

## Glossary

This glossary explains terms in the Medicare program, but it is not a legal document. The official Medicare program provisions are found in the relevant laws, regulations, and rulings.

A	
<b>Abuse (Personal)</b>	When another person does something on purpose that causes you mental or physical harm or pain.
<b>Access</b>	Your ability to get needed medical care and services.
<b>Accessibility of Services</b>	Your ability to get medical care and services when you need them.
<b>Accreditation</b>	A seal of approval from a private, independent group. Being accredited means that a facility has met certain quality standards.
<b>Act / Law / Statute</b>	Term for legislation that passed through Congress and was signed by the President or passed over his veto.
<b>Activities of Daily Living (ADL)*</b>	Activities you usually do during a normal day. Although definitions differ, ADL's are usually viewed as everyday activities, such as walking, getting in and out of bed, dressing, bathing, eating, and using the bathroom.
<b>Actual Charge</b>	The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. (See Approved Amount; Assignment.)

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<b>Adjusted Average Per Capita Cost (AAPCC)</b>	An estimate of how much Medicare will spend in a year for an average beneficiary. (See Risk Adjustment.)
<b>Adjusted Community Rating (ACR)</b>	How premium rates are decided based on members' use of benefits and not your individual use of benefits.
<b>Administrative Law Judge (ALJ)</b>	A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.

<b>Admitting Physician</b>	The doctor responsible for admitting you to a hospital or other inpatient health facility.
<b>Advance Beneficiary Notice (ABN)</b>	A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases: (1) Your doctor gives you a service that he or she believes that Medicare does not consider medically necessary; and (2) Your doctor gives you a service that he or she believes that Medicare will not pay for. If you do not get an ABN to sign before you get the service from your doctor, and Medicare does not pay for it, then you do not have to pay for it. If the doctor does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor for it. ABN only applies if you are in the Original Medicare Plan. It does not apply if you are in a Medicare managed care plan. (See Medicare Managed Care Plan; Original Medicare Plan.)
<b>Advance Coverage Decision</b>	A decision that your Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.
<b>Advance Directives</b>	Written ahead of time, this is your statement of how you want to get health care. This is done in case you can't say how. Such health care could include routine treatments and life-saving methods. You can also choose someone to make medical decisions in case you can't. Advance Directives are also called a Living Will.
<b>Advocate</b>	A person who gives you support or protects your rights.

<b>Affiliated Provider</b>	A health care provider or facility that is paid by a health plan to give services to plan members.
<b>Ambulatory Care</b>	All types of health services that do not require an overnight hospital stay.
<b>Ambulatory Surgical Center</b>	A separate part of a hospital that does outpatient surgery.
<b>Ancillary Services</b>	Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.
<b>Anesthesia</b>	Drugs that a person is given before surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse.
<b>Annual Election Period</b>	The Annual Election Period for Medicare beneficiaries is the month of November each year. Enrollment will begin the following January. Starting in January 2002, this is the only time that most current Medicare beneficiaries can switch or join a new Medicare health plan. (See Election Periods.)
<b>Appeal</b>	An appeal is a special kind of complaint you make if you disagree with any decision about your health care services, for example, if Medicare doesn't pay for a service you got. This complaint is made to your Medicare health plan or the Original Medicare Plan. There is usually a special process you must use to make your complaint. (See Appeals Process.)
<b>Appeals Process</b>	The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the

	<p>initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. (See also Organization Determination.)</p>
<p><b>Approved Amount</b></p>	<p>The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge." (See Actual Charge, Assignment.)</p>
<p><b>Approved Amount (Home Health)</b></p>	<p>The fee Medicare sets as reasonable for a covered medical service. It may be less than the actual amount charged. Approved amount is sometimes called "approved charge." (See Actual Charge; Assignment.)</p>
<p><b>Area Agency On Aging (AAA)</b></p>	<p>State and local aging programs that help older people plan and care for their life-long needs. These needs include adult day health care, skilled nursing care/therapy, transportation, personal care, respite</p>

	care, and meals.
<b>Assessment</b>	The gathering of information to rate or evaluate your health and needs, such as in a nursing home.
<b>Assignment</b>	In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor visit. (See Actual Charge; Approved Amount; Coinsurance.)
<b>Assisted Living Facility (ALF)</b>	A homelike place with staff who give help to residents, including: help with dressing, bathing, feeding, and housekeeping. Assisted Living Facilities usually give a less skilled level of care than you would get in skilled nursing facilities. Medicare does not cover care in an ALF.

