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 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, "refer to 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: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing their teeth.

# Aid paid pending: You can continue getting previously approved services while you are waiting for a decision about a Level 1 Appeal (and for a Healthy Connections Medicaid service, while you are waiting for a decision about a Level 2 Appeal). This continued coverage is called “aid paid pending.” Please refer to Chapter 9 to learn more. Please call Member Services at the number at the bottom of the page if you have other questions.

# 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.

# Brand name drug: A prescription drug that is made and sold by the company that originally made the drug.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

# [**Care coordinator/Care manager** *(plan’s preference)*]: 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. [*Plans may replace “care coordinator” with the term “care manager” and place the paragraph in correct alphabetical order.*]

# Care plan: A plan for what health services you will get and how you will get them.

# Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. You are an important member of the care team and can also include other family members or friends.

# [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 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: 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 assessment: A review aimed at getting a deeper look at your medical needs, social needs, and capabilities. We will get information from you, your providers, and family/caregivers when appropriate. This assessment will be done by qualified and trained health professionals, such as nurses, social workers, and [care coordinators/care managers *(plan’s preference)*].

# 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.

# Coordinated and Integrated Care Organization (CICO): Another name for a Medicare-Medicaid Plan.

# [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 [*plans with drug copays, insert:* or supply]. For example, you might pay $2 or $5 for a service [*plans with drug copays, insert:* 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 for drugs 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 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 name, 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 emergencyis when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part. The medical symptoms may be a serious injury or severe pain.

# 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 active 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/care managers (plan’s preference)] to help you manage all your providers and services. They all work together to provide the care you need.

# Healthy Connections Medicaid: South Carolina’s Medicaid program. For more information, refer to the definition of “Medicaid” below.

# Healthy Connections Prime: A demonstration program jointly run by South Carolina and the federal government to provide better health care for people who have both Medicare and Healthy Connections Medicaid.

# 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.

* A member 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 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): An organization that is hired by the Centers for Medicare & Medicaid Services (CMS) to conduct a Level 2 appeal review for a service or item that is covered by Medicare-only or by both Medicare and Healthy Connections Medicaid. If <plan name> denies approval for such a service or item during a member’s Level 1 appeal, the denied appeal is sent to the IRE to conduct a Level 2 review. The IRE is not connected to <plan name> and is not a government agency. Please refer to Chapter 9 [plans may insert reference, as applicable] for more information about Level 2 appeals.

# [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.

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

# 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.

# *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 are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

# 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:

* Services that are reasonable and necessary:
* For the diagnosis or treatment of your illness or injury; **or**
* To improve the functioning of a malformed body member; **or**
* Otherwise medically necessary under Medicare law.
* This includes care that keeps you from going into a hospital or nursing home.
* In accordance with Healthy Connections Medicaid law and regulation, services are medically necessary if they are:
* Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity; **and**
* Provided at an appropriate facility at the appropriate level of care for the treatment of your medical condition; **and**
* Provided in accordance with generally accepted standards of medical practice.

# 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 Plan,” 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 Healthy Connections 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 Healthy Connections 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. Healthy Connections Medicaid may cover some of these drugs.

# Member (member of our plan, or plan member): A person with Medicare and Healthy Connections 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] and the bottom of the page 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 (Healthy Connections Prime Advocate): 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. The Healthy Connections Prime Advocate is the ombudsman for people enrolled in Healthy Connections Prime. 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, including information on how to contact the Healthy Connections Prime Advocate.

# 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 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.

# 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.

# [Plans that do not use PCPs may omit this paragraph.] 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: [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 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 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 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 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.

# 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. 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 home 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 South Carolina Department of Health and Human Services (SCDHHS) is designated as the single state agency for the administration of the Medicaid program (called “Healthy Connections Medicaid”) in South Carolina. SCDHHS is a cabinet-level agency under the Governor of the State of South Carolina.

# 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.

# [Plans that do not have cost sharing for drugs should insert this paragraph:] Tier:A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

# 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.

[*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 the plan’s and Healthy Connections Prime’s logos 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 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 | [*Insert address.*]  [**Note*:*** *Plans may add email addresses here.*] |
| WEBSITE | [*Insert URL.*] |