Chapter 12: Definitions of important words

**Introduction**

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can’t find a term you’re looking for or if you need more information than a definition includes, contact Member Services.

[Plans should insert definitions as appropriate to the plan type described in the Member Handbook. You may insert definitions not included in this model and exclude definitions not applicable to your plan or to your contractual obligations with CMS and the state or enrolled Medicare/Medicaid members.]

[If revisions to terminology (e.g., changing “Member Services” to “Customer Service” or using a different term for Medicaid) affect glossary terms, plans should rename the term and alphabetize it correctly within the glossary.]

[If you use any of the following terms in your Member Handbook, you must add a definition of the term to the first section where you use it and here in Chapter 12, with a reference from the section where you use it: IPA, network, PHO, plan medical group, and point of service.]

[Plans should refer members to other parts of the handbook using the appropriate chapter number and section. For example, "refer to Chapter 9, Section A." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

# Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

# Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called “aid paid pending.”

# Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

# Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 [plans may insert reference, as applicable] explains appeals, including how to make an appeal.

# Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also “Original Biological Product” and “Biosimilar”).

# **Biosimilar:** A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (See “Interchangeable Biosimilar”).

# Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

# Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

# Care plan: A plan developed by you and your care coordinator that describes what medical, behavioral health, social and functional needs you have and identifies goals and services to address those needs.

# Care team: A care team, led by a care coordinator, may include doctors, nurses, counselors, or other professionals who are there to help you build a care plan and ensure you get the care you need.

# [Plans with a single coverage stage should delete this paragraph.] Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your [insert if the plan covers excluded drugs under an enhanced benefit with cost sharing in this stage for non-Part D drugs or other drugs: Part D] drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $<TrOOP amount> for Part D covered drugs during the year. [Insert if applicable: You pay nothing.] [Plans that cover excluded drugs under an enhanced benefit with cost sharing in this stage or cost sharing for other drugs insert: You may have cost sharing for excluded drugs that are covered under our enhanced benefit.]

# Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 [plans may insert reference, as applicable] explains how to contact CMS.

# [*Plans that do not have coinsurance should delete this paragraph.*] Coinsurance: A percentage (for example, 20%) of the total cost for services or prescription drugs that you need to pay at the time you get them.

# Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

# Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

# [*Plans that do not have copays should delete this paragraph.*] Copay: A fixed amount you pay as your share of the cost each time you get a service or supply. For example, you might pay $2 or $5 for a service or a prescription drug.

# [*Plans that do not have cost sharing should delete this paragraph.*] Cost sharing: Amounts you have to pay when you get services or drugs. Cost sharing includes copays and coinsurance.

[*Plans that do not have cost sharing should delete this paragraph*.] Cost sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in one of [insert number of tiers] cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

# Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 [plans may insert reference, as applicable] explains how to ask us for a coverage decision.

# Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

# Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

# **Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

# [Plans that do not have cost sharing for Part D drugs should delete this paragraph. Plans may revise the information in this definition to reflect the appropriate number of days for their one-month supplies as well as the cost-sharing amount in the example.] Daily cost sharing rate: A rate that may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month’s supply.

Here’s an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days’ supply of the drug, your payment will be less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

# Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

# [Plans that do not have cost sharing should add this paragraph.] Drug tiers: Groups of drugs on our *Drug List*. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in one of [insert number of tiers] tiers.

# Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

# Emergency: Amedical condition that a prudent layperson with an average knowledge of health and medicine, would expect is so serious that if it does not get immediate medical attention it could result in death, serious dysfunction of a body organ or part, or harm to the function of a body part, or, with respect to a pregnant woman, place her or her unborn child’s physical or mental health in serious jeopardy. Medical symptoms of an emergency include severe pain, difficulty breathing, or uncontrolled bleeding.

# Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

# Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

# Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

# Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

# Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

# Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

# Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

# Health assessment: A review of an enrollee’s medical history and current condition. It is used to figure out the patient’s health and how it might change in the future.

# Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

# Hospice:A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

* An enrollee who has a terminal prognosis has the right to elect hospice.
* A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
* <Plan name> must give you a list of hospice providers in your geographic area.

# Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan’s cost sharing amount for services. Show your <plan name> Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

[*Plans with cost sharing, insert:* As a member of <plan name>, you only have to pay the plan’s cost sharing amounts when you get services covered by our plan. We do not allow providers to bill you more than this amount.]

[*Plans with no cost sharing, insert:* Because <plan name> pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.]

# [Plans with a single coverage stage should delete this paragraph.] Initial coverage stage: The stage before your total Part D drug expenses reach $[insert initial coverage limit]. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

# Inpatient: A term used whenyou have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

# Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

# *List of Covered Drugs* (*Drug List*): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a “formulary.”

# Long-term services and supports (LTSS): Long-term services and supports include Long-Term Care and Home and Community-Based Service (HCBS) waivers. HCBS waivers can offer services that will help you stay in your home and community.