<b>B</b>	
<b>Balance Billing</b>	This is when Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.
<b>Basic Benefits (Medigap)</b>	Benefits provided in Medigap Plan A. They are also included in all other Medigap plans. (See Medigap.)
<b>Beneficiary</b>	The name for a person who has health insurance through the Medicare or Medicaid program.
<b>Benefit Period</b>	The way that Medicare measures your use of hospital and skilled nursing facility services. A benefit period starts the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received hospital or skilled nursing care

	for 60 days in a row. If you go into the hospital after 60 days, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. (See Deductible; Skilled Nursing Facility.)
<b>Benefits</b>	The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.
<b>Board-Certified</b>	This means a doctor has special training in a certain area of medicine and has passed an ADVANCED exam in that area of medicine. Both primary care doctors and specialists may be board-certified.

<b>C</b>	
<b>CAHPS (Consumer Assessment of Health Plans Study)</b>	A yearly nationwide survey that is used to report information on Medicare beneficiaries' experiences with managed care plans. The results are shared with Medicare beneficiaries and the public.
<b>Capitation</b>	A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.
<b>Care Plan</b>	A written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well being.
<b>Carrier</b>	A private company that has a contract with Medicare to pay your Medicare Part B bills. (See Part B.)
<b>Case Management</b>	A process used by a doctor, nurse, or other health

	Professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.
<b>Case Manager</b>	A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.
<b>Catastrophic Illness</b>	A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause you financial hardship.
<b>Catastrophic Limit</b>	The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.
<b>Certified</b>	This means a hospital has passed a survey done by a State government agency. Being certified is not the same as being accredited. However, Medicare only covers care in hospitals that are certified or accredited. (See also Accreditation.)
<b>Certified Registered Nurse Anesthetist</b>	A nurse who is trained and licensed to give anesthesia. Anesthesia is used during surgery and causes complete or partial loss of feeling. (See also Anesthesia.)
<b>CHAMPUS</b>	The Civilian Health and Medical Program run by the Department of Defense. CHAMPUS gives medical care to the dependents of active duty military members and to retired military members. (Now called TRICARE.)
<b>Claim</b>	A claim is a request for payment for services and

	benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Part A; Part B.)
<b>Clinical Practice Guidelines</b>	Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.
<b>Cognitive Impairment</b>	A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.
<b>Coinsurance</b>	The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).
<b>Coinsurance (Assignment)</b>	The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20% for Part B Services.) (See Assignment; Deductible (Medicare); Original Medicare Plan; Part A; Part B.)
<b>Coinsurance (Private Fee-for-Service Plan)</b>	The percentage of the Private Fee-for-Service plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service plan, the coinsurance payment is a percentage of the cost of the service (like 20%).
<b>Complaint</b>	Any oral or written expression of displeasure you have with a health plan, provider, or facility. This

	includes concerns about waiting times, satisfaction with facilities, or the respect paid to consumers.
<b>Confidentiality</b>	Your right to talk with your health care provider without anyone else finding out what you have said.
<b>Consolidated Omnibus Budget Reconciliation Act (COBRA)*</b>	COBRA is a law that makes an employer let you remain covered under the employer's group health plan for a period of time after: the death of your spouse, losing your job, or having your work hours reduced, or getting a divorce. You may have to pay both your share and the employer's share of the premium.
<b>Coordination of Benefits Clause</b>	A written statement that tells which health plan or insurance policy pays first if two health plans or insurance policies cover the same benefits. If one of the plans is Medicare, federal law may decide who pays first.
<b>Copayment</b>	In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be \$5.00 or \$10.00 for a doctor visit. Copayments may also be used for hospital outpatient services in the Original Medicare Plan later this year.
<b>Cost Sharing</b>	The cost for medical care that you pay yourself, like a copayment, coinsurance, or deductible. (See Coinsurance; Copayment; Deductible.)
<b>Covered Benefit</b>	A health service or item that is included in your health plan, and that is paid for either partially or

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	fully.
<b>Covered Charges</b>	Services or benefits for which a health plan makes either partial or full payment.
<b>Creditable Coverage</b>	Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. (See Pre-existing Conditions.)
<b>Custodial Care</b>	Personal care, such as bathing, cooking, and shopping. This is usually not covered by Medicare.

D	
<b>Deductible (Medicare)</b>	The amount you must pay for health care before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year. (See Benefit Period; Part A; Part B.)
<b>Deductible (Part B)</b>	The amount you must pay for health care each calendar year before Medicare begins to pay. This amount can change every year.
<b>Deductible (Private Fee-for-Service Plan)</b>	The amount you must pay for health care before the Private Fee-for-Service Plan begins to pay. This amount can change every year.
<b>Deductibles (Medigap)</b>	The amount you must pay for health care, before Medicare or some Medigap policies begin to pay. Some Medicare deductibles can change every year. (See Medigap.)
<b>Deficiency (Nursing Home)</b>	A finding that a nursing home failed to meet one or more federal or state requirements.
<b>Dehydration</b>	A serious condition where your body's loss of fluid is more than your body's intake of fluid.
<b>Diagnosis</b>	The name for the health problem that you have.
<b>Diagnosis Related Groups</b>	A way to pay hospitals for health care based on diagnosis, age, sex, and complications.

