

What Does that Mean? A Medicare Insurance Glossary



A

Advance Directive

Another name for a Living Will. See *Living Will*.

Ambulatory Surgical Center

A health care facility that may perform certain surgeries on patients expected to require 24 hours of care or less.

Appeal

A request to reconsider a payment decision or coverage made by the Medicare program or your health care plan (health care or prescription drug). You can appeal if there has been a denial of your request:

- For a health care service, supply, item, or prescription drug you believe you should receive;
- Payment for a health care service, supply, item, or prescription drug that you have previously received;
- To change how much you pay for a health care service, supply, item, or prescription drug;
- To pay/provide for all or part of a health care service, supply, item, or prescription you believe you still need.

Assignment

An agreement with your health care provider (a doctor or otherwise) to be paid by Medicare insurance for services. Part of the agreement is that they will not charge you any more than a Medicare deductible and coinsurance.

B

Beneficiary

The person receiving health insurance benefits.

Benefit Period

The method Original Medicare uses to measure your hospital and skilled nursing facility services. The period runs from when you are admitted to an inpatient facility to 60 days after you stop receiving care. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Benefits

The services or health care items that are covered by your insurance plan.

C

Centers for Medicare & Medicaid Services (CMS)

A federal agency that manages the Medicare program, Medicaid, Children's Health Insurance Program (CHIP), and the federally facilitated Marketplace.

Claim

The payment request you make for received services or other benefits.

Coinsurance

The potential amount you pay for your share of service costs. This is calculated after you pay any necessary deductibles. Usually portrayed as a percentage.

Comprehensive Outpatient Rehabilitation Facility

A medical facility that can provide many services on an outpatient basis. This can include, but is not limited to doctor services, physical therapy, and rehabilitation.

Copayment

The amount you may be required to pay for a medical service or item. This is usually a specific amount, depending on your plan.

Cost-Sharing

The amount you may have to pay for a medical service or item. This includes copayments, coinsurance, and/or deductibles.

Coverage Determination

The first step in your Medicare Part D plan. Your drug plan will decide:

- Whether a drug is covered by your plan;
- If you meet the requirements to receive a drug;
- The amount you are required to pay for the drug;
- Whether to make an exception to a plan rule when it is requested.

This decision must be made within 72 hours of a standard request (24 hours for an expedited request) and can be appealed by the beneficiary.

Coverage Gap

Prior to qualifying for catastrophic coverage, the period of time that you pay higher cost-sharing for prescription drugs. The period starts when you and your plan pay a set amount for prescription drugs during the year.

D

Deductible

The amount you pay for health care services or prescription drugs before your insurance plan begins to cover a claim.

Dental Coverage

An insurance plan that helps to pay for dentist office trips. The plans can sometimes cover preventative services including teeth cleaning, fillings, etc.

Department of Health and Human Services (HHS)

The federal agency that oversees Centers for Medicare and Medicaid Services.

Drug List

The list of prescription drugs that are covered by your Part D plan or other insurance plan that offers drug coverage.

Durable Medical Equipment

Medical equipment that is ordered by your doctor to be used in your home. This can include a walker, wheelchair, or hospital bed.

Durable Power of Attorney

A legal document that gives someone else you trust the ability to make health care decisions for you. This is important in situations where you may not be able to make decisions yourself. walker, wheelchair, or hospital bed.

E

End-Stage Renal Disease (ESRD)

Permanent kidney failure, requiring dialysis, or a transplant. Those with ESRD automatically qualify for Medicare insurance.

Exception

A type of prescription drug coverage determination for Medicare insurance. The types are:

- Formulary Exception: A drug plan's decision to cover a drug not on the drug list or to waive a coverage rule.
- Tiering Exception: A drug plan's decision to charge a lower amount for a drug on its non-preferred drug-tier.

You or your doctor must request the exception. Your doctor or the prescriber must provide a supporting statement for why you require the exception.

Excess Charge

The difference between the amount a health care provider is legally permitted to charge and the Medicare-approved cost.