# Low-income subsidy (LIS): Refer to “Extra Help.”

# Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

* It covers extra services and drugs not covered by Medicare.
* Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
* Refer to Chapter 2 [plans may insert reference, as applicable] for information about how to contact Medicaid in your state.

# Medically necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules. [Plans may revise the state-specific definition of “medically necessary” as appropriate a*nd ensure that it is updated and used consistently throughout member material models*]*.*

# Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

# Medicare Advantage Plan:A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

# Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

# Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual.”

# Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

# Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

# Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

# Medicare Part D: The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. <Plan name> includes Medicare Part D.

# Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

# Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

# Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

# Member Services: A department within our planresponsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2 [plans may insert reference, as applicable] for information about how to contact Member Services.

# Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

# Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

* They are licensed or certified by Medicare and by the state to provide health care services.
* We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount.
* While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

# Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

# Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information about the ombudsman in Chapters 2 [plans may insert reference, as applicable] and 9 [plans may insert reference, as applicable] of this handbook.

# Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 [plans may insert reference, as applicable] explains how to ask us for a coverage decision.

# Original Biological Product: A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

# Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

* You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
* Original Medicare is available everywhere in the United States.
* If you do not want to be in our plan, you can choose Original Medicare.

# Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out‑of‑network pharmacies are not covered by our plan unless certain conditions apply.

# Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 [plans may insert reference, as applicable] explains out-of-network providers or facilities.

# [Plans that do not have cost sharing should delete this paragraph.] Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

# Over-the-counter (OTC) drugs:Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

# Part A: Refer to “Medicare Part A.”

# Part B: Refer to “Medicare Part B.”

# Part C: Refer to “Medicare Part C.”

# Part D: Refer to “Medicare Part D.”

# Part D drugs: Refer to “Medicare Part D drugs.”

# Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to <plan name>’s Notice of Privacy Practices for more information about how <plan name> protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

# Primary care provider (PCP): Your primary care provider is the doctor or other provider you use first for most health problems.

* They make sure you get the care you need to stay healthy. They also may talk with other doctors and health care providers about your care and refer you to them.
* In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
* Refer to Chapter 3 [plans may insert reference, as applicable] for information about getting care from primary care providers.

# Prior authorization (PA): [Plans may delete applicable words or sentences if it does not require PA for any medical services or any drugs.] An approval from <plan name> you must get before you can get a specific service or drug or use an out-of-network provider. <Plan name> may not cover the service or drug if you don’t get approval.

Some network medical services are covered only if your doctor or other network provider gets PA from our plan.

* Covered services that need PA are marked in the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

Some drugs are covered only if you get PA from us.

* Covered drugs that need PA are marked in the *List of Covered Drugs* and the rules are posted on the plan website.

# Prosthetics and orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

# Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. Refer to Chapter 2 [plans may insert reference, as applicable] for information about how to contact the QIO for your state.

# Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

# Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

# Referral:A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. If you don’t get approval, <plan name> may not cover the services. You don’t need a referral to use certain specialists, such as women’s health specialists. You can find more information about referrals in Chapter 3 [plans may insert reference, as applicable] and about services that require referrals in Chapter 4 [plans may insert reference, as applicable].

# Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. Refer to Chapter 4 [plans may insert reference, as applicable] to learn more about rehabilitation services.

# Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get <plan name>.

# Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

# Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

# Specialist: A doctor who provides health care for a specific disease or part of the body.

# State Medicaid agency: The Illinois Department of Healthcare and Family Services.

# Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

# Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

# Urgently needed care: Care you get for an unforeseen illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers or you cannot get to them because given your time, place or circumstances, it is not possible, or it is unreasonable to obtain services from network providers (for example when you are outside the plan’s service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).

[Plans may add a back cover for the Member Handbook that contains contact information for Member Services. Below is an example plans may use. Plans also may add a logo and/or photographs, as long as these elements do not make it difficult for members to find and read the contact information.]

**<Plan name> Member Services**

|  |  |
| --- | --- |
| **CALL** | <phone number>  Calls to this number are free. [*Insert days and hours of operation, including information on the use of alternative technologies.*]  Member Services also has free language interpreter services available for non-English speakers. |
| **TTY** | <TTY number>  [*Insert if plan uses a direct TTY number:* This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]  Calls to this number are free. [*Insert days and hours of operation.*] |
| **FAX** | [*Optional:* *Insert fax number.*] |
| **WRITE** | <address>  [***Note:*** *Plans may add email addresses here.*] |
| **WEBSITE** | <URL> |