicare prescription drug benefit (Part D) in monetary value.

Crossover: A billing arrangement between your Medigap supplemental insurance and Original Medicare, which allows your Medigap to be automatically billed for its share of the cost of your health care services so that you do not have to pay up front and later seek reimbursement from the Medigap.

Curative Care: The treatment of patients with the intent of curing their disease or condition; for example, chemotherapy treatments to cure breast cancer.

Currently Working: You are considered to be "currently working" as long as you have employment rights at your company even if you do not work on a regular basis, are on sick leave, are a seasonal worker, or have been temporarily laid-off. You are not considered to be "currently working" if you receive Social Security Disability Insurance (SSDI), have received disability benefits from your employer for more than six months, or if you receive your employer insurance through COBRA.

Custodial Care: Non-medical care, such as cooking, cleaning, and shopping. Medicare generally does not cover custodial care.

Deductible: In long-term care, also known as the "elimination period." The amount you must pay for health care expenses before your health insurance begins to pay. Deductible amounts can change every year.

Demand Bill: When you receive an Advance Beneficiary Notice (ABN), a Home Health Advance Beneficiary Notice (HHABN), or Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) from a health care provider, a demand that

the provider continue to bill Medicare for the given services even though the provider does not think that Medicare will cover them. In order to demand bill, you must sign the ABN and agree to pay for the services in full if Medicare denies coverage.

Denial of Coverage: A refusal by Original Medicare, a Medicare private health plan (Part C), or Medicare private drug plan (Part D) to pay for medical services.

Department of Veterans Affairs (VA): A government agency that provides federal benefits to veterans and their families. These benefits include (but are not limited to) pensions, educational stipends and health care services. See also, VA Benefits.

Detailed Explanation of Non-Coverage (DENC): A notice that is given to you by a home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), or hospice agency when you appeal its decision to end your care to the Quality Improvement Organization (QIO). The DENC explains why the services will no longer be provided and any applicable Medicare coverage rules.

Detailed Notice of Discharge: A notice given to you by a hospital after you have requested a Quality Improvement Organization (QIO) review of the hospital's decision that you be discharged. (You would have been notified that the hospital wanted to discharge you in the "Important Message from Medicare" Notice). The Detailed Notice of Discharge explains why services will no longer be covered, provides a description of Medicare coverage restrictions, and explains how those rules apply to your case. Once you request QIO review of a discharge decision, the hospital must provide you this notice in all cases (whether you in are in Original Medicare or in a Medicare private health plan).

Dialysis: The technique used to artificially cleanse your blood of toxins when your kidneys no longer work either temporarily or permanently.

Disability: A restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being. The Social Security Administration (SSA) judges "disability"—and whether you qualify for financial assistance—based on whether you can work. (Definition of the World Health Organization)

Discharge: The end to your stay as an inpatient in a medical institution such as a hospital or skilled nursing facility (SNF).

Discharge Plan: A plan for post-hospitalization care intended to identify an individual's need for medical and social services and resources available to help prevent re-hospitalization. A discharge plan must involve input from you and your representatives about your preferences and care needs after hospitalization; information and instructions to you and your caregivers about post-hospitalization care you need; and arrangement of necessary post-hospital services, transfers and referrals to appropriate services and facilities.

Disenrollment: Leaving a private health plan or Medicare private drug plan.

DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics and Supplies): See Durable Medical Equipment (DME).

Doughnut Hole: See Coverage Gap.

Drug Class: A group of drugs that treat the same symptoms or have similar effects on the body. For example, people with Medicare often use statin class drugs, which are used for reducing cholesterol. Drugs in this class include (but are not limited to) Lipitor, Zocor, Pravachol, Zetia, and Vytorin.

Drug Tiers: See Cost Tiers.

Dual Eligible: A person who has both Medicare and Medicaid.

Durable Medical Equipment (DME): Equipment that primarily serves a medical purpose, is able to withstand repeated use, and is appropriate for use in the home; for example, wheelchairs, oxygen equipment and hospital beds. To be covered by Medicare, durable medical equipment must be prescribed by a doctor. Many types of adaptive equipment are not covered.

Durable Medical Equipment Medicare Admininstrative Contractor (DME MAC): A private insurance company that has a contract with Medicare to process durable medical equipment (DME) claims. DME MACs follow Medicare national guidelines to decide on a local level what types of equipment should be covered on a case-by-case basis and how much Medicare will pay for the equipment. See also, Medicare Administrative Contractors (MACs).

Durable Medical Equipment Regional Carrier (DMERC): The former name of DME MACs (Durable Medical Equipment Medicare Administrative Contractors), until September 2007.

Durable Power of Attorney: Legal document that lets you ("the principal") appoint another person(s) (your "agent" or "attorney in fact") to make decisions about your personal affairs (property, financial matters including health insurance, and other legal decisions) on your behalf. Making the document "durable" allows the agent(s) to act if you become ill or cannot otherwise act or your own behalf.

Earned Income: Money you get because you work, such as wages from work and earnings from self-employment.

Elimination Period: See Deductible.

Employer Group Health Plan: See Group Health Plan.

End-Stage Renal Disease (ESRD): Kidney failure that requires you to be on dialysis or have a kidney transplant.

Enrollment: Joining Original Medicare or becoming a member of a Medicare private health plan (Part C) or Medicare private drug plan (Part D).

Enrollment Periods: Certain periods of time when you can join the Original Medicare program, or elect a Medicare private health plan (Part C), Medicare private drug plan (Part D) or supplemental insurance plan (Medigap). (See also, Fall Open Enrollment Period, Medicare Advantage Disenrollment Period, General Enrollment Period, Initial Coverage Election Period, Initial Enrollment Period, Initial Open Enrollment Period, Open Enrollment Period, Special Election Period, and Special Enrollment Period.)

Evidence of Coverage (EOC): The list of Medicare Advantage or Part D plan costs and benefits that will take effect on January 1 of the following year. You should receive an EOC from your plan in the fall. Review the EOC to see if the plan will meet your health care needs for the following year. The EOC is typically mailed with the plan's Annual Notice of Change (ANOC), which is a notice informing you of plan changes that will take effect the following year.

Explanation of Medicare Benefits (EOMB): If you are enrolled in a Medicare private health plan (Part C), the notice you get from Medicare after receiving medical services from a doctor, hospital or other health care provider. It tells you what the provider billed Medicare, Medicare's approved amount, the amount Medicare paid, and what you have to pay. It is not a bill. See also, Medicare Summary Notice (MSN).

