

GLOSSARY

A

Abuse – When providers supply services or products that are not medically necessary and/or do not meet professional standards.

Accessibility of Services – Your ability to get medical care and services when you need them.

Accreditation – A seal of approval from a private independent group. Being accredited means that certain quality standards have been met.

Act / Law / Statute – Term for legislation that has passed through Congress and has been signed by the President, or passed over the President’s veto, and has become law.

Activities of Daily Living (ADL) – Activities you usually do during a normal day. Although definitions differ, activities usually considered to be everyday activities include walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. See: Custodial Care.

Actual Charge – The amount a physician or other health care provider bills a patient for a particular medical service or procedure. The actual charge may differ from the Medicare-approved amount or amount approved by other insurance programs.

Acute Care – Medical care designed to treat or cure disease or injury, usually within a limited time period. Acute care usually refers to physician and/or hospital services of less than three (3) months in length.

Administrative Law Judge (ALJ) – A hearing officer who presides over appeal conflicts between providers of service or beneficiaries, and Medicare contractors.

Admitting Physician – The doctor responsible for admitting you to a hospital or other inpatient health facility.

Advance Beneficiary Notice of Noncoverage (ABN) – A notice that a doctor or supplier should give a person with Medicare to sign if it is believed that Medicare does not consider the service medically necessary and Medicare will not pay for it. If you do not get an ABN to sign before you get the service from your provider of service (doctor), and Medicare does not pay for that service, then you do not have to pay for the service. If your doctor does give you an ABN to sign and Medicare does not pay for it, you will be responsible to pay for the service. (This form could also be given by a home health agency or hospital.)

Advance Coverage Decision – A determination that a Private Fee-for-Service Plan, a type of Medicare Advantage Plan, makes on whether or not it will pay for a certain service.

Advance Directive– A legal document that outlines how you want medical decisions made if you can no longer communicate your wishes. A health care directive may include a health care proxy and a living will. Completed while a person has decision making capacity, a health care proxy names someone who is designated as the health care agent authorized to make medically related decisions if, in the future, the person completing the document lacks capacity. A living will outlines the types of treatments

that the person would or would not want if seriously ill and not expected to recover. See Health Care Proxy.

Adult Day Care – A daytime community-based program for functionally impaired adults that provides a variety of health, social, and related support services in a protective setting.

Advocate – A person who gives you support or protects your rights.

Affiliated Provider – A health care provider (physician) or facility that is paid by a health plan to give services to plan members.

Affordable Care Act (ACA) – is the Patient Protection and Affordable Care Act (PPACA), informally known as Obama-care, and was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act amended the Affordable Care Act and was signed on March 30, 2010. This legislation comprises an extensive list of health care reform programs, provisions and initiatives.

Ambulatory Care – Health services that do not require an overnight hospital stay.

Ambulatory Payment Classifications (APC) – APCs are used to determine the amount that Medicare reimburses hospitals for outpatient services. It is part of the Outpatient Prospective Payment System (OPPS). The hospital is paid a fixed amount based on the APC code for the patient.

Ambulatory Surgical Center – A separate part of a hospital that does outpatient surgery.

Ancillary Services – Professional services by a hospital or other inpatient health program. These may include X-ray, drug, laboratory, or other services.

Anesthesia – Drugs that a person is given before surgery so he or she will not feel pain.

Annual Notice of Change (ANOC) - Notice you receive from your Medicare Advantage or Part D plan in late September which provides a summary of any changes in the plan's cost and coverage that will take effect January 1st of the next year

Annual Wellness Visit - Once a year visit covered by Medicare in which you can meet with your doctor to develop a prevention plan based on your needs, update your medical history, and list your current medications, healthcare providers and suppliers.

Appeal – People with Medicare have the right to request a review of a denied claim, and if not satisfied with the review, to appeal to a higher level review. See Medicare Appeal.

Appeals Process - The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Medicare Summary Notice (MSN). If you are in a Medicare managed care plan, see your plan's membership materials or contact your plan for details about your Medicare appeal rights. See: Medicare Appeal.

Approved Amount – The maximum fee that Medicare or other insurers will use in reimbursing a provider for a given service or piece of equipment. The Medicare “approved” charge may be lower than the actual billed amount and is based upon the Medicare Fee Schedule.

Area Agencies on Aging (AAA) – Local government agencies which grant or contract with public and private organizations to provide services that help older adults remain independent in their home and community.

Assessment – The gathering of information to rate or evaluate your health and needs, such as in a nursing home.

Asset Protection – This refers to the protection from Medicaid “spend-down” requirements available under the Medicaid extended coverage feature of the New York State Partnership for Long-Term Care.

Assignment – In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves for a particular service or supply as payment in full. (The person with Medicare is still responsible for any deductible and coinsurance amount.) **Not accepting assignment** means the provider does not accept Medicare’s approved amount as payment in full. A provider cannot, however, charge whatever he/she chooses to people with Medicare. Federal and New York State laws limit how much a doctor may charge in excess of Medicare’s approved amount.

