# Medicare 101 Guide: Glossary

**Accepts the assignment** – When a healthcare provider accepts Medicare and has agreed to the Medicare-approved payment for a service.

**Accountable care organization (ACO)** – A group of doctors, hospitals, and other healthcare providers who work together with a goal of providing high-quality care for Medicare patients. They have agreements with Medicare to be accountable for the cost and experience of care that Medicare patients receive. If they work well to coordinate and improve care while keeping costs down, they may earn a financial bonus from Medicare. If they underperform, they may pay a penalty.

**Beneficiary** – A person who is enrolled in Medicare and receives Medicare benefits.

**Cardiopulmonary resuscitation (CPR) direction (also called do-not-resuscitate order)** – A document that directs a medical team not to administer CPR if the heart or breathing stops.

**Coinsurance** – An amount (often a percentage) that a person must pay for services after a deductible has been reached.

**Copayment (or copay)** – A preset, flat fee that a person must pay for each healthcare service, appointment prescription, test, etc.

**Creditable drug coverage** – Prescription drug coverage that is expected to pay, on average, at least as much as Medicare Part D for prescriptions. Individuals with creditable coverage from an employer, union, or another source can delay enrolling in Medicare Part D without facing a late enrollment penalty.

**Deductible** – A preset amount that a person must pay before their insurance kicks in.

**Dual-Eligible Special Needs Plans (D-SNPs)** – Plans that enroll people who are entitled to both Medicare and Medicaid.

**Do-not-resuscitate (DNR) order (also called cardiopulmonary resuscitation (CPR) direction)** – A document that directs a medical team not to administer CPR if the heart or breathing stops.

**Explanation of benefits (EOB)** – A summary of your claims and costs sent by your plan. The EOB describes the costs involved for your visits to your healthcare provider or prescriptions you received and how your plan processed the claim for these services. You will receive an EOB every month that you fill a prescription or visit a healthcare provider.

**Extra Help (also called Low Income Subsidy)** – A program to help people with limited income and resources pay for Medicare Part D costs. Some people may get Extra Help automatically, including those who receive full Medicaid coverage. Others may qualify after applying.

**Formulary** – A list of generic and brand-name prescription medications covered by a specific health insurance plan.

**General Enrollment Period (GEP)** — A time period each year (January 1–March 31) when people who didn't sign up for Medicare Part A and/or Medicare Part B when they were first eligible for Medicare can enroll. Coverage begins the month after you sign up. People who don't sign up when they are first eligible may have to pay a late enrollment penalty.

**Healthcare power of attorney (also called medical power of attorney/power of attorney for health care)** – A legal document in which someone appoints a person to make medical decisions on their behalf if they become temporarily or permanently unable to do so.

**In-network coverage** – Healthcare services received from providers who have a contract with your insurance company. These providers have agreed to the plan's set prices, so you typically will only need to pay your deductible and any applicable copay or coinsurance.

**Income-Related Monthly Adjustment Amounts (IRMAA)** – An additional charge on Medicare Part B and Medicare Part D premiums for people above a certain income. The IRMAA is calculated on a sliding scale and is based on your past two years of tax returns.

**Initial Coverage Election Period (ICEP)** – The time frame during which individuals who are newly eligible for Medicare can first enroll in a Medicare Advantage (also called Medicare Part C) plan. The ICEP coincides with the Initial Enrollment Period (IEP) for Medicare Parts A and B, which includes the three months prior, the month of, and the three months after a person's birthday.

**Initial Enrollment Period (IEP)** — The seven-month window around your 65th birthday to sign up for Medicare Part A, Medicare Part B, and Medicare Part D — specifically the three months prior, the month of, and the three months after the person's birthday. This same period is called the initial coverage election period (ICEP) for Medicare Part C.

**Late Enrollment Penalty** – An extra cost someone may have to pay if they sign up for Medicare any time after they were first eligible. Late enrollment penalties are not just one-time fees. They are usually added to your monthly premium and can last as long as you have Medicare.

**Living will** – A legal document that outlines what treatments or types of care are and are not wanted, and in what situation each decision applies.

**Low Income Subsidy (also called Extra Help)** – A program to help people with limited income and resources pay for Medicare Part D costs. Some people may get Extra Help automatically, including those who receive full Medicaid coverage. Others may qualify after applying.

**Medical power of attorney (also called healthcare power of attorney/power of attorney for health care)** – A legal document in which someone appoints a person to make medical decisions on their behalf if they become temporarily or permanently unable to do so.

**Medicare Advantage (also called Medicare Part C)** – Health plans offered by private companies that cover the same type of services covered by Medicare Part A and Medicare Part B and are an alternative to Original (traditional) Medicare. Medicare Advantage often includes extra benefits like vision, dental, and hearing.