Explanation of Benefits (EoB)

In a Medicare Part C or D plan, a description of your coverage after you receive medical services or equipment. It explains what the plan billed Medicare insurance, the Medicare program's approved amount, what Medicare insurance paid, and what is expected to be covered by the beneficiary. The EoB is not a bill, but a description of what was paid and by whom.

Extra Help

A program that helps those with limited income/resources afford Medicare Part D plans.

F

Federally Qualified Health Center

A federally funded nonprofit health center or clinic helping medically underserved areas. These centers provide health care, even if you cannot afford it. Many work on a fee scale based on the patient's ability to pay.

Formulary

Another name for the drug list. See *Drug List*.

G

Generic Drug

A prescription drug that has identical active ingredients to a name-brand drug, often costing less.

Grievance

A complaint about the way your Medicare insurance plan is providing customer and patient service. This is separate from an appeal for a plan's refusal to cover a claim.

Group Health Plan

A health plan offered by an employer or organization that covers employees and families.

Guaranteed Issue Rights

The rights a beneficiary has in situations where an insurance company is required by law to sell or offer a Medigap policy. When this happens, a beneficiary cannot be denied a policy and an insurance company cannot place conditions on a plan. The beneficiary also cannot be charged extra for the Medigap policy because of past or current health concerns. Sometimes called Medigap Protections.

H

Health Care Facility

A location that provides health services. This can include hospitals, clinics, outpatient care centers, or specialized care centers.

Health Care Provider

An individual or group that is licensed to provide health care. This may include doctors, nurses, or hospitals.

Health Coverage

The legal entitlement to payment/reimbursement for your health care costs. This is usually through a contract with a health insurance company, an employer-offered plan, or a government program like the Medicare program.

Health Insurance Marketplace

A service that is operated by the federal or state government (depending on your state) that assists you in looking for and enrolling in affordable health insurance.

Health Maintenance Organization

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

High-Deductible Medigap Policy

A Medigap policy that has a high deductible, but also offers a lower premium.

Homebound

When you have difficulty leaving your home without assistance due to sickness or injury or leaving isn't recommended for the same reasons. You may also leave the home infrequently for a variety of reasons, like medical treatment or religious services.

Home Health Care

Health care services that are provided at your home under a plan from your doctor. This plan must be ordered by your doctor in order to be covered by Medicare insurance.

Hospice

A team-oriented service that addresses the many needs of terminally ill patients. This can include the medical, psychological, or even spiritual needs of the patient. Hospice care can also aid the patient's family or caregivers.

Hospital Outpatient Setting

The section of the hospital where outpatient services are provided. In many hospitals, these departments are: emergency department, observation unit, pain clinic, etc.

Hospital-Related Medical Condition

Any condition that was treated during your three-day stay at an inpatient hospital. This does not have to be the reason you went to the hospital.

I

Independent Review Entity

An organization with no connection to your health care plan that Medicare contracts to review a repeal case. They are called to review an appeal if the plan doesn't make a timely appeal decision.

Initial Coverage Limit

The maximum out-of-pocket limit that is reached by paying your yearly deductible, copayment, or coinsurance for each drug covered by your prescription drug plan. You then enter the plan's coverage gap.

In-Network

The group of health care providers — including pharmacies, hospitals, and doctors — that has agreed to provide services to beneficiaries of certain insurance plans at a discounted rate. Some insurance plans only cover in-network providers.

Inpatient Care

The health care services that you receive when you are admitted to a health care facility.

Inpatient Hospital Care

The services and treatment that a beneficiary receives at a hospital, including your bed, medical procedures, or nursing.

Inpatient Prospective Payment System (IPPS)

The system of payment where hospitals contract with the Medicare program to provide care and accept payment at a predetermined rate.

Inpatient Rehabilitation Facility

A hospital (either the entire hospital or part of it) that offers beneficiaries an intensive rehabilitation program.

L

Large Group Health Plan

A group health plan that covers at least 100 beneficiaries. Usually offered by an employer or an employee organization.

Lifetime Reserve Days

The additional days that Medicare insurance covers for hospital care after 90 days. This covers all regular costs except a daily coinsurance. The total is 60 days over the course of your lifetime and is offered through Original Medicare.

