Bancorp Insurance Medicare Vocabulary

Advance Beneficiary Notice (ABN)
A notice indicating the cost of a service that Medicare might not cover.

Accepting Assignment
Your Doctor agrees to accept payment for the Medicare-approved amount for services provided. This means you only pay your coinsurance which is usually 20% of the Medicare-approved amount.

Annual Enrollment Period (AEP)
Between October 15th - December 7th when you may join or disenroll from your Medicare Advantage or Part D prescription drug coverage Plan. This is also called Fall Open Enrollment.

Alternative Care
Preventive Health care practices, such as naturopathy, acupuncture, homeopathy, chiropractic and herbal medicine.

Balance Billing
If you Doctor does not **Accept Assignment** (see definition above) the balance due is called your **Balance Billing.** Good news is if your Doctor requests additional payment because he/she does not accept assignment they can only bill your for 15% of the Medicare-approved bill amount.

Benefit Period
Starts the moment you enter a hospital for an overnight stay and end when you have been out of the hospital for 60 days.

Benefits
Also referred to as coverage are items covered under your insurance plan.

Brand-Name Drug
A prescription drug that is trademarked or is sold under a brand name. An example would be Viagra.

Catastrophic Coverage
You reach **Catastrophic Coverage** levels once you or another person on your plan has spent $4,550 (2014) in total out-of-pocket cost for your covered drugs in one year. Once you have reached **Catastrophic Coverage** you only pay a small coinsurance or copay for the cost of your Drugs.

Centers for Medicare & Medicaid Services (CMS)
The Branch of the Federal Government that runs the Medicare program and works with Oregon to manage their Medicaid program.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law that insures that all employees have the ability to continue their health insurance coverage even after leaving their job.

Coinsurance
Splitting the cost of your medical bills on a percentage basis. For example your Medicare Part B might pay 80% and you would pay 20%.

Coordinated Care
A group of doctors and hospitals that work together to provide medical care to you. Often these groups are set up by the insurance company.

Copayment
A kind of cost sharing where you pay a fixed percentage for each service or prescription. For example, you might pay $10 for each prescription you receive.

Cost Sharing
Is how Medicare shares cost with you. Common types of cost sharing are coinsurance, copayment, and deductibles.

Coverage Gap
A hole in your coverage that results in a higher payment from you often referred to as a Donut Hole.

Creditable Drug Coverage
Prescription drug insurance that is better than or as good as coverage provided through a Medicare plan.

Custodial Care
Providing care associated with daily living, like bathing, eating or getting dressed. Most long-term care is defined as **Custodial Care.**

Deductible
A kind of cost sharing where a dollar amount determined by your insurance policy (including Medicare) must be paid fist by you before Medicare or insurance begins paying.

Direct Bill
A payment method to pay your insurance bill which pays your insurance company directly from an account you select.

Donut Hole
A term to describes a coverage gap often associated with lack of **Creditable Drug Coverage.**

Durable Medical Equipment (DME)
Medical Equipment prescribed by your doctor for your use such as wheelchairs, churches, or oxygen equipment.

Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS)
Another way to say **Durable Medical Equipment.**

Dual Eligible
If you are **dual eligible** you are qualified for both Medicare and Medicaid.

Effective Date
The date your insurance policy becomes effective/starts.

Election Period AKA Open Enrollment
A period of time which you may join or leave Original Medicare, a Medicare Advantage plan, or a Part D Prescription Drug Plan.

End Stage Renal Disease (ESRD)
A Disease when your kidneys no longer function, requiring dialysis or a kidney transplant to live.

Excess Charge
The difference between the Medicare approved dollar amount and the charge which you must pay that cannot exceed 15% of the Medicare approved dollar amount.

Extra Help
A Medicare Program that helps lower income individuals pay Medicare prescription drug costs, such as deductibles, premiums, and co-insurance.

Formulary
A list of Prescription Drugs that are covered by Medicare Part D or your insurance plan.

Generic Drug
Prescription drugs that have the same formula of active ingredients as a brand-name drug. Generic drugs can cost less money than brand-name drugs, and are just as effective as brand-name drugs.

Guaranteed Issue (GI)
Guaranteed Issue means you cannot be turned down or charged more for a policy by an insurance company due to pre-existing conditions, your past health conditions.

Guaranteed Renewable Policy

As long as you pay your insurance premium and don't commit any fraud, the insurance company must automatically renew your insurance policy every year.

Health Maintenance Organization (HMO) Plan

A Medicare Advantage plan in which you must use doctors and hospitals in the plan's network. To see a specialist outside the network, you may have to get referrals and the cost of seeing these specialist may not be covered by your plan.