<b>Discharge Planning</b>	A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.
<b>Disenroll</b>	Ending your health care coverage with a health plan.
<b>Dual Eligibles</b>	Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.
<b>Durable Medical Equipment (DME)</b>	Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Medicare Part B, and you pay 20% coinsurance in the Original Medicare Plan.

<b>E</b>	
<b>Elder Law*</b>	The group of laws about rights and issues of the health, finances, and well-being of the elderly.
<b>Eldercare</b>	Public, private, formal, and informal programs and support systems, government laws, and funding ways to meet the needs of the elderly, including: housing, home care, pensions, Social Security, long-term care, health insurance, and elder law.
<b>Election</b>	Your decision to join or leave the Original Medicare Plan or a Medicare+Choice plan.

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<b>Election Periods</b>	<p>Time when an eligible person may choose to join or leave the Original Medicare plan or a Medicare+Choice plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.</p> <ol style="list-style-type: none"><li>1) Annual Election Period: The Annual Election Period is the month of November each year. Medicare health plans enroll eligible beneficiaries into available health plans during the month of November each year. Starting in January 2002, this is the only time that most current Medicare beneficiaries will be able to switch or join a new Medicare health plan.</li><li>2) Initial Coverage Election Period: The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. If you choose to join a Medicare health plan during your Initial Coverage Election Period, the plan must accept you. The only time a plan can deny your enrollment during this period is when it has reached its member limit. This limit is approved by the Health Care Financing Administration. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP).</li><li>3) Special Election Period: You are given a Special Election Period to change Medicare+Choice plans or to return to Original Medicare in certain situations, which include: you make a permanent</li></ol>
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	<p>move outside the service area, the Medicare+Choice organization breaks its contract with you or does not renew its contract with HCFA; or other exceptional conditions determined by HCFA. The Special Election Period is different from the Special Enrollment Period (SEP).</p> <p>4) Open Enrollment Period: If the Medicare health plan is open and accepting new members, you may join or enroll in it. If a health plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.</p>
<p><b>Eligibility / Medicare Part A</b></p>	<p>You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if:</p> <ol style="list-style-type: none"> <li>1) You are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or</li> <li>2) You are under 65 and you have received Social Security disability benefits for 24 months, or</li> <li>3) You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or</li> <li>4) You or your spouse had Medicare-covered government employment, or</li> <li>5) You are under 65 and have End-Stage Renal Disease.</li> </ol> <p>If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if:</p>

	<ol style="list-style-type: none"> <li>1) You are age 65 or older, and</li> <li>2) You are enrolled in Part B, and</li> <li>3) You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.</li> </ol>
<b>Eligibility / Medicare Part B</b>	You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the five years immediately before the month during which you enroll in Part B.
<b>Emergency Care</b>	Care given for a medical emergency when you believe that your health is in serious danger—when every second counts.
<b>Employer Group Health Plan (GHP)</b>	A GHP is a health plan that: 1) gives health coverage to employees, former employees, and their families, and 2) is from an employer or employee organization.
<b>End-Stage Renal Disease (ESRD)*</b>	Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Social Security payments if

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	found to be disabled.
<b>Enroll</b>	To join a health plan.
<b>Enrollment / Medicare Part B</b>	<p>You must choose whether or not you want to keep Part B. There are three periods that you can make a choice about Part B: Initial Enrollment Period (IEP), General Enrollment Period (GEP), and Special Enrollment Period (SEP).</p> <ol style="list-style-type: none"> <li>1) Initial Enrollment Period: The IEP is the first chance a person has to enroll in Part B. Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for 7 months.</li> <li>2) General Enrollment Period: January 1 through March 31 of each year. Your Part B coverage is effective July 1 after the GEP in which you enroll.</li> <li>3) Special Enrollment Period: You can use the SEP only if you haven't taken Part B during the IEP, because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up at any time you are covered under the group plan. If the employment or group health coverage ends, you have 8 months to sign up. The 8-month SEP starts the month after the employment ends or the group health coverage ends, whichever comes first. The cost of Part B may go up 10% for each 12-month period that you could have had Part B but did not take it. (See Eligibility.)</li> </ol>