Exception Request: A formal, written request to your Medicare private drug plan (Part D) asking that it pay for a drug you need that is not on its list of covered drugs (formulary) or asking it to lower the price of a drug you need that is on its formulary but it costs too much.

Excess Charges: The difference between a doctor's or other health care provider's actual charge and Medicare's approved amount for payment.

Extra Help: A federal program administered by Social Security that helps people with Medicare who have low incomes and assets pay for their Medicare prescription drug coverage (Part D), including coinsurance, deductibles, and premiums. There are different levels of Extra Help. You may get "full" Extra Help or "partial" Extra Help, depending on your income.

Extra Help Premium Amount: Also known as a "benchmark." The amount of money that "full" Extra Help will pay for the monthly premium of a Medicare private drug plan (Part D) that offers basic benefits.

Expedited Appeal: A fast appeal of a Medicare private health plan's or Medicare private drug plan's denial of coverage when a person's "life, health, or ability to regain maximum function" is in jeopardy. These appeals may take up to 72 hours.

Fall Open Enrollment: The period of time from October 15 through December 7. During this period you can change your Medicare private drug plan (Part D) and/or your Medicare health plan choice (Original Medicare or a Medicare Advantage plan) for the following year. This is also the time you can enroll in Part D for the first time if you did not enroll during your Initial Enrollment Period. (You may have to pay a premium penalty if you enroll during this time unless you have had other creditable coverage.) Your new coverage will begin January 1.

Federal District Court: General trial court of the United States court system. Each federal judicial district has at least one courthouse, and most districts have more than one. Each state has at least one judicial district. The level in the Medicare process of appeals that comes after the Medicare Appeals Council (MAC) level. This is the final level of the Medicare appeals process.

Federal Employee Health Benefit Program (FEHBP): Health insurance for full-time permanent civilian employees and retirees of the United States Government, offered through private health plans.

Federal Poverty Level (FPL): The federally set level of income that an individual or family can earn below which it is recognized that they can not afford necessary services. The FPL is used in eligibility criteria of many programs, including Extra Help and Medicaid. The FPL changes every year and varies depending on the number of people in your household. It is higher in Alaska and Hawaii.

Federally Qualified Health Center (FQHC): Health centers located in “medically underserved areas” which provide low-cost health care. Medicare will pay for some health services in FQHCs that it generally does not cover, such as routine check-ups. FQHCs include community health centers, migrant health centers, and health centers for the homeless.

Fee-for-Service: Payment to providers for each service they provide, as in Original Medicare.

Fiscal Intermediary: Also known as an “Intermediary.” A private company that has a contract with Medicare to process Medicare Part A claims.

Formulary: The list of prescription drugs for which a Medicare private health plan (Part C) that offers drug coverage—Medicare Advantage Prescription Drug Plan (MA-PD)—or a Medicare private drug plan (Part D) will help pay. Drugs not on the formulary are generally not covered by private plans.

Formulary Restrictions: See Coverage Restrictions.

Free Look: A period of time when you can try out a Medicare supplemental insurance (Medigap) policy. During this time (usually 30 days), you can cancel the policy and get a full refund.

Gaps in Coverage: Services or costs that are not covered under the Original Medicare health insurance plan, such as prescription drugs, deductibles, and coinsurance.

Gatekeeper: In a managed care plan your primary care physician (PCP), who oversees your care and decides when to refer you to a specialist.

General Enrollment Period: The time period between January 1 and March 31 of every year when you can enroll in Medicare Part B for the first time. If you enroll during this period (and it is after your Initial Enrollment Period), your coverage will begin on July 1.

Generic Drug: A copy of a brand-name drug that is regulated by the Food and Drug Administration to be identical in dosage, safety, strength, how it is taken, quality, performance and intended use (Definition from the U.S. Food and Drug Administration). Generics generally work just as well as the brand-name version but are cheaper because they are not patented.

Grievance: A complaint or dispute filed with your Medicare private health plan (Part C) or Medicare private drug plan (Part D) about any part of the plan’s operations, behavior or activities. You must file a grievance orally or in writing within 60 days of the event or incident. For example, you may file a grievance if you are dissatisfied with the condition of a health care facility or the facility’s operating hours, or if you have a complaint about the behavior of those working for the facility or the private health or drug plan, itself. An appeal, not a grievance, is the appropriate way to complain about a denial of

coverage. However, Medicare private health plans and drug plans must respond to grievances within 24 hours if they involve the plan's failure to grant an expedited appeal (and in the case of a drug plan, you have not yet purchase the medication). A Medicare drug plan must notify you of its decision about other grievances within 30 days of receiving them (but can extend that time up to 14 calendar days).

Group Health Plan: Employer or union-based health insurance administered to current or former employees of a company or organization through a private insurance company. This insurance may be primary or secondary to Medicare coverage depending on the size of the company and whether or not you are currently working.

Guaranteed Issue: A consumer protection that gives people the right to buy Medigap supplemental insurance. Because of this right, which is in effect during certain times, an insurance company cannot deny you insurance coverage or place conditions on a policy, must cover your pre-existing conditions, and cannot charge you more for a policy because of your health status.

Health Care Financing Administration (HCFA): See Centers for Medicare and Medicaid Services (CMS).

Health Care Provider: An individual or facility, such as a doctor or hospital, which provides health care services. (See also Provider.)

Health Care Power of Attorney: Legal document that lets you ("the principal") appoint another person(s) (your "agent" or "attorney in fact") to make health care decisions for you if you become too sick or disabled to make them yourself. State law determines whether Medicare plan enrollment is a health care decision that your health care agent can carry out for you.

Health Care Proxy: Legal document that allows you to appoint another person (a "proxy" or "agent") to make health care decisions for you if you can not speak for yourself.

Hill-Burton Program/Facilities: Hospitals and clinics that offer free or reduced-cost care to patients who meet qualifying income limits. These vary in what types of services they offer and do not provide services that are covered by a patient's insurance.

Health Insurance: Insurance that protects you against loss from illness, generally through compensation for medical expenses. Programs like Medicare and Medicaid are government-sponsored forms of health insurance. Health insurance can also be administered by private companies that offer individual policies, group health plans, and supplemental insurance. Medicare private health plans (Part C) and Medicare private drug plans (Part D) are examples of government-sponsored health insurance that is administered by private companies.

