



## **Glossary: Making Sense of Medicare Terms and Phrases**

As you read about Medicare Advantage plans in various publications or online, you'll see some of the same words or phrases – over and over. If you're not sure what those terms mean, this glossary will help. Keep it handy for future reference.

### **ACTUAL CHARGE**

The amount of money a doctor or supplier charges for a specific medical service or supply. Because Medicare and insurance companies usually negotiate lower rates for members, this amount is often greater than the “approved amount” that you and Medicare actually pay.

### **ANNUAL ELECTION PERIOD**

November 15 through December 31 of each year. Usually, this is the only time when Medicare Advantage health plans and prescription drug plans are open and accepting new members, other than those who are newly eligible. Medicare Supplement plans are open for enrollment year-round if you meet certain requirements. See the definition for Medicare Supplement insurance.

### **BENEFITS**

The services provided by an insurance policy. In a health plan, benefits are the health care services you receive, such as doctor's office visits, etc.

### **CATASTROPHIC ILLNESS**

A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services for this type of condition could cause you financial hardship if you are not properly insured.

### **CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)**

The federal agency that runs the Medicare program. In addition, CMS works with the states to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high-quality healthcare.

### **COINSURANCE**

The percentage of billed charges that you may have to pay after you pay any plan deductibles. The coinsurance payment is a percentage of the cost of the service. For instance, your health plan might pay 70 percent of billed charges, and your coinsurance payment is the remaining 30 percent.

### **COPAYMENT**

The flat amount you pay to a health care provider or pharmacy at the time of service. Copayments vary depending on your plan and the services you receive. Copayments do not reduce your annual deductible or out-of-pocket maximums.

### **DEDUCTIBLE**

The total amount you must pay for health care before your health plan begins to pay.

### **DUAL ELIGIBLES**

Persons who are entitled to Medicare and also eligible for Medicaid.

### **EFFECTIVE DATE**

The date your coverage begins.

### **EMERGENCY CARE**

Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

### **END-STAGE RENAL DISEASE (ESRD)**

Permanent kidney failure requiring dialysis or a kidney transplant.

### **EVIDENCE OF COVERAGE**

A complete list of your benefits under a Medicare Advantage plan.

### **EXCLUSIONS**

Items or services a health plan doesn't cover, such as long-term care and custodial care in a nursing or private home.

### **FORMULARY**

A list of prescription medications that are approved for coverage by a health plan and that will be dispensed through participating pharmacies.

### **GENERIC DRUG**

A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

### **HOSPITAL INSURANCE (PART A)**

The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

### **INITIAL COVERAGE ELECTION PERIOD**

The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. During this time you may choose a Medicare health plan.

### **LOCK-IN PERIOD**

People with a Medicare Advantage plan are “locked-in,” meaning they can only switch Medicare plans during certain times of the year unless they qualify for special circumstances.

### **MAXIMUM ENROLLEE OUT-OF-POCKET COSTS**

The maximum dollar amount you would be required to pay out of your own pocket for health services during a specified period of time.

### **MAXIMUM PLAN BENEFIT COVERAGE**

The maximum dollar amount that a plan will insure per benefit period. Medicare plans have a Maximum Plan Benefit Coverage expenditure limit only for service categories where the plan offers enhanced benefits.

### **MEDICAID**

A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

### **MEDICALLY NECESSARY**

Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the inconvenience of you or your doctor.

### **MEDICARE**

The federal health insurance program for people 65 years of age or older, some people under age with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

### **MEDICARE ADVANTAGE ORGANIZATION**

A public or private organization licensed by the state as a risk-bearing entity that is under contract with The Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Guardian Healthcare is a Medicare Advantage Organization.

### **MEDICARE ADVANTAGE PREFERRED PROVIDER OPTION (PPO) PLAN**

A Medicare Advantage PPO gives you two ways to receive medical services. You can use doctors and hospitals inside the network and pay less for your care. Or you have the option of going outside the network, but you will pay more for your health care services. Each time you need care, the choice is yours.

### **MEDICARE ADVANTAGE PRIVATE-FEE-FOR-SERVICE (PFFS) PLAN**

Medicare Advantage PFFS plans have no network. You can visit any doctor, specialist, or hospital you like for medical care, as long as the provider accepts Medicare and health plan's terms and conditions of payment.

### **MEDICARE SAVINGS PROGRAMS**

There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay your Medicare deductibles and coinsurance.

### **MEDICARE-APPROVED AMOUNT**

This is the payment amount that Medicare and you pay to a doctor or supplier for a service or supply. It may be less than the actual amount charged by a doctor or supplier.

### **MEDICARE SUPPLEMENT INSURANCE**

A policy sold by a private insurance company that helps cover the "gaps" in coverage that are left unpaid after Original Medicare pays its portion of your healthcare expenses. For this reason, these plans are often called "Medigap" plans. Medicare Supplement policies pay only for services Medicare considers medically necessary. Payments are generally based on the Medicare-approved charge. The policy might not fully cover all of your medical costs.

### **NETWORK**

A group of doctors, hospitals, and pharmacies who have contracts with an insurance plan to provide care to the plan's members. Your network choices may vary, depending on your plan and where you live.

### **NON-FORMULARY DRUGS**

Drugs that are not included on a plan-approved list.

### **OPEN ENROLLMENT PERIOD (OEP)**

The Open Enrollment Period for Medicare is from January 1 through March 31 of each year. If you are not satisfied with the choice you made during the Annual Election Period (November 15 through December 31), you may still be able to switch during this time. Some rules may apply to this change, depending on the coverage you chose during the Annual Election Period.

### **ORIGINAL MEDICARE**

A plan that is available everywhere in the United States. Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

### **OUT-OF-NETWORK BENEFIT**

Generally, an out-of-network benefit gives you the option to use a doctor, specialist, or hospital that is not a part of the plan's contracted network. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

**OUT-OF-POCKET COSTS**

Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

**OUTPATIENT CARE**

Medical or surgical care that does not include an overnight hospital stay.

**PART A (MEDICARE)**

Medicare hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

**PART B (MEDICARE)**

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Medicare Part A.

**PART C (MEDICARE ADVANTAGE PLANS)**

Health benefits coverage offered by a Medicare Advantage Organization. You receive a specific set of health benefits at a uniform premium and uniform level of cost-sharing. Part C is available to all Medicare beneficiaries residing in a plan's service area.

**PART D (MEDICARE)**

Prescription Drug Plan that provides prescription drug coverage through private companies and organizations. You may choose any of the Medicare-approved drug plans (or Medicare Advantage HMO, PPO or PFFS plans) that offer drug coverage in your area

**PARTICIPATING PHYSICIAN OR SUPPLIER**

A doctor or other provider who agrees to accept all Medicare claims. These providers accept "Medicare assignment." They may bill you only for the Medicare deductible and/or your coinsurance or copayment amounts.

**PRIMARY CARE PHYSICIAN (PCP)**

A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a plan member.

**REFERRAL**

A written OK from your primary care physician for you to see a specialist or to receive certain services.

**SERVICE AREA**

The geographic area in which a health plan accepts members. For Medicare plans that require you to use participating doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.

**SPECIAL ELECTION PERIOD (Medicare Advantage Plans)**

A set time that a beneficiary can change health plans or return to Original Medicare. Examples of special election situations are:

- You move outside the service area
- The organization does not renew its contract with CMS

Other exceptional conditions may exist, as determined by CMS.

**SUMMARY OF BENEFITS**

A brief description or outline of your coverage, including the amounts or percentage you pay for certain services, the amounts or percentage your plan pays, and the services for which coverage is limited or excluded.