<p><b>Enrollment / Premium Part A</b></p>	<p>There are four periods during which you can enroll in premium Part A: Initial Enrollment Period (IEP), General Enrollment (GEP), Special Enrollment Period (SEP), and Transfer Enrollment Period (TEP).</p> <ol style="list-style-type: none"><li>1) Initial Enrollment Period: The IEP is the first chance you have to enroll in premium Part A. Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for 7 months.</li><li>2) General Enrollment Period: The GEP is January 1 through March 31 of each year. Your premium Part A coverage is effective July 1 after the GEP in which you enroll. THE PART A PREMIUM IS INCREASED BY 10% FOR THOSE WHO DELAY ENROLLING FOR 12 MONTHS OR MORE.</li><li>3) Special Enrollment Period: The SEP is for people who did not take premium Part A during their IEP because they or their spouse currently work and have group health plan coverage through the employer or union. You can sign up for premium Part A at any time you are covered under the group health plan. If the employment or group health plan coverage ends, you have 8 months to sign up. The 8 months start the month after the employment ends or the group health plan coverage ends.</li><li>4) Transfer Enrollment Period: The TEP is for people who have Part B only and are enrolled in</li></ol>
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	<p>a Health Maintenance Organization or a Competitive Medical Plan (CMP). You can sign up for premium Part A during any month in which you are enrolled in an HMO/CMP. If you leave the HMO or CMP or if the plan coverage ends, you have 8 months to sign up. The 8 months start the month after the month you leave the plan or the plan coverage ends.</p>
<b>Episode of Care</b>	<p>The health care services given during a certain period of time, usually during a hospital stay.</p>
<b>EverCare</b>	<p>A HCFA demonstration project developed to manage the medical care of Medicare beneficiaries who are long stay residents of a nursing home. A network of physicians and nurse practitioners, who have been trained in treating the elderly, provide this care. EverCare demonstration sites are located in Atlanta, Baltimore, Boston, Denver, Phoenix, and Tampa. The project is scheduled to end on December 31, 2001.</p>
<b>Evidence</b>	<p>Signs that something is true or not true. Doctors can use published studies as evidence that a treatment works or does not work.</p>
<b>Excess Charge (Medigap)*</b>	<p>The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount. (See Actual Charge; Approved Amount; Medigap.)</p>

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<b>Excess Charges*</b>	The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount. (See Actual Charge; Approved Amount; Medigap.)
<b>Exclusion Period</b>	A period of time of up to 6 months when an insurance company can delay coverage of a pre-existing condition. Sometimes called a pre-existing condition waiting period. (See Pre-Existing Condition.)
<b>Exclusions (Medicare)</b>	Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.
<b>Exclusions (Medigap)</b>	Items or services that Medigap generally does not cover, such as custodial care.
<b>Explanation of Medicare Benefits (EOMB)</b>	A notice that is sent to you after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. This is being replaced by the Medicare Summary Notice (MSN), which sums up all the services (Part A and B) that were given over a certain period of time, generally monthly. (See Medicare Summary Notice; Medicare Benefits Notice.)

<b>F</b>	
<b>Federally Qualified Health Center (FQHC)</b>	Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in

	FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, Tribal health clinics, migrant health services, and health centers for the homeless.
<b>Fee Schedule</b>	A complete listing of fees used by health plans to pay doctors or other providers.
<b>Fiscal Intermediary</b>	A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")
<b>Fiscal Year</b>	For Medicare, a year long period that runs from October 1st through September 30 <sup>th</sup> of the next year. The government and some insurance companies follow a budget that is planned for a fiscal year.
<b>Formulary</b>	A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.
<b>Fraud and Abuse</b>	Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service provided. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.
<b>Free Look (Medigap)*</b>	A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled. If you cancel, you will get your money

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	back.
<b>Freedom of Information Act (FOIA)</b>	A law that requires the U.S. Government to give out certain information to the public when it receives a written request. FOIA applies only to records of the Executive Branch of the Federal Government, not to those of the Congress or Federal Courts, and does not apply to state governments, local governments, or private groups.

<b>G</b>	
<b>Gag Rule Laws</b>	Special laws that make sure that health plans let doctors tell their patients complete health care information. This includes information about treatments not covered by the health plan. These laws make it illegal to include "gag" clauses in doctor contracts, which limit a doctor's ability to give information to patients about treatment choices for a health problem.
<b>Gaps</b>	The costs or services that are not covered under the Original Medicare Plan. Also called Medicare gaps.
<b>Gatekeeper</b>	In a managed care plan, this is another name for the primary care doctor. This doctor gives you basic medical services and coordinates proper medical care and referrals.
<b>General Enrollment Period (GEP)</b>	The GEP is January 1 through March 31 of each year. If you enroll in Part B or Part A (if you don't get it automatically without paying a premium) during the GEP, your coverage starts on July 1. (See Enrollment.)