High-Deductible Medicare Advantage Plan

A health insurance plan which requires you to pay a very high deductible usually more than $1,000 before the plan begins to help with your cost.

Home Health Care

Skilled nursing care and therapy provided to you if you are homebound on a part-time or irregular basis.

Hospice Care

Hospice Care classically focuses on controlling symptoms and managing pain for those who are terminally ill. Part A covers both hospice and at home care received in or out of the home. It can also include support for caregivers.

Initial Enrollment Period

Three months before the first day of the month that you turn 65 continuing 90 days after the last day of your birthday month. During this **initial enrollment period** you will be able to sign up for Medicare plans.

Inpatient Care

Care you receive in a hospital, nursing home, or other medical inpatient stay.

Institutional Care

Care provided in a hospital, nursing home, or other state facility. Care includes diagnostic, preventive, maintenance, rehabilitative, and therapeutic.

Issue Age

Insurance policies whose premiums are based on your age at the time of purchase. Premiums will not rise due to an increase in age, but can increase for other reasons.

Late Enrollment Penalty (LEP)

The dollar amount added to your premium if you did not enroll during your **Initial Enrollment Period** or the **Open Enrollment Period.**

Limiting charge

The dollar amount you must pay that cannot exceed 15% more than Medicare approved amount. Also known as **Excess charge**.

Lifetime reserve Days

A reserve of 60 days of care after Medicare Provides 90 days of benefits for hospitalization. A **lifetime reserve day** cannot be replaced. When it is used up, it is gone.

Lookback

A pre-set amount of time set by your health insurance policy that must pass before benefits are paid or before particular illnesses are covered.

Low or Limited Income Subsidy (LIS)

A program operated by the Social Security Administration that offers help with prescription drug costs for you when you meet the income and asset requirements.

Long-Term Care

A general term that includes a wide range of care for daily life like bathing, eating, and dressing for an extended period of time.

Maximum out-of-pocket Limit

This is the maximum amount of money you will have to spend out of your own pocket in your insurance plan year. Once you have reached this limit, your insurance will cover all your Medicare approved expenses.

Medicaid

A program funded by the federal and state governments that pays for medical assistance for low income families and individuals. This partnership is designed to ensure that America's sick, aged, and impoverished are cared for.

Medical Savings Account (MSA) Plans

A combination of a special bank saving account and a high deductible Medicare Advantage Plan that helps pay for your medical expenses.

Medically Necessary Care

Supplies and services that are needed to treat or diagnose a medical condition.

Medicare

A program run by the federal government that helps provide health care for:

- People over the age of 65
- People under the age of 65 with certain disabilities
- People of all ages with permanent kidney failure requiring dialysis or a kidney transplant.

Medicare Advantage

A type of Medicare Plans that provides you with both hospital and doctors care through private companies that manage your care. Normally Medicare pays these private companies a set amount per person and you pay the rest of the cost through co-pays, deductibles, premiums, and co-insurance.

Medicare Advantage Disenrollment Period

Between Jan. 1 to Feb. 14 when you can cancel your Medicare Advantage plan with no questions asked. Once you cancel your Medicare Advantage plan you default to Original Medicare coverage (Parts A and B only). If prescription drug coverage was included in your canceled policy you can enroll in Medicare Part D plan during this time.

Medicare Advantage with Prescription Drug Coverage

A Medicare plan provided by a private company that includes prescription drug coverage also referred to as Part D.

Medicare-Approved Amount

The amount of money that Medicare has permitted as the amount that a doctor or hospital should be paid for a specific service. If the doctor or hospital feels they should be paid more, additional cost must be paid by you though cost sharing.

Medicare Open Enrollment Period

From October 15th through December 7th of each year when you may enroll in, change your prescription drug plans and Medicare Advantage plans.

Medicare Saving Program

A federal state partnership program that helps eligible people pay some or all of their Medicare deductibles and premiums.

Medicare SELECT

A type of Medicare supplement policy that requires you to use specific hospitals and doctors to get your complete insurance benefits. This does not pertain to emergency visits.

Medicare Supplement Policy

An insurance policy you buy from a private insurance company that pays for all or some of the cost not covered by Medicare such as copays, and deductibles. This insurance helps pays for the gaps in coverage you have to pay for when using Original Medicare (Parts A and B), which is why it is sometimes called a **Medigap policy**. These policies are also named with letters A, F, G, and N do not confuse them with Original Medicare.

Network

A Medicare Advantage Coordinated care plan that is comprised of a group of health care providers such as pharmacies, doctors and hospitals that provide care to you. These doctors and hospitals are called network providers. When you use these providers you are getting health care from in-network providers which can save you money.

