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.]

[Plans must revise references to “Medicaid” to use ”MassHealth”. Plans should add “(Medicaid)” after the name at the first use.]

[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, section, and/or page number. For example, "see Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

# Activities of daily living — things that people do on a normal day, like eating, using the toilet, getting dressed, bathing, or brushing teeth.

# Adverse action— an action, or lack of action, by <plan name> that you can appeal. This includes:

* <Plan name> denied or approved a limited service your doctor requested;
* <Plan name> reduced, suspended or ended coverage that we had already approved;
* <Plan name> did not pay for an item or service that you think is a Covered Service;
* <Plan name> did not resolve your service authorization request within the required time frames;
* You could not get a Covered Service from a provider in <plan name>’s network within a reasonable amount of time; and
* <Plan name> did not act within the time frames for reviewing a coverage decision and giving you a decision.

# Aid paid pending — getting your benefits while you are waiting for an appeal decision. This continued coverage is called “aid paid pending.”

# Ambulatory surgical center — a facility that provides outpatient surgical services to patients who do not need hospital care and who are not expected to need more than 24 hours of care in the facility.

# Appeal — a formal way for you to challenge our decision if you think we made a mistake. You can ask us to change or reverse our decision by filing an appeal. For example, you may ask for an appeal if we don’t pay for a drug, item, or service you think you should be able to get. Chapter 9 [plans may insert reference, as applicable] explains appeals, including telling you how to make an appeal.

# **Behavioral health services** — treatments for mental health and substance abuse.

# Brand name drug — a prescription drug that is made and sold by the company that first made the drug. Brand-name drugs have the same active 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, <plan name>, and your care providers to make sure that you get the care you need. [Plans should change “Care Coordinator” to the term used by the state or plan, if applicable, and place the paragraph in correct alphabetical order.]

# Care Team — a team that may include doctors, nurses, counselors, other health professionals, and others who you choose who help you get the care you need. Your Care Team will also help you make an Individualized Care Plan (ICP).

# [Plans with a single coverage stage should delete this paragraph.] Catastrophic-coverage stage — the part of the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the $<TrOOP amount> limit for your prescription drugs.

# 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.

# Complaint or Grievance — a written or spoken statement saying that you have a 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.

# **Continuity of Care** — the amount of time you can keep seeing your doctors and getting your current services after you become a member of <plan name>. The Continuity of Care period lasts for 90 days or until your comprehensive assessment and Individualized Care Plan (ICP) are complete.

# [Plans that do not have copays should delete this paragraph.] Copay — a fixed amount you pay each time you get a service or supply. For example, you might pay $1.30 or $3.90 for a prescription drug. <Plan name> only charges copays for prescription drugs and some other things you get at the pharmacy.

# [Plans that do not have cost-sharing should delete this paragraph.] Cost-sharing — amounts you have to pay when you get drugs. Cost-sharing includes copays.

# [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 which benefits we cover. This includes decisions about covered drugs and services, or the amount that 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 drugs that our plan covers.

# 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 that our plan covers.

# **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 is an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is $1.30. This means that the amount you pay for your drug is a little more than $.04 per day. If you get a 7 days’ supply of the drug, your payment will be a little more than $0.04 per day multiplied by 7 days, for a total payment of $0.30.

# Disenrollment — the process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice, for example if you are no longer eligible for MassHealth).

# [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 that 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 needed to treat a medical emergency, given by a provider trained to give emergency services.

# Enrollment — the process of becoming a member in our plan.

# Exception — permission to get coverage for a drug that is not normally covered by our plan or to use the drug without certain rules and limitations.

# [Plans that do not have cost-sharing should delete this paragraph.] 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.”

# 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 active ingredients as a brand-name drug. It is usually cheaper and works just as well as the brand-name drug.

# Grievance — see “Complaint or Grievance.”

# Health assessment — a review of a patient’s medical history and current condition. It is used to determine the patient’s health and how it might change in the future.

# Health plan — an organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators [plans should change “Care Coordinator” to the term used by the state and/or plan, if applicable] to help you manage all your providers and services. They all work together to make sure you get the care you need.

# Home health aide — a person who provides services that do not need the skills of a licensed nurse or therapist, like help with personal care (for example, bathing, using the toilet, dressing, or doing the exercises that a provider orders). 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. Services include nursing; medical social services; physician; counseling, including bereavement, dietary, spiritual, or other types of counseling; physical, occupational, and speech language therapy; homemaker/home health aide; medical supplies, drugs, biological supplies; and short term inpatient care.
* <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.]

# **Independent Review Entity (IRE)** — the independent organization hired by Medicare to review External (Level 2) Appeals if we don’t decide fully in favor of your Internal Appeal.

# Individualized Care Plan (ICP) — a plan that describes which health services you will get and how you will get them. (Also known as an individualized Personal Care Plan.)

# [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 the amounts you have paid, the amounts our plan has paid for you, 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 officially admitted to the hospital for skilled medical services. If you were not officially admitted, you might still be considered outpatient instead of inpatient, even if you stay in the hospital overnight.

# **Level 1 Appeal** — a request by a member to a plan to review an Adverse Action (also called an Internal Appeal).

# **Level 2 Appeal** — an appeal sent to an independent organization not connected to the plan to review the plan’s decision on a Level 1 Appeal (the first stage in an External Appeal for a Medicare service).

# *List of Covered Drugs* (Drug List) — a list of prescription drugs covered by <plan name>. We choose 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) — assistance so that you can stay at home instead of going to a nursing home or a hospital.