<b>Gerontology*</b>	The study of, and learning about, older people and the process of aging.
<b>Grievance</b>	A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem with the cleanliness of the health care facility, problems calling the plan, staff behavior, or operating hours. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered.
<b>Group or Network HMO</b>	A health plan that contracts with group practices of doctors to give services in one or more places.
<b>Guarantee Issue Rights</b>	A right you have in certain situations when insurance companies are required by law to issue you a Medigap policy.
<b>Guaranteed Renewable</b>	A Medigap policy that your insurance company must allow you to automatically renew or continue, unless you do not pay your premiums.
<b>Guaranteed Renewable (Medigap)</b>	A Medigap policy that your insurance company must allow you to renew or continue, unless you do not pay your premiums.

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<b>H</b>	
<b>Health Care Financing Administration (HCFA)</b>	The federal agency that oversees the Medicare, Medicaid, and state Children's Health Insurance Program. HCFA works to make sure that the beneficiaries in these programs are able to get high quality health care.
<b>Health Care Provider</b>	A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.
<b>Health Employer Data and Information Set (HEDIS)</b>	A set of standard performance measures that can give you information about the quality of a health plan. You can find out about the quality of care, access, cost, and other measures to compare managed care plans. The Health Care Financing Administration (HCFA) collects HEDIS data for Medicare plans. (See Health Care Financing Administration.)
<b>Health Insurance Portability &amp; Accountability Act</b>	In 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act (HIPAA), which is also sometimes called the "Kassebaum-Kennedy" law. This legislation expands your health care coverage if you have lost your job, or if you move from one job to another. HIPAA protects you and your family if you have: 1) pre-existing medical conditions, and/or 2) problems getting health coverage, and you think it is based on past or present health. HIPAA also: 1) limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage; 2) usually gives you credit for

	<p>health coverage you have had in the past; 3) may give you special help with group health coverage when you lose coverage or have a new dependent; and 4) generally, guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.</p>
<b>Health Maintenance Organization (HMO)</b>	<p>A group of doctors, hospitals, and other health care providers who agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. In an HMO, you usually must get all your care from the providers that are part of the plan.</p>
<b>HMO with a Point of Service (POS) Option</b>	<p>A managed care plan that lets you use doctors and hospitals outside the plan for an additional cost. (See Medicare Managed Care Plan.)</p>

<b>Home Health Agency</b>	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.
<b>Home Health Care</b>	Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury. (See Activities of Daily Living.)
<b>Homebound</b>	Normally unable to leave home. Leaving home takes considerable and taxing effort. You may leave home for medical treatment or short, infrequent absences for nonmedical reasons, like a trip to the barber.
<b>Hospice</b>	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (hospital insurance).
<b>Hospital Insurance (Part A)</b>	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
<b>Hospitalist</b>	A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.

<b>I</b>	
<b>Information, Counseling, and Assistance Program</b>	(See State Health Insurance Assistance Program.)

<p><b>Initial Coverage Election Period</b></p>	<p>The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare health plan during your Initial Coverage Election Period. The plan must accept you unless it has reached its limit in number of members. This limit is approved by the Health Care Financing Administration. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP). (See Election Periods, Enrollment; Initial Enrollment Period.)</p>
<p><b>Initial Enrollment Period (IEP)</b></p>	<p>The IEP is the first chance a person has to enroll in Part B or Part A (if you don't get it automatically without paying a premium). Your IEP starts three months before you first meet all the eligibility requirements for Medicare and continues for 7 months. The Initial Enrollment Period is different from the Initial Coverage Election Period. (See Enrollment; Election Periods; Initial Coverage Election Period.)</p>
<p><b>Inpatient Care</b></p>	<p>Health care that you get when you stay overnight in a hospital.</p>
<p><b>Insolvency</b></p>	<p>When a health plan has no money or other means to stay open and give health care to patients.</p>
<p><b>Intermediary</b></p>	<p>A private company that contracts with Medicare to pay Medicare (Part A) bills. (Same as "Fiscal Intermediary.")</p>
<p><b>Internist</b></p>	<p>A doctor who finds and treats health problems in adults.</p>

**K**

<b>L</b>	
<b>Lifetime Reserve Days (Medicare)</b>	Sixty days that Medicare will pay for when you are in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance (\$388 in 2000).
<b>Limiting Charge</b>	The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment. (See Approved Amount; Assignment.)
<b>Long-Term Care</b>	Custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses. Long-term care is not covered by Medicare.
<b>Long-Term Care Ombudsman</b>	A supporter for nursing home patients who works to solve problems between patients and nursing homes. These are also called "Ombudsman."