Limiting Charge

A part of Original Medicare, the highest amount you can be charged for a service offered by a health care supplier who hasn't accepted assignment. The charge will be 15 percent over Medicare insurance's approved amount. This will only apply to certain services.

Living Will

A legal document that lays out the type of treatments you want or don't want should you be unable to speak for yourself. This includes cases where you are unconscious. Also known as Advanced Directive and Medical Directive.

Long-Term Care

Services provided for people who are unable to perform the basics of everyday life. This can include dressing, bathing, or eating. These services can be offered in special communities, assisted living, nursing homes. Long-term care is often not covered by Medicare insurance.

Long-Term Care Hospital

A hospital that specializes in providing treatment for patients that stay an average of over 25 days. The services provided in these facilities can include: comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. Generally, patients in long-term care hospitals are transferred from intensive or critical care units.

Long-Term Care Ombudsman

An independent advocate for residents of nursing or assisted living facilities. They act as intermediaries to help solve issues of residents and inform residents of their rights and protections.

M

Maximum Out-of-Pocket (MOOP)

Maximum dollar amount a member is required to pay out-of-pocket during a plan year.

Medical Directive

Another name for a Living Will. See *Living Will*.

Medical Emergency

An injury or illness you believe needs immediate medical attention due to the threat of disability or death.

Medically Necessary

Any health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms. These must meet the accepted standards of medicine.

Medical Underwriting

The process through which an insurance company decides whether to accept your application. It will also decide whether to add a waiting period for pre-existing conditions (if your state allows it) or how much to charge for the insurance. This decision is primarily based on your medical history.

Medicare Program

The federal health insurance program for people over the age of 65 or younger people in certain situations.

Medicare Administrative Contractor (MAC)

A company that processes claims for Medicare.

Medicare Advantage

Another name for Medicare Part C. See *Medicare Part C*.

Medicare Advantage Prescription Drug (MAPD) Plan

A Medicare Part C plan that offers coverage for both Original Medicare and prescription drug coverage.

Medicare-Approved Supplier

A person, agency, or company that is certified by the Medicare program to provide a medical item or service, except while you're an inpatient in a hospital or skilled nursing facility.

Medicare Certified Provider

A health care provider that has been approved by the Medicare program after passing a state-conducted inspection. Medicare insurance will only cover care provided by certified parties.

Medicare Cost Plan

A type of Medicare health plan that is available in certain areas. In this plan, if you receive services outside of the plan's network without a referral, the Medicare insurance-covered services are paid by Original Medicare. The Cost Plan covers emergency services or urgent care services.

Medicare Health Maintenance Organization (HMO) Plan

A type of Medicare Part C plan that is offered in certain parts of the United States. The plan only covers health care providers that are on a list provided by the HMO. Many plans also require you to choose a primary care physician. This physician will provide required referrals for any specialist visits.

Medicare Health Plan

A privately offered plan that contracts with the Medicare program to provide Part A and B services to Medicare insurance beneficiaries who enroll in the plan. This includes Medicare Part C, Medicare Cost Plans, Demonstration/Pilot Programs, and PACE plans.

Medicare Medical Savings Account (MSA) Plan

A combination of a high-deductible Medicare Part C plan and a bank account. The Medicare program deposits money into the account, which can be used to pay for health care costs. Only Medicare insurance-covered expenses count toward your deductible. Generally, the deposited amount is less than the deductible, so there will be out-of-pocket costs.

Medicare Part A

The part of Original Medicare that covers your stay at a health care facility, including hospitals, skilled nursing facilities, or nursing homes, among others.

Medicare Part B

The part of Original Medicare that covers medically necessary services, including doctor visits, ambulance services, and physical therapy. Part B covers many preventive and screening services, as well.

Medicare Part C

A comprehensive alternative to Original Medicare offered by private insurance companies. Plans may include additional benefits. Also known as Medicare Advantage.

Medicare Part D

Medicare Part D is an optional plan that covers your prescription drugs offered by private insurance companies. This can be paired with Original Medicare.