Hill-Burton Program/Facilities: Hospitals and clinics that offer free or reduced-cost care to patients who meet qualifying income limits. These vary in what types of services they offer and do not provide services that are covered by a patient's health insurance.

HIPAA: Amended the Employee Retirement Income Security Act (ERISA), to provide new rights and protections for members of group health plans. HIPAA contains protections both for health coverage offered in connection with employment (group health plans) and for individual insurance policies sold by insurance companies.

HMO (Health Maintenance Organization): A type of managed care plan that generally covers only the care you get from providers that are in the HMO's network. People with Medicare can choose to get their Medicare benefits through an HMO. HMO members must choose a primary care physician (PCP) who coordinates their care and acts as a gatekeeper to their care. See also, Part C.

Homebound: The state of having a condition such that there exists a normal inability to leave home and leaving home requires "a considerable and taxing effort." A person does not have to be confined to bed to be considered homebound by Medicare. Leaving home for short periods of time for special non-medical events such as a family reunion, funeral or graduation would not exclude someone from being considered homebound. A doctor must certify this condition.

Home Health Agency: An organization that provides home care services, such as skilled nursing, physical therapy, occupational therapy, speech/language pathology, and personal care.

Home Health Aide: A worker who helps a patient at home with activities of daily living. Medicare does not pay separately for aides to perform custodial care, but they may do light housekeeping related to personal care during the visit. Medicare will not pay for home health aide services unless they are accompanied by a need for skilled care.

Home Health Care: Care provided at home to treat an illness or injury. Medicare will only cover care in the home if the person has a need for skilled care.

Homemaking Services: See Custodial Care.

Hospice: Comprehensive care for people who are terminally ill that includes pain management, counseling, respite care, prescription drugs, inpatient care and outpatient care, and services for the terminally ill person's family.

Hospital Insurance: See Part A.

Hospital-Issued Notice of Non-Coverage (HINN): A written notice which explains:

That Original Medicare probably will not cover your hospital stay;

What you will have to pay if you decide to go ahead with your care anyway; and

Your rights to an immediate QIO appeal of the hospital's decision.

Hospitals may also use HINNS during your hospital stay when the hospital believes Medicare will not pay for part of your care. You can request that the hospital submit a bill to Medicare anyway and appeal if Medicare denies the claim.

Housekeeping Services: See Custodial Care.

Important Message from Medicare: A notice given to you by the hospital whether you are in Original Medicare or in a Medicare private health plan when you are going to be discharged that explains your rights as a patient. It also tells you how to ask for an expedited review of the discharge decision by the Quality Improvement Organization (QIO). This is the same document you should have been asked to sign within two days of being admitted to the hospital.

Independent Review Entity (IRE): An independent entity with which Medicare contracts to handle the second level of appeals of a denial of coverage (except for of hospital care) if you are in a Medicare private health plan (Part C) or Medicare private drug plan (Part D).

Individual Policy: A private health plan that covers an individual person as opposed to a group (such as a group of employees covered by an employer group health plan). It is separate from Medicare coverage.

Initial Coverage Election Period: A period of time that begins the three months immediately before you are entitled to Medicare Part A and enrolled in Part B and ends either the last day of the month before you are entitled to Part A and enrolled in Part B or three months after the month of your 65th birthday or the 25th month of receiving Social Security Disability Insurance (SSDI). If you choose to join a Medicare private health plan (Part C) during this period, the plan must accept you, unless it has reached its member limit.

Initial Enrollment Period: The first chance you have to enroll in Part A, Part B or Part D if you do not get it automatically. If you enroll during this time, which begins three months before you first meet the eligibility requirements for Medicare and continues for seven months, you do not pay a premium penalty.

Initial Open Enrollment Period: A six month period beginning the month you enroll in Part B during which you can buy any Medigap supplemental insurance plan you want. If you are 65 or older, you are guaranteed this enrollment period in all states. Only a few states extend this enrollment period to people who are under 65. If you enroll during this time, the insurance company cannot deny you Medigap coverage or make you wait for coverage to start; or charge you more for a policy because of past or present health problems.

In-Network: Part of a managed care plan's network of providers. If you use doctors, hospitals, pharmacies, home health agencies, skilled nursing facilities and equipment suppliers that are in your private health plan's or Medicare private drug plan's network, you will generally pay less than if you go to out-of-network providers.

Inpatient: A patient who has been formally admitted into the hospital by a doctor. Most inpatient care is covered under Medicare Part A (hospital insurance).

Inpatient Care: Care that you receive when you have been formally admitted into the hospital by a doctor. Most inpatient care is covered under Medicare Part A (hospital insurance).

Intermediate Care Facility for the Mentally Retarded (ICF/MR): A skilled nursing facility specifically designed to provide "active treatment" to people with mental retardation.

Intermediary: See Fiscal Intermediary.

Language Therapy: See Speech/Language Pathology.

Lifetime Reserve Days: Also known as "reserve days." When you are in the hospital for more than 90 days, Medicare pays for 60 additional reserve days that you can only use once in your lifetime. They are not renewable once you use them.

Limiting Charge: An upper limit on how much doctors who do not accept Medicare's approved amount as payment in full can charge to people with Medicare. Federal law sets the limit at 15 percent more than the Medicare-approved amount. Some states limit it even further. For example, in New York doctors can only charge 5 percent more than Medicare's approved amount for certain services. This charge is in addition to 20 percent coinsurance (45 percent for mental health services). Providers who opt-out of Medicare are not subject to these limiting charges and can charge as much as they want, if the patient signs an agreement with them prior to receiving care.

Living Will: Also called "directive to physicians," "health care declaration" or "medical directive." Describes the type of care you want to receive as you near the end of your life in specific circumstances. In some states it only goes into effect only when your doctor certifies your health condition and that you are no longer capable of making decisions ("incapacitated"). It is narrow in scope and works best as a guide for your physicians and the person you have legally named to make health care decisions on your behalf using a health care proxy.

Long-Term Care: Custodial care given at home or in a nursing home. Medicare does not cover long-term care. See also, Long-Term Care Insurance.

Long-Term Care Insurance: Provided by private insurance companies. It covers some of the costs of long-term care and can help you preserve your assets, but is often very expensive and is not a good option for most people.