**M**

<b>Malnutrition</b>	A health problem caused by the lack (or too much) of needed nutrients.
<b>Mammogram</b>	A special x-ray of the breasts. Medicare covers the

	cost of a mammogram once a year for women over 40 who are enrolled in Medicare.
<b>Mediate</b>	To settle differences between two parties.
<b>Medicaid</b>	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 health care costs are covered if you qualify for both Medicare and Medicaid.
<b>Medicaid Only Dual Eligibles (Non-QMB, -SLMB, -QI)</b>	Medicare beneficiaries who are entitled to Medicare Part A and/or Part B and qualify for full Medicaid benefits.
<b>Medical Insurance (Part B)</b>	The part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A doesn't cover, like physical and occupational therapy. (See Medicare Part B.)
<b>Medical Underwriting</b>	The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for preexisting conditions (if your state law allows it), and how much to charge you for that insurance.
<b>Medically Necessary</b>	Services or supplies that: 1) are proper and needed for the diagnosis, or treatment of your medical condition; 2) are used for the diagnosis, direct care, and treatment of your medical condition; 3) meet the standards of good medical practice in the local community; and 4) are not mainly for the convenience of you or your doctor.
<b>Medicare</b>	The federal health insurance program for: people 65

	years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).
<b>Medicare + Choice</b>	A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.
<b>Medicare Benefits Notice</b>	A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) (for Part B services) or a Medicare Summary Notice (MSN). (See Explanation of Medicare Benefits; Medicare Summary Notice.)
<b>Medicare Carrier</b>	A private company that contracts with Medicare to pay Part B bills.
<b>Medicare Coverage</b>	Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). (See Medicare Part A and Medicare Part B.)
<b>Medicare Managed Care Plan</b>	These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.
<b>Medicare Medical Savings</b>	A Medicare health plan option made up of two parts.

<b>Account Plan (MSA)</b>	One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.
<b>Medicare Part A (Hospital Insurance)</b>	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
<b>Medicare Part B (Medical Insurance)</b>	Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A. (See Medical Insurance.)
<b>Medicare Secondary Payer</b>	The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.
<b>Medicare SELECT</b>	A type of Medigap policy that may require you to use doctors and hospitals within its network to be eligible for full benefits.
<b>Medicare Summary Notice (MSN)</b>	A notice you get after the doctor files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get a notice called an Explanation of Medicare Benefits (EOMB) for Part B services. (See Explanation of Medicare Benefits; Medicare Benefits Notice.)
<b>Medicare Supplemental Health Insurance Policy</b>	A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through

	Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps; Supplemental Insurance.)
<b>Medigap</b>	A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan. (See Gaps; Supplemental Insurance.)

<b>N</b>	
<b>National Committee For Quality Assurance (NCQA)</b>	A non-profit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Set (HEDIS) data reporting system. (See Health Employer Data and Information Set.)
<b>Neglect</b>	When care takers do not give a person they care for the goods or services needed to avoid harm or illness.
<b>Network</b>	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.
<b>Nonparticipating Physician</b>	A doctor or supplier who does not accept assignment on all Medicare claims. (See Assignment.)
<b>Notice of Medicare Benefits</b>	A notice that you get to show what action was taken on a claim. (See Explanation of Medicare Benefits;

	Medicare Benefits Notice; Medicare Summary Notice.)
<b>Nurse Practitioner (NP)</b>	A nurse who has 2 or more years of advanced training and has passed a special exam. They may work as primary care providers, often with a doctor.
<b>Nursing Home</b>	A place that gives nursing care, help with healing after an injury or hospital stay, or custodial care. Medicare does not pay for nursing home care, but Medicaid may.

<b>O</b>	
<b>Occupational Therapy</b>	Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after an illness either on an in- or out-patient basis.
<b>Ombudsman</b>	A supporter for nursing home patients who works to solve problems between patients and nursing homes. Also called "Long-Term Care Ombudsman."
<b>Open Enrollment Period (Medigap)</b>	A one-time only, six month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. You cannot be denied coverage or charged more due to your history during this time.
<b>Open Enrollment Periods</b>	A certain period of time when you can join a Medicare health plan. The plan must be open and accepting new members. If a health plan chooses to be open, it must allow all eligible beneficiaries to join. (See Election Periods.)
<b>Organization Determination</b>	A health plan's decision on whether to pay all or part of a bill, or to give medical services, after you file an appeal. If the decision is not in your favor, the plan