Original Medicare (OM)

A commonly used term for Part A and Part B of Medicare.

Outpatient Care

Any care you receive as a hospital patient or care you receive in a surgery center as an outpatient.

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

A program that provides seniors with a combination of medical, long-term and social care services to help keep them living independently in their communities for as long as possible.

Part A

Helps with cost of Hospital stays and skilled nursing services as well as some skilled care following a hospital stay. Part A is a part of Original Medicare.

Part B

Provides help with the cost of doctor visits and additional medical services that don't include overnight hospital stays.

Part D

Helps with the cost of prescription drugs. You can purchase Part D as part of a Medicare Part D coverage, a Medicare Advantage Plan, or as a stand-alone drug plan.

Point of Service (POS) Plan

A type of Medicare Advantage HMO plan that give you the option to use doctors and hospitals outside of their network for an additional cost.

Pre-Existing Condition

A medical condition diagnosed, treated, or needing treatment before you apply/purchase an insurance policy is referred to as a **Pre-Existing Condition**.

Preferred Provider Organization (PPO)

If you use doctors and hospitals within your insurance policy's network they are a **Preferred Provider Organization** and the service will normally cost you less money. If you visit an outside of network provider you'll usually pay a large share of the cost out-of-pocket.

Preferred Drug List

A list of specific prescription drugs that is covered by your insurance plan. This can also be called a Formulary.

Preferred Pharmacy
A pharmacy that is in network and offers pharmaceutical drugs at a reduced price to those that are part of a member insurance plan.

Premium
A payment made to your insurance company usually on a monthly basis to pay for coverages and services listed in your insurance policy/contract.

Prescription Drug Plan (PDP)
Prescription drug coverage that can be a stand-alone plan or a part of a Medicare Advantage plan. This is sometimes called Medicare Part D.

Preventive Care
Health care that is meant to keep you healthy or from becoming ill. Examples include flu shots, checkups, mammograms, and screenings.

Private Fee-For -Service Plan (PFFS)
A Medicare Advantage plan that allows you to visit any Medicare eligible provider who accepts your health insurance payment terms and conditions.

Provider
A doctor, hospital, hospice, nursing facility, pharmacy, or laboratory that provides medical services and products.

Qualified Medicare Beneficiary (QMB)
A federal state partnership that provides financial help to those with low incomes or disability's. This financial help can pay for Medicare Part A and B premiums and deductibles.

Quantity Limits
The limitation of the amount of drugs you are covered for in a specific period of time. For example if you take one pill a day for 30 days and your **Quantity Limit** is equal to 30 you are fine. If you currently take two pills per day and your **Quantity Limit** is 30 then you will run out of medication half way through the month. You need to work with your insurance provider to make sure you are covered for the correct amount of medications.

Referral
A written note from your in network primary care doctor to see a specialist or receive medical services outside of your coverage network.

Retiree Health Coverage
An insurance plan purchased by a company to provide retired employees health insurance.

Service Area
A specified area that your insurance plan offers service. A **service area** example is a state county or region.

Skilled Nursing Care
Care for an illness or injury which should be provided only by a licensed professional nurse.

Special Enrollment Period
A period of time that you can join or leave an insurance plan separate from regular enrollment periods.

Special Needs Plan (SNP)
A Medicare Advantage plan that specializes in treating those with special health care needs.

Social Security Administration (SSA)
An agency in our government who is in charge of the Social Security System.

Social Security Disability Insurance (SSDI)
If you are unable to work for a year or more due to a disability you may be eligible for a monthly benefit provided by Social Security.

Step Therapy

A procedure you and your doctor follow for prescription drugs which states if you are prescribed a drug from your doctor you must use the less expensive version of that drug (generic drug) fist before you can Step Up to a more expensive version of that same drug (brand name drug).

Supplemental Security Income (SSI)

Monthly amount paid by Social Security to those with a limited income or who have disabilities, are over 65 with no income, are blind, or meet other factors.

Tiered Formulary

A drug plan that divides drugs into different levels based on the type and cost of the drug. The lowest tier has the lowest co-pay normally generic drugs, followed by higher tiers for brand-name version of the drug.

Total Drug Cost

The retail cost of a prescription drug or the sticker price for the medication.

True Out-of-Pocket (TrOOP) Cost

The total amount you pay toward the cost of your prescription drugs including payments made to your insurance coverage, your deductible, and co-pays. Premiums do not go toward **True Out-of-Pocket Cost**.

Underwriting

A process that an insurance company goes through to determine whether or not they will accept a part of your risk by accepting your insurance application.

Waiting Period

The specified amount of time that must pass before pre-existing conditions are covered by your health insurance policy.