Medicare Preferred Provider Organization (PPO) Plan

A type of Medicare Part C plan where beneficiaries pay less if they use doctors, hospitals, or other health care providers within the plan's network. Health care providers outside of the network may be used at an additional charge. These plans are only available in certain areas.

Medicare Savings Program

A program designed to aid beneficiaries with limited income or resources pay some or all the Medicare insurance premiums, deductibles, or coinsurance. This program is offered through Medicaid.

Medicare SELECT

A type of Medicare Supplement plan that may require you to use hospitals and, in some cases, health care providers within its network to be eligible for full benefits.

Medicare Special Needs Plan (SNP)

A type of Medicare Part C plan that provides specialized care for specific groups of beneficiaries. Examples: Beneficiaries who have both Medicare insurance and Medicaid; Beneficiaries who live in nursing homes; Beneficiaries who have chronic medical conditions.

Medicare Summary Notice (MSN)

A notice given every three months to a beneficiary after a health care provider or supplier files a claim for Original Medicare services. The notice explains services provided, the amount Medicare insurance pays, and how much the beneficiary must pay.

Medicare Supplement Plan

Plans offered by private insurance companies to cover the "gaps" in Original Medicare coverage. Also known as Medigap coverage.

Medigap Basic Benefits

Benefits that all Medicare Supplement plans must cover, including Original Medicare coinsurance amounts, blood, and additional hospital benefits not within Original Medicare's coverage.

Monthly Premium

The dollar amount paid for insurance coverage on a recurring monthly basis.

Multi-Employer Plan

A group health plan sponsored by two or more employers jointly.

N

Network

The health care facilities, providers, and suppliers that have contracted with your insurer to provide services.

Network Pharmacies

Pharmacies that have contracted with certain Medicare insurance plans to provide services and supplies at a discounted rate. In certain plans, your prescriptions are only covered if you get them filled by these pharmacies.

Non-Preferred Pharmacy

A pharmacy that is part of a Medicare insurance plan's network but isn't defined as a preferred pharmacy. In these cases, you may pay higher out-of-pocket costs for prescription drugs.

O

Occupational Therapy

Treatment assisting beneficiaries to return to usual activities after an illness or injury. These activities can be bathing, preparing meals, housekeeping, etc. Original Medicare coverage is limited annually, although coverage is allowed for medically necessary therapy over the cap.

Optional Supplemental Benefits

Services not covered by the Medicare program, but that a plan may choose to offer. If the beneficiary chooses to purchase these benefits, they will pay for them directly, usually as a premium, copayment, and/or coinsurance. These services may be offered individually or as a group of services. They may be different for each Medicare health insurance plan.

Original Medicare

Another name that refers to Medicare Parts A and B.

Out-of-Network

A benefit that may be offered by a Medicare Part C plan. This benefit gives beneficiaries the choice to get a plan's services from outside of the network of health care providers. In some instances, the out-of-pocket costs may be higher.

Out-of-Pocket Costs

Health or prescription drug costs that a beneficiary must pay on their own since these aren't covered by Medicare insurance or other insurances.

Outpatient Hospital Care

Medical or surgical care a beneficiary receives from a hospital when a doctor hasn't written an order to admit the beneficiary to the hospital as an inpatient. Care includes, but is not limited to, emergency or observation services, outpatient surgery, lab tests, or x-rays. Care may be considered outpatient hospital care even if the beneficiary spends the night at the hospital.

P

Penalty

An amount added to a monthly premium for Medicare Part B or Part D plans if the beneficiary doesn't join when they are first eligible. This higher amount is paid as long as the beneficiary has Medicare insurance. There are some exceptions to this.

Pharmacy Network

A pharmacy that has agreed to provide beneficiaries of certain Medicare insurance plans with services and supplies at an agreed-upon rate. Some Medicare insurance plans will only cover your prescription costs if they are filled at network pharmacies.

Physical Therapy

Treatment for an injury or disease through physical or mechanical methods, such as exercise, massage, or light treatment.

Power of Attorney

A document that appoints a person of your choosing to make medical care decisions. Specifically used in situations where you are unable to make decisions for yourself. Also known as health care proxy, appointment of health care agent, or a durable power of attorney for health care.