# Long-term Supports (LTS) Coordinator — a person who works with you and your Care Team to make sure you get the services and supports you need for independent living.

# [Plans that do not have cost-sharing should delete this paragraph.] Low-income subsidy (LIS) — see “Extra Help.”

# MassHealth — the Medicaid program of the Commonwealth of Massachusetts.

# **MassHealth Board of Hearings (BOH)** — the Board of Hearings within the Massachusetts Executive Office of Health and Human Services’ (EOHHS) Office of Medicaid.

# Medicaid (or Medical Assistance) — a program run by the federal and state governments 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 change from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
* See Chapter 2 [plans may insert reference, as applicable] for information about how to contact Medicaid in your state. MassHealth is the Medicaid program of the Commonwealth of Massachusetts.

# Medically necessary — services that are reasonable and necessary:

* For the diagnosis and treatment of your illness or injury; **or**
* To improve the functioning of a malformed body member; **or**
* Otherwise medically necessary under Medicare law.

In accordance with Medicaid law and regulation, and per MassHealth, services are medically necessary if:

* They could be reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger your life, cause you suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; **and**
* There is no other medical service or place of service that is available, works as well, and is suitable for you that is less expensive.

The quality of medically necessary services must meet professionally recognized standards of health care, and medically necessary services must also be supported by records including evidence of such medical necessity and quality.

# Medicare — the federal health insurance program for certain people: those who are 65 years of age or older, those under age 65 with certain disabilities, and those with end-stage renal disease (generally, this means 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 (see “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 both 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 health plan called 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 MassHealth. <Plan name> includes Medicare Part D.

# Medicare Part D drugs — drugs that can be covered under Medicare Part D. (See the Drug List for covered drugs.) Congress specifically excluded certain categories of drugs from coverage as Part D drugs, but MassHealth may cover some of these drugs.

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

# *Member Handbook* and Disclosure Information — this document, along with your enrollment form and any other attachments or riders, which explain your coverage, our responsibilities, and your rights and responsibilities as a member of our plan.

# Member Services — a department within our planwhose job it is to answer your questions about your membership, benefits, grievances, and appeals. See 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 that we use for doctors, nurses, and others who give you health care 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 — a person or organization 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. Ombudsman services for One Care members are provided by My Ombudsman. You can find more information about My Ombudsman in Chapters 2 [plans may insert reference, as applicable] and 9 [plans may insert reference, as applicable] of this handbook.

# Organization determination — a decision by a plan, or one of its providers, 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 Medicare (traditional Medicare or fee-for-service Medicare) — Medicare offered by the government. Under Original Medicare, Medicare pays doctors, hospitals, and other health care providers. These payment amounts are set by Congress.

* You can go to 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 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 are met.

# Out-of-network provider or Out-of-network facility — a provider or facility that is not employed, owned, or operated by our plan and has not agreed to work with us 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. See 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 — see “Medicare Part A.”

# Part B — see “Medicare Part B.”

# Part C — see “Medicare Part C.”

# Part D — see “Medicare Part D.”

# Part D drugs — see “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. See <plan name>’s Notice of Privacy Practices for more informationabout how <plan name> protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

# **Personally identifiable information (PII)** – information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other information that is linked or can be linked to a specific individual.

# [Plans that do not use PCPs may omit this paragraph.] Primary care provider (PCP) — your primary care provider is the doctor or other provider that you see first for most health problems.

* They make sure you get the care you need to stay healthy. They will work with your Care Team.
* They also may talk with other doctors and health care providers about your care and may refer you to them.
* See Chapter 3 [plans may insert reference, as applicable] for information about getting care from primary care providers.

# Prior authorization — [Plans may delete applicable words or sentences if it does not require prior authorization 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 see 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 prior authorization from our plan.

* Covered services that need our plan’s prior authorization are marked in the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

Some drugs are covered only if you get prior authorization from us.

* Covered drugs that need our plan’s prior authorization are marked in the *List of Covered Drugs*.

# **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 on and improve the care given to patients. See 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. There may be limits on the amount of the drug that we cover for each prescription.

# **Referral** – a referral means that your primary care [insert the term the plan uses (e.g., provider or physician)] (PCP) must give you approval before you can see 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 see 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, including physical therapy, speech and language therapy, and occupational therapy. See Chapter 4 [plans may insert reference, as applicable] to learn more about rehabilitation services.

# Service area — a specific area covered by a health plan (some health plans accept members only if they live in a certain area). 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 rehabilitation 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 SNF 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.

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

# Subrogation — a process of substituting one creditor for another, which applies if you have a legal right to payment from an individual or organization because another party was responsible for your illness or injury. We may use this subrogation right, with or without your consent, to recover from the responsible party or that party’s insurer the cost of services provided or expenses incurred by us that are related to your illness or injury.

# 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 a sudden 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 when network providers are unavailable or you cannot get to them.

# Women’s health specialist — a specialist, including an obstetrician or gynecologist, within <plan name>’s provider network for covered services who provides women’s routine and preventive health care services.

[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** | [Insert phone number(s).]  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** | [Insert number.]  [Insert if plan uses a direct TTY number: This number requires special telephone equipment and is for people who are deaf, hard of hearing, or speech disabled.]  Calls to this number are free. [Insert days and hours of operation.] |
| **FAX** | [Optional: Insert fax number.] |
| **WRITE** | [Insert address.]  [Note: Plans may add email addresses here.] |
| **WEBSITE** | [Insert URL.] |