	<p>must give you a written notice. This notice must give a reason for the denial and a description of steps in the appeals process. (See also Appeals Process.)</p>
<b>Original Medicare Plan</b>	<p>A pay-per-visit health plan 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 (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). (See Deductible (Medicare); Approved Amount; Coinsurance; Part A; Part B.)</p>

<b>Out-of-Pocket Costs</b>	Health care costs that you must pay on your own, because they are not covered by Medicare or other insurance.
<b>Outpatient Care</b>	Medical or surgical care that does not include an overnight hospital stay.
<b>Outpatient Hospital Services* (Medicare)</b>	Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including: 1) blood transfusions; 2) certain drugs; 3) hospital billed laboratory tests; 4) mental health care; 5) medical supplies such as splints and casts; 6) emergency room or outpatient clinic, including same day surgery; and 7) x-rays and other radiation services.

<b>P</b>	
<b>Part A (Medicare)</b>	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
<b>Part B (Medicare)</b>	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.
<b>Participating Provider</b>	A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors/suppliers may bill you only for Medicare deductible and/or coinsurance amounts. (See Assignment.)

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<b>Peer Review Organization (PRO)</b>	Groups of practicing doctors and other health care experts. They are paid by the federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service plans, and ambulatory surgical centers.
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<b>Periods of Care (Hospice)</b>	A set period of time that you can get hospice care after your doctor says that you are eligible and still need hospice care.
<b>Physical Therapy</b>	Treatment of injury and disease by mechanical means, as heat, light, exercise, and massage.
<b>Physician Assistant (PA)</b>	A person who has 2 or more years of advanced training and has passed a special exam. They work with a doctor and can do some of the jobs that a doctor can do.
<b>Plan of Care</b>	Your doctor's written plan saying what kind of services and care you need for your health problem.
<b>Pre-Existing Condition (Medigap)</b>	A health problem for which you got medical treatment or advice within 6 months of the date that a new insurance policy starts.
<b>Preferred Provider Organization (PPO)</b>	A managed care plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
<b>Premium</b>	What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.
<b>Preventive Care</b>	Care to keep you healthy or to prevent illness, such as colorectal cancer screening, yearly mammograms, and flu shots.
<b>Primary Care</b>	A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetrician), and children (pediatrician). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic

	level of health care.
<b>Primary Care Doctor</b>	A doctor who is trained to give you basic care. This includes: being the first one to check on health problems; coordinating your preventive health care with other doctors, specialists, and therapists. In many Medicare managed care plans, you must see your primary care doctor before you can see any other health care provider. (See Managed Care Plan.)
<b>Primary Payer</b>	The insurance company that pays first on a claim for medical care. This could be Medicare or another insurance company.
<b>Private Contract</b>	A contract between you and a doctor who has decided not to offer services through the Medicare program. This doctor cannot bill Medicare for any service or supplies given to you and other Medicare patients for at least 2 years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.
<b>Private Fee-for-Service Plan</b>	A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare covered benefits. You may have extra benefits the Original Medicare Plan does not cover.
<b>Procedure</b>	Something done to fix a health problem or to learn more about it. For example, surgery, tests, and putting in an IV (intravenous line) are procedures.

<b>Program of All-Inclusive Care for the Elderly (PACE)</b>	PACE is a special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.
<b>Protections and Guarantees (Medigap)</b>	Your rights to buy a Medigap policy in certain situations after your Medigap open enrollment period.
<b>Provider</b>	A doctor, hospital, health care professional, or health care facility.
<b>Provider Sponsored Organization (PSO)</b>	A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company. (See Managed Care Plan.)

<b>Q</b>	
<b>Qualified Medicare Beneficiary (QMB)</b>	A Medicaid program that pays the Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services provided by Medicare providers for individuals who have Medicare Part A, a low monthly income, and limited resources.
<b>Qualifying Individuals (1) (QI-1s)</b>	A Medicaid program that pays Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources, but who are not otherwise eligible for Medicaid.
<b>Qualifying Individuals (2) (QI-2s)</b>	A Medicaid program that pays a portion of Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources, but who are not otherwise eligible for Medicaid.
<b>Quality</b>	Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person--and getting the best possible results.
<b>Quality Assurance</b>	The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.

<b>R</b>
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<b>Referral</b>	A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from anyone except your primary care doctor. If you do not get a referral first, the plan may not pay for your care. (See Emergency Care, Primary Care Doctor, Urgently Needed Care.)
<b>Regional Home Health Intermediaries</b>	A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.
<b>Religious Fraternal Benefit Society Plans</b>	A Medicare health plan option that is only available to members of a Religious Fraternal Benefit Society. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization.
<b>Reserve Days</b>	(See Lifetime reserve days.)
<b>Respite Care</b>	Care given to a hospice patient by another caregiver so that the usual caregiver can rest.
<b>Restraint</b>	Any physical or chemical way to stop a patient from being free to move. These restraints are used to prevent patient injury and are not used for treating medical symptoms.
<b>Risk Adjustment</b>	The way that payments to health plans are changed to take into account a person's health status.