Long-Term Care Ombudsman: An independent advocate for nursing home and assisted living facility residents who provides information about how to find a facility and how to get quality care. Every state is required to have an Ombudsman Program that addresses complaints and advocates for improvements in the long-term care system.

Low-Income Subsidy (LIS): See Extra Help.

Maintenance Care: Care given to people with chronic illnesses to keep them from getting worse. For example, exercise and physical therapy can minimize abnormal or painful positioning of the joints and may prevent or delay curvature of the spine in a person with Muscular Dystrophy.

Managed Care Plan: Any arrangement for health care in which an organization, such as an insurance company, acts as an intermediary between the person seeking care and the medical care provider. In Medicare, you have the choice to get your benefits through the federal government (Original Medicare) or a private managed care plan that receives a set amount of money from the government to provide Medicare-covered benefits. See also, Part C.

MA-PD (Medicare Advantage Drug Plan): A Medicare private health plan (Part C) that offers Medicare prescription drug coverage (Part D).

Marketplaces (also known as Exchanges): A shopping forum, created by the Affordable Care Act, where individuals and small business owners can compare and purchase health insurance plans. Each state chooses how the Marketplace will operate in its own state. Beginning in October 2013, almost all U.S. citizens and lawfully present residents will be able to enroll into health insurance plans through the online Marketplaces, with earliest possible coverage beginning January 1,

2014. People who have Medicare will not be able to get Medicare coverage in the Marketplaces. Medicare Advantage and Medigap plans will not be sold in the Marketplaces.

Marketing Fraud: When Medicare private plans deceive you—through marketing materials or through a person misrepresenting the plan—about what the plan offers and how much it costs. See also, Medicare Fraud.

Maximum Out-of-Pocket Cost (MOoP): Starting January 1 2011, all Medicare Advantage plans must have an out-of-pocket maximum. Once you reach have spent this amount out of pocket you have no more copays for Parts A and B services.

Maximus: Formerly known as the Center for Health Dispute Resolution (CHDR) for Medicare private health plan (Part C) appeals. The Qualified Independent Contractor (QIC) level of appeals for Medicare private health plans (Part C) and for Medicare private drug plans (Part D).

Medicaid: A state-run program that covers medical expenses for people with low or limited incomes.

Medicaid Buy-In: A state-run Medicaid program that allows people with disabilities under the age of 65 to work and still get the comprehensive benefits of Medicaid. The program allows people who are not eligible for traditional Medicaid—because their income or assets are too high—to "buy in" to the program for a small percentage of their income. Not all states have Medicaid Buy-In.

Medicaid Spend-Down: A state-run Medicaid program for people whose income is higher than would normally qualify them for Medicaid, but who have high medical expenses that reduce their incomes to the Medicaid eligibility level. Not all states have Medicaid spend-down.

Medical Insurance: See Part B.

Medical Social Services: A service generally intended to help the patient and family cope with the logistics of daily life with an advanced illness. Medical social services include assessing social and emotional factors related to the patient's illness and care; evaluating the patient's home situation, financial resources, and availability of community resources; and helping the patient access community resources to assist in recovery. The social worker may also provide counseling to the patient and family to address emotions and issues related to the illness.

Medical Supplies: Under Medicare, items covered by Medicare if they are used by home health agency staff to fulfill the plan of care, such as wound dressings.

Medically Necessary: Procedures, services, or equipment that meet good medical standards and are necessary for the diagnosis and treatment of a medical condition.

Medicare: A federal government health insurance program that gives you health care coverage if you are 65 or older, or are under 65 and receive Social Security Disability Insurance (SSDI) for 24 months due to a severe disability, begin receiving SSDI due to ALS/Lou Gehrig's Disease or have End-Stage Renal Disease (ESRD), no matter your income. You can receive health coverage directly through the federal government (see Original Medicare) or administered through a private company (see Part C).

Medicare Administrative Contractor (MAC): Beginning in 2008, Medicare began replacing fiscal intermediaries, carriers and Regional Home Health Intermediaries with Medicare Administrative Contractors (MACs). These MACs will process claims for both Medicare Part A and Part B in assigned regions. To find who you should call with billing issues, and whether your state has already been assigned to a MAC region, call 800-MEDICARE.

Medicare Advantage: See Part C.

Medicare Advantage Disenrollment Period: The period of time from January 1 through February 14 each year when you can switch from a Medicare Advantage plan to Original Medicare. You can pick up a stand-alone prescription drug plan regardless of whether or not your MA plan had drug coverage. You cannot make any changes during this period if you have Original Medicare.

Medicare Appeals Counsel (MAC): The second highest level of Medicare appeals in the Medicare appeals process.

Medicare-Approved Amount: See Approved Amount.

Medicare Card: Also know as the “red, white and blue card.” Everyone who enrolls in Medicare receives a Medicare card. It lists your name and the dates that your Original Medicare hospital insurance (Part A) and medical insurance (Part B) began. It also shows your Medicare claim number, which is the same as your Social Security number and identifies you in the Medicare system. If you get Medicare through the Railroad Retirement Board, your card will say "Railroad Retirement Board" at the top. If you choose to get your Medicare benefits from a Medicare private health plan (Part C), you will use your plan’s card instead of the Medicare card. See also, Private Plan Card.

Medicare-Certified: Offering services at a level of quality approved by Medicare. Medicare will not pay for services received from a health care provider that is not Medicare-certified.

Medicare+Choice: See Part C.

Medicare Fraud: When doctors or other health care providers deceive Medicare into paying when it should not or into paying more than it should. See also, Marketing Fraud.

Medicare Private Health Plan: See Part C.

Medicare Prescription Drug Benefit: See Part D.

Medicare Private Drug Plan: A drug plan run by a private a company through which people with Medicare can get Medicare prescription drug coverage (Part D). A stand-alone Medicare private drug plan, which generally works with Original Medicare, is called a PDP (Prescription Drug Plan). A Medicare private health plan (Part C) that offers prescription drug coverage is called an MA-PD (Medicare Advantage Prescription Drug Plan).

Medicare Savings Programs (MSP): Also known as “Medicare Buy-In” programs. They help pay your Medicare premiums and sometimes also coinsurance and deductibles. There are three main Medicare Savings Programs, with different eligibility limits: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) program. The Qualified Disabled Working Individual (QDWI) program is a less common MSP for people who are under 65, have a disabling impairment, and continue to work.

