Glossary of Medicare Terms

Advance Directive
Written documents that describe the type of care you'd like to receive, or not receive, if you're ever too ill or injured to speak for yourself. In addition to a living will, an Advance Directive includes a designated health care proxy, someone who can speak on your behalf to doctors and health care providers in the event that you can't do so yourself.

AEP (Annual Election Period)
The time when you can join, switch or drop Medicare plans, including Medicare Advantage or Medicare Prescription Drug Plans (MA-PD). The AEP currently takes place from October 15 through December 7 each year.

Assignment
Medicare pays doctors, hospitals and other health care providers a set amount for specific procedures and items. If a doctor agrees to accept what Medicare will pay as full payment for the bill, he or she has accepted assignment and you won't be charged anything additional (though copayments and deductibles may still apply).

Beneficiary
The person receiving benefits from Medicare.

Benefit Period
Time spent receiving inpatient care at a hospital or skilled nursing facility. The benefit period typically begins on the day you are admitted as an inpatient to the facility, and ends when you haven't received any inpatient care for 60 days in a row. When a new benefit period starts, you may be responsible for additional costs, including deductibles and copayments.

Bone Mass Measurement
A preventive care service that measures bone density to determine if you are at risk for breaking a bone. Medicare Part B covers a bone mass measurement once every two years, or more frequently if you have certain conditions.

CAH (Critical Access Hospital)
Hospital/facility that provides outpatient care and limited inpatient services, typically in more rural areas.

CMS (The Center for Medicare and Medicaid Services)
CMS is the government agency that oversees and administers the Medicare and Medicaid programs. Private health insurers that provide Medicare Advantage plans and/or Medicare Prescription Drug Plans (MA-PD) must be approved by, and have a current contract with, CMS.

Copayment
The amount you must pay, usually a flat fee, for a specific health care product or service. Medicare and many Medicare Advantage plans require that you pay a small copayment for doctor visits, outpatient hospital visits, prescriptions and more.

Coinsurance
The amount you must pay, after deductibles, for health care services. Your coinsurance payment is usually a percentage of the total cost of the service, instead of a flat fee.

Coverage Gap
A Medicare Prescription Drug Plan (MA-PD) will pay a portion of your drug costs up to a pre-set limit. Once that limit is reached, the plan stops paying and you are responsible for 100% of your drug costs. This is known as the coverage gap, or "donut hole". Once you reach another pre-determined amount of spending on drugs, the MA-PD kicks back in and pays an even higher portion of your drug costs.

Deductible
Just like with home and automobile insurance, a deductible is a set amount that you must pay for services before your Medicare coverage kicks in.

Deemed
If you have a type of Medicare Advantage Plan known as Private Fee For Service (PFFS), you'll want to be sure that each doctor or other health care provider you visit is deemed. Similar to assignment, being deemed means that your provider is willing to accept as payment in full whatever amount your plan is willing to pay for a service.

DME (Durable Medical Equipment)
Reusable health care products used at home that are expected to last five years or more. Examples include wheelchairs, walkers, hospital beds, oxygen equipment and the like.

Donut Hole
Another name for the coverage gap. A Medicare Advantage Prescription Drug Plan (MA-PD) will stop paying for a portion of your medications once a pre-set spending limit is met. At this point, the beneficiary has reached the "donut hole" and is responsible for paying 100% of their drug costs. Once payments reach another pre-set spending limit, the drug plan kicks back in and begins paying a higher portion of the beneficiary's drug costs.

ESRD (End-Stage Renal Disease)
Permanent kidney failure requiring dialysis and/or a transplant. People with ESRD may qualify for Medicare, even if they aren't 65.

Extra Help
A Medicare program to help people with low income and limited resources to pay for prescription drug coverage. Also known as the Low-Income Subsidy (LIS).

FFS (Fee for Service)
A health care payment system where each service is identified and paid for separately. Original Medicare is based on the fee for service model.

Formulary
A list of drugs, both brand and generic, that an insurance plan will cover.

Generic Drug
A prescription medication made up of the same active ingredients as its brand-name counterpart. Generic drugs often cost less than brand-name drugs. Generic drugs must be approved by the U.S. Food and Drug Administration (FDA), just like brand-name drugs.

HIPAA (Health Insurance Portability and Accountability Act)
Put in place in 1996, HIPAA requires certain health care organizations to take specific steps to protect patients' private information. It also helped make it easier for consumers to get health insurance when changing jobs or simply purchasing individual health coverage.

HMO (Health Maintenance Organization)
A type of health plan where patients see increased savings by visiting doctors, hospitals and other providers in a pre-defined network. Many HMOs also require patients to select a Primary Care Physician (PCP) who will act as a gatekeeper, referring patients, as needed, to physician specialists and health care facilities that are in the HMO's network.

Hospice
Care specifically designed for terminally ill patients, sometimes provided in the home. Hospice care focuses on relieving pain (palliative care) and helping patients and their families with end-of-life issues.