<b>S</b>	
<b>Savings for Medicare Beneficiaries</b>	Medicaid programs that help pay Medicare out-of-pocket expenses.
<b>Second Opinion</b>	This is when another doctor gives his or her view

	about what you have and how it should be treated.
<b>Secondary Payer</b>	The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other health insurance depending on the situation.
<b>Service Area</b>	The area where a health plan accepts members. For plans that require you to use their 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.
<b>Service Area (Private Fee-for-Service)</b>	The area where a Private Fee-for-Service plan accepts members.
<b>Side Effect</b>	A problem caused by treatment. For example, medicine you take for high blood pressure may make you feel sleepy. Most treatments have side effects.
<b>Skilled Nursing Care*</b>	A level of care that must be given or supervised by licensed nurses. This care is also under the general direction of a doctor. All of your needs are taken care of with this type of service. Examples of skilled nursing care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound. Any service that could be safely done by an average nonmedical person (or one's self) without the supervision of a licensed nurse is not covered.

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<p><b>Skilled Nursing Facility (SNF)</b></p>	<p>A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.</p>
<p><b>Skilled Nursing Facility Care*</b></p>	<p>A level of care that must be given or supervised by licensed nurses or other professional staff, such as physical and occupational therapists under the general direction of a doctor. All of your needs are taken care of with this type of service, including getting direct services. Examples of skilled care are: getting intravenous injections, tube feeding, oxygen to help you breathe, and changing sterile dressings on a wound, physical occupational, and speech-language therapy. Any service that could be safely performed by an average nonmedical person (or one's self) without the direct supervision of a licensed nurse is not covered.</p>
<p><b>Social Health Maintenance Organization (SHMO)</b></p>	<p>A special type of health plan that provides the full range of Medicare benefits offered by standard Medicare HMOs, plus other services that include the following: 1)prescription drug and chronic care benefits, respite care, and short-term nursing home care; and 2)homemaker, personal care services, and medical transportation. 3)eyeglasses, hearing aids, and dental benefits.</p>
<p><b>Special Election Period</b></p>	<p>A set time that a beneficiary can change health plans or to return to the Original Medicare Plan,</p>

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	<p>such as: you move outside the service area, your Medicare+Choice organization violates its contract with you, the organization does not renew its contract with HCFA, or other exceptional conditions determined by HCFA. The Special Election Period is different from the Special Enrollment Period (SEP). (See Election Periods; Enrollment; Special Enrollment Period.)</p>
<p><b>Special Enrollment Period (SEP)</b></p>	<p>A set time when you can sign up for Medicare Part B if you did not take Part B during the Initial Enrollment Period, because you or your spouse currently work and have group health plan coverage through the employer or union. You can sign up at any time you are covered under the group plan. If the employment or group health coverage ends, you have 8 months to sign up. The 8-month SEP starts the month after the employment ends or the group health coverage ends, whichever comes first. The Special Enrollment Period is different from the Special Election Period. (See Enrollment; Election Periods; Special Election Period.)</p>
<p><b>Specialist</b></p>	<p>A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.</p>
<p><b>Specified Low-Income Medicare Beneficiaries (SLMB)</b></p>	<p>A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.</p>
<p><b>State Health Insurance Assistance Program</b></p>	<p>A state program that gets money from the federal Government to give free health insurance</p>

<b>(SHIP)</b>	counseling and assistance to people with Medicare.
<b>Supplier</b>	Generally, any company, person, or agency that gives you a medical item or service; like a wheelchair or walker.

<b>T</b>	
<b>Treatment</b>	Something done to help with a health problem.
<b>Treatment Options</b>	The choices you have when there is more than one way to treat your health problem.
<b>TRICARE</b>	TRICARE is the health care program for members of the military, eligible dependents, and military retirees. TRICARE was called the CHAMPUS program in the past.

U	
<b>Unforeseen Out-of-Area Urgently Needed Care</b>	Care you get for a sudden illness or injury that needs medical care right away, but is not life threatening, while you are out of your health plan's service area for a short time, and can not wait until you return home.
<b>Urgently Needed Care</b>	Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.

V

W	
<b>Waiting Period</b>	The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

X

Y

Z

Glossary of HCFA Terms—REACH 2000 Modules  
Train the Trainer

This glossary explains terms in the Medicare program, but it is not a legal document. The official Medicare program provisions are found in the relevant laws, regulations, and rulings.

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