Medicare SELECT: A type of Medigap policy that will generally give you full coverage as long as you go to doctors and hospitals in its network.

Medicare Summary Notice (MSN): A notice you get in the mail from Original Medicare that lists services you received over the previous three months from doctors, hospitals or other health care providers. It tells you what the provider billed Medicare, Medicare's approved amount for the service, the amount Medicare paid, and what you have to pay. The MSN is not a bill. See also, Explanation of Medicare Benefits (EOMB).

Medigap: A supplemental insurance policy that is sold by private insurance companies to fill "gaps" in Medicare. This insurance policy is usually available in the form of twelve different plans labeled A through L and works only with Original Medicare.

MSA (Medical Savings Account): A type of managed care plan included in the choices offered through Medicare Part C that combines a savings account and a very high-deductible health plan. Medicare deposits a certain amount of money you can use towards the deductible. The amount deposited each year is generally much lower than the deductible. MSAs cannot offer Medicare prescription drug coverage (Part D).

National Coverage Determination (NCD): A decision about particular treatments that Medicare will or will not cover for particular conditions. Medicare contractors are required to follow NCDs.

Network: A group of doctors, hospitals and pharmacies that contract with a managed care plan to provide health care services to plan members. Generally, managed care plan members may only receive covered services from providers in the plan's network. Networks may be made up of both preferred and non-preferred providers.

Non-Participating Provider: In Original Medicare, a health care provider that does not routinely take assignment. When you see such a provider, you may pay up to 15 percent of Medicare’s approved amount for the service or item on top of

the Medicare coinsurance. In addition, the provider can request full payment up front and you must submit the bill to Medicare for reimbursement. See also, Participating Provider.

Non-Preferred Provider/Care: A health care provider or service covered by a private health plan or Medicare private drug plan (Part D) for which the plan will pay lower reimbursement rates. You will pay more for non-preferred services or services given at a non-preferred provider than for preferred providers and services.

Notice of Medicare Non-Coverage (NOMNC): If you are enrolled in a Medicare private health plan (Part C), a notice that tells you when care you are receiving from a home health agency (HHA), skilled nursing facility (SNF) or comprehensive outpatient rehabilitation facility (CORF) is ending and how you can contact a Quality Improvement Organization (QIO) to appeal.

Notice of Medicare Provider Non-Coverage (NOMPNC): If you have Original Medicare, tells you when care you are receiving from a home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF) or hospice agency is ending and how you can contact a Quality Improvement Organization (QIO) to appeal.

Nursing Home: Also called a “convalescent home” or “long-term care facility” or “skilled nursing facility.” A residential facility for persons with chronic illness or disability, particularly older people who have mobility and eating problems. Nursing homes may provide skilled care. If you meet certain health criteria, Medicare covers a limited stay in a Medicare-certified skilled nursing facility. While a skilled nursing facility is a nursing home, not all nursing homes are Medicare-certified skilled nursing facilities.

Observation Stay: An outpatient hospital stay in which an individual receives medical services to help the doctor decide whether he/she should be admitted to the hospital as an inpatient or should be discharged. Observation stays may occur when patients go to the emergency room and have symptoms that require hospital physicians to monitor them. Observation stays can last as little as a few hours, but may also last longer.

Occupational Therapy: Therapy using meaningful activities of daily living to assist people who have difficulty acquring or performing meaningful work due to impairment or limitation of physical or mental function.

Off-Label: The prescribed use of a particular drug for a reason other than the use approved by the U.S. Food and Drug Administration.

Opt-Out: Doctors can “opt-out” of Medicare by notifying the Medicare carrier that they will not accept Medicare payments and telling their patients–in writing before treating them–that Medicare will not pay for their services and that the patients must pay for the care themselves. Doctors who have “opted-out” can charge as much as they want, and their patients have to pay the entire bill themselves. The only time a doctor who has opted out can receive payment from Medicare is when the doctor provides a patient emergency or urgent care services and the patient does not have a contract with that doctor. If the doctor did not provide a written contract before the patient received the services, the patient is not liable for payment.

Original Medicare: Also known as "Traditional Medicare." The federal health insurance program, created in 1965, under which the government pays providers directly for each service a person receives (on a fee-for-service basis). Almost all doctors and hospitals in the United States accept Original Medicare. The majority of people with Medicare are enrolled in Original Medicare, as opposed to a Medicare private health plan (Part C).

Out-of-Network: Not part of a managed care plan's network of health care providers. If you get services from an out-of-network doctor, hospital or pharmacy, it usually means that you likely will have to pay the full cost out of your own pocket for the services you received.

Out-of-Pocket Costs: Health care costs that you must pay because Medicare or other health insurance does not cover them.

Out-of-Pocket Limit: See Catastrophic Limit.

Outpatient: A patient who has not been formally admitted into the hospital as an inpatient. Most outpatient care is covered under Medicare Part B (medical insurance).

Outpatient Care: Care that you receive when you have not been formally admitted into the hospital by a doctor as an inpatient. Outpatient care may include emergency room visits, doctor's office visits or observation stays.

Outpatient Prospective Payment System (OPPS): The system through which Medicare decides how much money a hospital or community mental health center will get for outpatient care to patients with Medicare. The rate of reimbursement varies with the location of the hospital or clinic.

Over-the-Counter Drug: A drug that you can buy, without a prescription, at your local pharmacy or drug store. These drugs are not covered by the Medicare prescription drug benefit (Part D).

Palliative Care: The care of patients with a terminal illness, not with the intent of trying to cure them but to relieve their symptoms. Palliative care consists of relief of pain and nausea, as well as psychological, social and spiritual support services.

Part A: Also known as "Hospital Insurance." The part of Medicare that covers most medically necessary hospital care, skilled nursing facility (SNF) care, home health care, and hospice care.

Part B: Also known as "Medical Insurance." The part of Medicare that covers most medically necessary doctors' services, preventive care, durable medical equipment (DME), hospital outpatient care, laboratory tests, x-rays, mental health, and some home health care and ambulance services.