Home Health Care
Health care services that can be provided effectively in a home setting. Home health services are often more convenient, and less expensive, for the patient. Examples of home health services include physical, occupational and speech therapy, wound care, injections or infusion therapy, help with activities of daily living (bathing, dressing, etc.) and more.

Inpatient Services
Services you receive once you are officially admitted to a hospital or skilled nursing facility. Services may include room and board, surgical/medical services, therapeutic services, etc.

In-Network Provider
A doctor, hospital, pharmacy or other health care provider that has a contracted with your health insurance plan to provide care to the plan's members. Plan members typically must pay more to see a provider outside the health plan's network.

LIS (Low-Income Subsidy)
Also known as "Extra Help", the low-income subsidy is a Medicare program to help beneficiaries with limited income and resources get prescription drug coverage.

Living Will
Part of an Advance Directive, a living will lets you describe exactly what type of life-prolonging treatments you may want, or not want, should you become serious ill, injured or incapacitated. It's typically used in conjunction with a health care proxy (durable power of attorney) to ensure that your wishes for your own medical care are carried out in the event you can't communicate them for yourself.

Long-Term Care
Services and care provided to people who have a chronic illness or disability. Long-term care can be provided at home or in a facility.

Medicare Advantage
Private insurance that covers everything original Medicare covers, and sometimes more. Also known as Part C, Medicare Advantage plans must be approved by, and have a contract with, CMS.

MA-PD (Medicare Advantage Prescription Drug Plan)
Medicare prescription drug coverage is only available through private insurance companies. Medicare beneficiaries can get a stand-alone prescription drug plan, or drug coverage may be bundled with a Medicare Advantage (Part C) plan.

Medigap
Also known as Medicare supplement plans, Medigap plans cover many of the out-of-pocket

expenses that come with traditional Medicare. These include deductibles, copayments, coinsurance and more. Private health insurers provide Medigap plans and availability varies by state.

MOOP (Maximum Out-of-Pocket)
Maximum Out-of-Pocket is the most you could pay in fees (deductibles, copayments, coinsurance, etc.) in any given year, as defined by your health plan.

Network
A list of doctors, hospitals, pharmacies and other health care providers that have contracts with an insurance plan to provide services to members. By visiting providers in the health plan's network, members, and the plan itself, can realize lower health care costs overall.

Original Medicare
Medicare coverage provided by the federal government, as opposed to Medicare Advantage and Medicare supplement plans provided by private insurers.

Out-of-Pocket
Expenses that are paid by the beneficiary, not Medicare, such as deductibles, copayments, coinsurance and the like.

Outpatient Services
Services provided to a patient without having to be admitted to a hospital, skilled nursing facility or similar environment.

Out-of-Network
Beneficiaries who visit doctors, hospitals and other providers not on their health plan's list of providers are said to be going "out-of-network". Visiting an out-of-network provider often results in higher costs to the beneficiary.

PPO (Preferred Provider Organization)
A network of doctors, hospitals and other health care providers that provide services to an insurance company for discounted rates. Unlike an HMO, PPOs typically don't require that patients use a Primary Care Physician (PCP) as gatekeeper for all care. However, as with an HMO, costs will be higher for visiting a provider that's not in the PPO network.

PFFS (Private Fee For Service)
A specific type of Medicare Advantage (Part C) plan that allows beneficiaries to see almost any doctor, hospital or other health care provider, as long as that provider is deemed. A deemed provider is one that has accepted the payment terms and conditions of the Medicare Advantage PFFS plan before services are rendered.

POS (Point of Service)
A type of managed care plan that combines aspects of both an HMO and a PPO. Patients with a POS plan typically choose a Primary Care Physician (PCP) to act as gatekeeper. The PCP can refer the patient to any provider, however, inside or outside of the POS network. Patients will pay more for visiting providers outside the network.

Referral
In some managed care plans (HMO, POS), your Primary Care Physician (PCP) may send you to see another provider for more specialized care. Your HMO or POS may require a written explanation of the referral from your PCP before it will cover any associated costs.

SNF (Skilled Nursing Facility)
For services that can only be provided by a nurse or doctor, but don't require the full resources of a hospital, patients can visit a Skilled Nursing Facility. Services offered may include intravenous injections, rehabilitation services and more.

SHIP (State Health Insurance Assistance Program)
Federally-funded state programs that provide one-on-one counseling to people with Medicare, and their families.

TTY (Teletypewriter)
A device that allows people with hearing or speech impairments to communicate via the telephone.

Tier
Health plans sometimes segment their prescription drug formularies into tiers. Each tier typically has a different cost. Patients can quickly get an idea of how much they may pay for a medication based on the tier in which it appears.

Urgent Care
Care delivered to patients with an illness or injury that requires immediate attention, but doesn't require a trip to the emergency room. Most urgent care centers allow walk-in patients without an appointment, and costs can be much lower than visiting an emergency room.