**Medicare Advantage Open Enrollment Period** – Period from January 1–March 31 (or within the first 3 months of getting Medicare) for individuals who are already enrolled in a Medicare Advantage Plan to switch to another Medicare Advantage Plan (with or without drug coverage) or drop a Medicare Advantage Plan and return to Original Medicare.

**Medicare Part A (Hospital Insurance)** – A health plan managed by the federal government that covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

**Medicare Part B (Medical Insurance)** – A health plan managed by the federal government that covers outpatient care, medical supplies, preventive services, and certain doctors' services, such as those related to diagnosis, treatment, and prevention of medical conditions.

**Medicare Part C (also called Medicare Advantage)** – Health plans offered by private companies that cover the same type of services covered by Medicare Part A and Medicare Part B and are an alternative to Original (traditional) Medicare. Medicare Advantage often includes extra benefits like vision, dental, and hearing.

**Medicare Part D** – The part of Medicare that helps cover the cost of prescription drugs. Medicare Part D is offered by private insurance companies approved by Medicare and can be added to Original Medicare or included in some Medicare Advantage plans.

**Medicare supplement insurance (also called Medigap)** – Extra insurance that people can purchase from a private health insurance company to help pay for their share of out-of-pocket costs in Original Medicare.

**Medigap (also called medical supplement insurance)** – Extra insurance that people can purchase from a private health insurance company to help pay for their share of out-of-pocket costs in Original Medicare.

**Out-of-network** – Healthcare services received from providers or at facilities that do not have a contract with your health plan. These providers and facilities haven't agreed to the plan's set prices, so you may pay more, or the service might not be covered at all.

**Out-of-pocket costs** – The portion of healthcare costs a person is responsible for paying, including copayments, coinsurance, and costs for noncovered healthcare services.

**Open Enrollment Period** – The time period each year (October 15–December 7) when people can make changes to Medicare health plans for coverage or prescription drug plans. Changes can include moving from an Original Medicare to a Medicare Advantage plan or vice versa; joining, leaving, or moving to another Medicare drug plan (if in Original Medicare); or joining, leaving, or switching to another Medicare Advantage plan with or without drug coverage (or adding or dropping drug coverage). Coverage begins January 1 of the next calendar year.

**Original Medicare (also called Traditional Medicare)** – A federally managed healthcare plan that includes Medicare Part A and Medicare Part B.

**Patient navigator (also called a patient advocate)** – People who help guide patients through the healthcare system and may be able to offer a wide variety of services, including setting up healthcare provider's appointments, communicating with insurance, and providing social support while individuals navigate complex medical conditions and care.

**Payer (or payor)** – An entity — often a health insurance company — that pays for healthcare services on behalf of an individual.

**Power of attorney (POA)** – A legal document that gives someone the authority to act on another person's behalf for various matters. The scope of a power of attorney document may involve financial, legal, and medical matters.

**Power of attorney for health care (also called medical power of attorney/healthcare power of attorney)** – A legal document in which someone appoints a person to make medical decisions on their behalf if they become temporarily or permanently unable to do so.

**Premium** – The monthly fee that people will pay for their Medicare coverage.

**Premium-free Part A** – Hospital insurance under Medicare that doesn't require a monthly premium. Most people qualify for premium-free Part A if they or their spouse paid Medicare taxes while working for at least 10 years.

**Prior authorization** – A process used by some health insurance companies that requires the review and approval of a specific procedure, service, or drug before it is paid for, even if it has been recommended or prescribed by a healthcare provider.

**Secondary insurance (also called supplemental insurance)** – An additional insurance plan that helps pay for health care costs that are not covered by a person's regular health insurance plan.

**Skilled nursing facility three-day rule waiver** – An exception allowing someone to get Medicare-covered care in a skilled nursing facility even if they haven't stayed in the hospital for the three days typically required by Medicare.

**Special Enrollment Period (SEP)** – A time outside of regular enrollment periods when people can sign up for Medicare, typically triggered by life events like losing employer-sponsored insurance coverage or moving to a new address.

**State Health Insurance Assistance Program (SHIP)** – A national program that provides free, unbiased counseling and assistance to Medicare beneficiaries, their families, and caregivers on topics such as enrollment and plan comparisons. SHIP has offices across the country and, depending on the region of the country, may be referred to by another name.

**Secondary insurance** – An additional insurance plan that helps pay for healthcare costs that are not covered by a person's regular health insurance plan.

**Traditional Medicare (also called Original Medicare)** – A federally managed healthcare plan that includes Medicare Part A and Medicare Part B.