Part C: Also known as "Medicare Advantage" or "Medicare private health plans." Formerly known as "Medicare+Choice." The part of Medicare concerning private health plans. Part C is not a separate benefit. It lets you get your Medicare benefits from a private health plan contracted by the government to provide this coverage. All Medicare private health plans must offer at least the same benefits as Original Medicare (Part A and Part B), but can do so with different rules, costs and coverage restrictions. Some plans (MA-PDs—Medicare Advantage Prescription Drug Plans) offer Part D drug coverage as part of their benefits packages. You must have Medicare Part A and Part B to join a Part C plan. Medicare private health plans include HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), PFFS (Private Fee-for-Service) plans, SNPs (Special Needs Plans) and MSAs (Medical Savings Accounts), and may have a POS (Point-of-Service) option. See also Private Plan Card.

Part D: Also known as the "Medicare prescription drug benefit." The part of Medicare that provides prescription drug coverage. The benefit is optional to most and provided only by private companies. You can get Part D coverage either through a stand-alone prescription drug plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD)—a Medicare private health plan (Part C) that offers Medicare prescription drug coverage. You must choose Part D coverage that works with your Medicare health benefits. People who enroll in Part D pay a monthly premium in addition to their Part B premium. See also Private Plan Card.

Participating Provider: A health care provider who agrees to always take assignment. Participating providers may not charge you more than Medicare's approved amount, even if they charge non-Medicare patients more for the service. You will still pay a coinsurance or copayment of the cost for a visit or service—usually 20 percent of the Medicare-approved amount, if you have Original Medicare. See also, Non-Participating Provider.

Pastoral Care: Counseling or comfort provided by religious leaders (ministers, rabbis, etc.) to members of their group (church, congregation, etc). This can range from home visitation, to formal counseling by pastors who are licensed to provide pastoral counseling.

Patient Assistant Program: A program typically run by a pharmaceutical company that offers low-cost or free drugs manufactured by that company to people with low incomes.

Personal Care: Assistance with activities of daily living. Providers of personal care (home health aides) are not required to undergo medical training. Medicare only covers personal care if you are homebound and receiving skilled care.

PDP (Prescription Drug Plan): A "stand-alone" Medicare prescription drug plan (Part D) offered through a private insurance company that only offers prescription drug benefits. PDPs work with Original Medicare, MSA (Medical Savings Account) plans, Cost Plans, and PFFS (Private Fee-For-Service) plans without drug coverage.

PFFS (Private Fee-for-Service): A type of managed care plan that allows you to use any doctor or hospital anywhere in the country as long as that provider accepts the plan's terms and conditions. People with Medicare can choose to get their Medicare benefits through a PFFS plan. You may pay more for Medicare benefits, many providers will not take PFFS plans, and you cannot buy a Medigap plan to fill gaps in coverage. See also, Part C.

Pharmacotherapy: The use of drugs to treat a disease or condition.

Physical Therapy: Exercise and physical activities used to condition muscles and improve levels of activity. Physical therapy is helpful for those with physical debilitating illness.

Plan of Care: A doctor's written plan describing the type and frequency of services and care a particular patient needs.

POS (Point-of-Service Option) Option: The right of managed care plan members to partial coverage for certain services they get outside the managed care plan's network of providers. People with Medicare can choose to get their Medicare benefits through a private managed care plan; some of these plans offer the POS option. See also, Part C.

PPO (Preferred Provider Organization): A type of managed care plan. To get full coverage, you must use providers in the plan's network, but you should also have partial coverage of care you get from out-of-network providers. People with Medicare can choose to get their Medicare benefits through a PPO. See also, Part C.

Pre-Approval: See Prior Authorization.

Pre-Authorization: See Prior Authorization.

Pre-Existing Condition: A condition or illness with which you were diagnosed or for which you received treatment before your new health care coverage began. Some health plans may impose a waiting period on coverage of any pre-existing conditions you have.

Preferred Provider/Care: A health care provider that is part of a private health plan's network or a service that is covered by that private health plan for which the plan will pay its highest reimbursement rates. See also, Non-Preferred Provider/Care.

Premium: The amount that an individual must pay to a Medicare or other health insurance plan for coverage. Generally paid on a monthly basis.

Premium Penalty: An amount that you must pay to Medicare in addition to the regular monthly premium for late enrollment in Part B or Part D. The Part B premium is an additional 10 percent of the premium for each year you delay enrollment that you did not have coverage from a current employer. Part D will have a premium penalty of at least 1 percent for every month you delay enrollment that you were without creditable coverage.

Prescription: An order for a health care service or drug written by a qualified health care professional.

Prescription Drug: A drug that can be obtained only by means of a prescription from a provider. Prescription drugs cannot be bought over-the-counter.

Prescription Drug Insurance: Health coverage that helps you pay for prescription drugs. With a prescription drug insurance plan, you generally pay a copayment or coinsurance for each prescription drug you get that is covered by your plan (on its formulary). If you have Medicare, you can get prescription dug insurance through Part D, the Medicare prescription drug benefit.

Preventive Care: Care to keep you healthy or prevent illness, such as routine checkups, flu shots, and tests like prostate cancer screenings and yearly mammograms.

Primary Care Physician (PCP): The doctor that manages your health care and gives you a referral to consult a specialist if you need it. A managed care plan requires you to have a PCP. If you do not consult your PCP before seeing a specialist, your managed care plan will generally not cover your care.

Primary Insurance: Health insurance that pays first on a claim for medical and hospital care. In most cases, Medicare is your primary insurer. See also, Secondary Insurance.

Prior Authorization: Also called “pre-authorization” or “pre-approval.” A restriction placed on coverage by private health plans and Medicare private drug plans. If a service or medication is covered with “prior authorization,” your doctor must get special permission from the plan to prescribe the service or medication to you before it will be covered. If you fail to get prior authorization before you get a service, your plan generally will not cover it.

Private Duty Nursing: Direct, comprehensive care on an hourly or live-in basis.

Private Health Plan: Also known as a “Managed Care Plan.” Any arrangement for health care in which a private company acts an intermediary between the person seeking care and the physician. In Medicare, you have the choice to get your benefits through the federal government (Original Medicare) or a private health plan that receives a set amount of money from the government to provide Medicare-covered benefits. See also, Part C.

Private Plan Card*: The membership card your Medicare private health plan (Part C) or Medicare private drug plan (Part D*) sends to you to get health services or prescription drugs covered. You will use this instead of an Original Medicare “red, white and blue card.” It will generally include your name, the name of your insurance policy and the name of the company that sponsors it, as well as your member ID number. It may also list specific copayment or coinsurance amounts for your primary care physician (PCP) and specialist visits, and show what benefits your insurance plan includes (health, dental, prescription drug coverage, etc.). See also, Medicare Card.