Pre-Existing Condition

An injury, sickness, or health issue that was diagnosed or treated before the date health care coverage begins.

Preferred Pharmacy

A pharmacy that is part of Medicare drug insurance plan's network. You will typically pay lower out-of-pocket costs for prescriptions than at a non-preferred pharmacy.

Premium

The periodic payment made to the Medicare program, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services

Health care aimed at averting or detecting illness at an early stage, when treatment is most effective.

Primary Care Physician (PCP)

The physician who acts as a patient's first point of contact and provides any continuing care of certain medical conditions. Some Medicare Advantage plans require selection of a PCP.

Product Type

How a plan is classified based on its benefits and terms.

Programs of All-Inclusive Care for the Elderly (PACE)

A special kind of plan that provides all care and services covered by Medicare insurance and Medicaid, as well as additional medically necessary care and services. These are based on the needs of the beneficiary, determined by an interdisciplinary team.

Typically serves frail seniors who need nursing home services but are also capable of living in a community. PACE combines medical, social, and long-term care services, as well as prescription drug coverage. PACE is only available in states that offer it under Medicaid.

Q

Qualified Disabled and Working Individuals (QDWI) Program

A state program that assists Part A beneficiaries with limited income or resources in affording their Part A premiums.

Qualified Individual (QI) Program

A state program that assists Part A beneficiaries with limited income or resources in affording their Medicare Part B premiums.

Qualified Medicare Beneficiary (QMB) Program

A state program that assists Part A beneficiaries with limited income or resources in affording Medicare Part A and Part B premiums and other cost-sharing (such as deductibles, coinsurance, or copayments).

R

Referral

A written order from your primary care physician directing you to see a specialist or receive certain medical services. Many Health Maintenance Organizations (HMOs) require a referral before covering certain services.

Rehabilitation Services

A health care service aimed at maintaining or improving physical capabilities that have been lost or impaired by illness or injury. These services may include physical or occupational therapy, speech-language pathology, or psychiatric services in inpatient and/or outpatient facilities.

Respite Care

Temporary care provided in a nursing home, inpatient hospice facility, or hospital so that the patient's caregiver can rest. This care is short-term.

S

Secondary Payer

An insurance policy, plan, or program that pays second on a medical care claim. This can include Medicare insurance, Medicaid insurance, or another insurance.

Skilled Nursing Care

A health care facility with the staff and equipment to provide skilled nursing care.

Skilled Nursing Facility

A health care facility with the staff and equipment to provide skilled nursing care.

Specified Low-Income Medicare Beneficiary (SLMB) Program

Like a QI program, a state program that assists Part A beneficiaries with limited income or resources in affording Medicare Part B premiums.

State Pharmaceutical Assistance Program (SPAP)

A state program that helps pay for drug coverage based on financial need, age, or medical condition.

Star Rating

The Medicare overall insurance plan rating as determined by the Centers for Medicare & Medicaid Services (CMS) that determines how well those plans perform. The rating combines scores for the types of services each plan offers.

Supplier

A person, agency, or company that gives a beneficiary a medical item or service, except when the beneficiary is in inpatient care at a hospital or skilled nursing facility.

T

Telemedicine

Any medical or health care service from a health care provider that can be accessed through a phone, computer, or television from a different location.

Tiers

The costs of different groups of drugs. Usually, a drug in a lower tier will be less expensive than one in a higher tier.

Treatment

A combination of medical services and prescription drugs that are used to treat a patient's illness or injuries.

U

Unassigned Claim

A claim that has been submitted for a service or item by a health care provider that does not accept assignment.

Urgently Needed Care

Care received outside of a Medicare insurance plan's service area for sudden illness or injury that requires immediate medical care but isn't considered life threatening.

W

Waiting Period

The timespan between when you sign up for a Medicare Part C or Medigap plan and when coverage begins. Days in the waiting period do not count toward creditable coverage or in determining a significant break in coverage. Waiting periods for Medicare insurance plans are most often imposed on plans of beneficiaries with pre-existing conditions.

Read more:

CMS.gov. *Glossary* – <https://www.cms.gov/glossary>

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