Program of All-Inclusive Care for the Elderly (PACE): Serves individuals who are age 55 or older who are certified by their state to need nursing home care to be able to live safely in the community at the time of enrollment and who live in a PACE service area. The philosophy of PACE states that it is better for the well being of seniors with chronic illness care needs and their families to be served in the community (rather than in a living facility) whenever possible.

Provider: In the realm of health care, an individual or facility (such as a doctor, hospital or durable medical equipment (DME) supplier), that provides health care services and/or items.

PSO (Provider-Sponsored Organization) A type of managed care plan that is operated by a group of doctors and hospitals that form a network of providers within which you must stay to receive coverage for your care. People with Medicare can choose to get their Medicare benefits through a PSO. This type of plan is not available in most parts of the country. See also, Part C.

QDWI (Qualified Disabled Working Individual): A less common Medicare Savings Program (MSP) administered by each state’s Medicaid program. It pays the Medicare Part A premium for people who are under 65, have a disabling impairment, continue to work, and are not otherwise eligible for Medicaid.

QI (Qualifying Individual): Federal program administered by each state's Medicaid program that pays the Medicare Part B premium for people with Medicare who have low income.

QIO Review: The initial step in making an appeal to a denial of coverage (either barring admittance to or discharge from a hospital, home health agency (HHA), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF) or hospice). See also, Quality Improvement Organization (QIO).

QMB (Qualified Medicare Beneficiary): Federal program administered by state Medicaid programs that helps people with Medicare who have low income pay their coinsurance, deductibles, and premiums.

Qualified Independent Contractor (QIC): An independent entity with which Medicare contracts to handle the reconsideration level of an Original Medicare (Part A or Part B) appeal.

Quality Improvement Organization (QIO): Formerly known as “Peer Review Organization.” A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. QIOs must review your complaints about the quality of care you get and appeals for care in inpatient hospitals, hospital outpatient care departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Private Fee-for-Service (PFFs) plans, and ambulatory surgical centers. QIOs also contract with Medicare to

conduct appeals. For example, QIOs review expedited appeals when a Medicare private health plan (Part C) denies coverage or terminates services from a hospital, home health agency, SNF, or comprehensive outpatient rehabilitation facility (CORF), or Original Medicare denies coverage of home health care, SNF care, hospice care or CORF care.

Quantity Limit: A restriction used by private health plans and Medicare private drug plans that limits coverage of a particular drug to a specific amount (such as 30 pills a month each year).

Railroad Medicare Carrier: A private company that provides Medicare coverage for railroad retirement beneficiaries.

Railroad Retirement Board: An independent agency in the executive branch of the federal government that administers comprehensive retirement-survivor and unemployment-sickness benefit programs for the nation's railroad workers and their families, under the Railroad Retirement Act and Railroad Unemployment Insurance Act.

Reconsideration: In the Original Medicare (Part A and Part B) appeals process, the second level of appeal, where your appeal is reviewed by a Qualified Independent Contractor (QIC).In a Medicare private health plan (Part C) appeals, there are two “reconsideration” phases. Reconsideration by the Medicare private health plan. The first step in the appeal of a denial of coverage or denial of payment, in which the plan reviews its initial denial. Reconsideration by the Independent Review Entity (IRE). If the plan upholds its initial decision in the redetermination, the appeal is automatically forwarded to the IRE for reconsideration. In a Medicare private drug plan (Part D), a review of the plan’s redetermination of its decision to deny coverage or payment. Reconsiderations are conducted by the Independent Review Entity.

Redetermination: The first step in the Original Medicare process of appeals once you have received a Medicare Summary Notice (MSN) giving you notice of a denial of coverage. The first step in the Part D appeals process after the plan denies your coverage or exception request.

Red, White and Blue Card: See Medicare Card.

Referral: Authorization that Medicare private health plans (Part C) usually require for services not provided by your primary care physician (PCP). For instance, HMOs generally require you to get a referral from your primary care doctor in order to see a specialist or get an eye exam.

Rehabilitative Care: The care of patients with the intent of curing, improving or preventing a worsening of their condition. For example, physical therapy after hip replacement surgery to resume walking, or occupational therapy to prevent carpal tunnel syndrome. Request for Reconsideration of Part B Premium Amount: The first level of appeal to the Social Security Administration if you think that Social Security has overestimated your income and is charging you a higher Part B premium than the standard amount. The next level of appeal is to the Administrative Law Judge (ALJ).

Reserve Days: See Lifetime Reserve Days.

Respite Care: A hospice service that provides relief for caregivers of hospice patients by arranging a brief period (up to five days) of inpatient care for the patient.

Retiree Insurance: Health insurance provided by employers to former employees who have retired. Retiree insurance always pays secondary to Medicare. See also, Supplemental Insurance.

Retroactive Disenrollment: A way to discontinue enrollment in a Medicare private health plan (Part C) or Medicare private drug plan (Part D) that you mistakenly joined or joined due to marketing fraud, effective back to the date you joined. You will be disenrolled from your Medicare private health or drug plan as if you had never joined it.

Secondary Insurance: Health insurance that covers your health care after the primary insurance on a claim for medical or hospital care. It usually pays for all or some of the costs that the primary insurer did not cover, but may not cover services not covered by the primary insurer. See also, Supplemental Insurance.

Semiprivate Room: A hospital room that contains two or more beds (generally just two), usually with a curtain separating the beds.

Service Area: The area within which a private health plan or Medicare private drug plan provides medical services to its members. In many private health plans, the area where your network of providers is located.

SHIP (State Health Insurance Assistance Program): A federally-funded program in each state that answers questions about Medicare, free of charge.

Skilled Care: Medically necessary care performed by a skilled nurse or therapist. If a home health aide (someone who provides help with activities of daily living) or other person can perform the service, it is not considered skilled care. Skilled nursing includes care from Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Skilled therapy includes care from licensed physical, occupational and speech therapists.

Skilled Nursing Facility (SNF): A Medicare-approved facility that provides short-term post-hospital extended care services, at a lower level of care than provided in a hospital.

Skilled Nursing Services: Services from a registered nurse, which include administration of medications; tube feedings; catheter changes; wound care; teaching and training activities; observation and assessment of a patient's condition; and management and evaluation of a patient's plan of care.

Skilled Therapy Services: Services from licensed physical, speech/language, and occupational therapists (if originally accompanied by physical therapy or speech/language pathology services). Physical therapy services which qualify people for home health care include: assessment; therapeutic exercises; gait training; range of motion tests; ultrasound, shortwave, and microwave diathermy treatments; teaching services; and development, implementation, management, and evaluation of a patient plan of care. Maintenance care is covered if a physical therapist's skills are necessary for the safe and effective provision of repetitive services which use complex, sophisticated procedures.

SLMB (Specified Low-Income Medicare Beneficiary Program): Federal program administered by each state's Medicaid program that pays the Part B premium for people with Medicare with low incomes.

SNP (Special Needs Plan): A Medicare private health plan (Part C) that exclusively or primarily serves members who have a particular special need. A SNP may serve people who have both Medicare and Medicaid (dual-eligibles); people who have a specific chronic illness, like diabetes; or people who are in long-term care facilities or require an institutional level of care. Some SNPs may serve more than one type of special need.

Social Security Administration (SSA): The United States government agency responsible for advancing the economic security of Americans through shaping and managing various programs, including Medicare, Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) and Extra Help.

Special Election Period: A set period of time from October 1 through December 31 of every year when you can switch to another Medicare private health plan (Part C) if your plan is closing and another one is available in your area. During this time, Medicare private plans must enroll individuals who apply whose private plans are closing.

Special Enrollment Period (SEP): A period of time outside of the general enrollment period, Fall Open Enrollment Period or Medicare Advantage Disenrollment Period triggered by specific circumstances, during which you can enroll in Medicare Part B, Part D, or a private health plan (Part C). SEPs may also allow you to switch or disenroll from Part D and private health plans. In Part B, an SEP absolves you from having to pay a premium penalty. Your Part B SEP begins the month after your or your spouse’s employment or group health plan coverage ends (whichever comes first). In Part D and private health plans, you are eligible for an SEP in many situations; for example, if you were to lose any type of drug coverage that was considered creditable coverage or you were to move out of your plan’s service area. Only two Part D SEPs absolve you from the premium penalty: getting Extra Help and receiving inadequate information about the creditability of your drug coverage.

Specialist: A doctor who specializes in treating only a certain part of the body or a certain condition. For instance, a cardiologist only treats people with heart problems.

Speech/Language Pathology: Therapeutic treatment of speech impairments (such as lisping and stuttering) or speech difficulties that result from illness.

Speech Therapy: See Speech/Language Pathology.

SSDI (Social Security Disability Insurance): Monthly benefits provided through the United States Social Security Administration for people who lose their ability to work because of a severe medical impairment (disability). People who receive SSDI for 24 months are eligible for Medicare.

SSI (Supplementary Security Income): Monthly benefits for people with low incomes and assets who are 65 or older, blind, or have a disability.

State Pharmaceutical Assistance Program (SPAP): State-subsidized programs that provide assistance in paying for prescription drug costs. SPAPs vary by state.

Step Therapy: A coverage restriction placed on drug coverage by private health plans and Medicare private drug plans. Before your plan will cover some (generally more expensive) drugs, you must try other (generally less expensive) drugs that treat your condition to see if they will be effective for you.

Supplemental Insurance: Fills gaps in Original Medicare coverage by helping to pay for the portion of health care expenses that Original Medicare does not pay for, such as deductibles and coinsurances. Supplemental insurance includes Medigap plans and retiree insurance from a former employer. Supplemental insurance may offer additional benefits that Medicare does not cover. See also, Secondary Insurance.

Supplier: A person or business from whom you can buy medical equipment, like a walker or wheelchair. See also Provider and Durable Medical Equipment (DME).

Take Assignment: A term used to describe an agreement by a doctor to accept Medicare's approved amount for a service or item as payment in full. See also, Participating Provider and Non-Participating Provider.

Temporary First Fill: See Transition Policy.

Terminal Illness: A disease or condition that cannot be cured or adequately treated, and is expected to result in eventual death.

Therapy Caps: Limits on the amount of physical therapy, occupational therapy and speech/language pathology that Medicare will cover in a given year.

Tiers: See Cost Tiers.

Transition Policy: Also called a “temporary first-fill.” Allows new members of Medicare private drug plans (Part D) to get temporary coverage of drugs they were taking when they joined if those medications are not covered by their new plan.

TRICARE: The Department of Defense’s health insurance program for active duty and retired military personnel and their family members. TRICARE consists of several different programs, including TRICARE for Life (TFL), a retiree benefit that acts as supplemental insurance to Medicare. TRICARE also offers coverage to reserve force members who are on active duty for 30 days or more.

TRICARE for Life: The health insurance program for military retirees who have served honorably for at least 20 years. They must be enrolled in Part B to receive the benefits. It pays secondary to Medicare and covers out-of-pocket costs including deductibles and coinsurance. People who qualify can receive free or low-cost medications from military treatment facilities, TRICARE network and out-of-network pharmacies, and the National Mail Order Pharmacy.

Unearned Income: Money you get from sources other than current employment. Includes Social Security benefits, Veterans benefits, pensions, annuities and other regular payments you receive, such as alimony and workers' compensation.

Urgent Care: Immediate medical attention for a sudden illness or injury that is not life threatening.

Unskilled Care: See Personal Care.

Utilization Management Tools: See Coverage Restrictions.

Veterans Administration (VA) Benefits: Benefits given by the federal government to people who have been in “active” service in the military, naval, or air service (veterans, not career officials) and, under certain conditions, to their family members. These benefits include pensions, educational stipends and health care, among others. Veterans can receive VA health care services only at VA facilities. See also, Department of Veteran's Affairs.

Waiting Period: The time between when you sign up for a Medigap or Medicare private health plan (Part C) and when the coverage begins. Waiting periods for Medicare-related benefits are most often imposed if you have a pre-existing condition and have not had creditable coverage for a certain amount of time.

Waiver of Liability: See Advance Beneficiary Notice (ABN).

Work Credits: The unit of measurement that determines when you are eligible to receive Social Security benefits, including Social Security Disability Insurance (SSDI). How many work credits you earn during a year (up to a maximum of four) depends on how much money you make during that year. The Social Security Administration (SSA) determines the amount that you must earn to receive one work credit.