Assisted Living Facility – A residential living arrangement that provides individual personal care and health services for people requiring assistance with ADLs.

Automatic Enrollment – Individuals who are receiving monthly Social Security benefits or Railroad Retirement Board (RRB) benefits prior to attainment of age 65 are automatically enrolled in Medicare Part A and Part B when they attain age 65. Individuals of any age who have been receiving Social Security disability benefits for 24 months are automatically enrolled in Medicare in their 25th month.

B

Benchmark – The maximum monthly amount that the Low Income Subsidy, or Extra Help, will pay toward the Medicare Part D monthly premium. Some plans are referred to as benchmark plans due to premiums at or below the benchmark. See: Extra Help.

Beneficiary – Any person who receives benefits (also referred to as a person with Medicare).

Benefit Maximum – The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as 1) a length of time (for example, 60 days), or 2) a dollar amount (for example, \$350 for a specific procedure or illness), or 3) a percentage of the Medicare approved amount. The benefits may be paid to the policyholder or to a third party. This may refer to specific illness, time frame, or the life of the policy.

Benefit Period – The period of time for which payments for benefits covered by an insurance policy are available. The availability of certain benefits may be limited over a specified time period.

Medicare Benefit Period – A Medicare benefit period begins upon entry into a qualified hospital and ends when the patient has been out of a hospital and not receiving Medicare benefits in a skilled nursing facility or rehabilitation services for 60 consecutive days, including the day of discharge.

Benefit Triggers – Term used by insurance companies to describe when to pay benefits. Long-term care policies may use functional impairment, limitations in cognitive impairment, medical necessity, and/or a physician’s certification to trigger benefits.

BIPA – Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 (BIPA), which includes changes to Medicare coverage, payment mechanism and appeals procedures. Expands Medicaid programs, including the State Children’s Health Insurance Program (SCHIP).

Board and Care Homes – Are typically privately operated facilities that provide a room, meals, personal care services, and 24-hour protective oversight.

Bundled payment - the reimbursement of health care providers such as hospitals and physicians on the basis of expected costs for clinically-defined episodes of care

C

CAHPS (Consumer Assessment of Health Providers and Systems) – CMS sponsored surveys used to report Medicare beneficiaries’ experience with, among other topics, fee-for-service care plans. The results are shared with Medicare beneficiaries and the public.

Calendar Quarters - A three-month period of time ending with March 31, June 30, September 30, or December 31. Social Security counts each calendar quarter that you work and pay into Social Security and Medicare taxes toward your eligibility for premium-free Part A.

Calendar Year – January 1 through December 31.

Capitated - relationship between a managed care organization (MCO) and primary care physician (PCP), where a payment arrangement for [health care](#) service providers such as [physicians](#) or [nurse practitioners](#). It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care. Under capitation, physicians are given [incentive](#) to consider the cost of treatment. Also See Fully Capitated and Partially Capitated

Care Plan – A written plan for your care. It tells what services you will need to reach and keep your best physical, mental and social well-being.

Case Management – A process used by a doctor, nurse or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.

Catastrophic Coverage – The Medicare Part D prescription drug coverage you will receive until the end of the calendar year after you have spent up to your plan’s out-of-pocket limit for that year (\$4,750 in 2013).

Catastrophic Illness – A very serious and costly health problem that could be life-threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause financial hardship.

Centers for Medicare & Medicaid Services (CMS) – A branch of the Department of Health and Human Services. This federal agency is responsible for administering the Medicare, Medicaid, and Child Health Insurance Programs.

Certificate of Medical Necessity (CMN) – The order, prescription or certificate signed by your Medicare-enrolled provider that explains why you need a particular service (medical necessity). Medicare requires this documentation before it will cover certain Durable Medical Equipment (DME).

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) – Relating to auxiliary medical services for active/retired military and their dependents. See: TRICARE.

Charges – Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

Chronic (Illness) – A lasting, lingering or prolonged illness.

Claim – A bill requesting that medical services be paid by Medicare or by some other insurance.

Cognitive Impairment – A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

Coinsurance – A percentage amount that you pay for a medical service after you have paid any deductibles that apply. In Medicare Part B, the percentage of the approved amount (usually 20 percent) that you are responsible for after you have met the annual Part B deductible.

Community-Based Organization (CBO) – Community-based service provider.

Community-Based Services – Those services that are designed to help older people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meal sites, visiting nurses or home health aides, contingent upon certain specified conditions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – a facility that provides outpatient rehabilitation for the treatment of Medicare beneficiaries who are injured, disabled, or recovering from an illness.

Confidentiality – Your right to talk with your health care provider without anyone else finding out what you have discussed.

Conservatorship – Legal procedure by which one person, the conservator, is given power over the living arrangements, property and/or finances, of another person, the conservatee. Conservatorships are established with legal safeguards for a person in need.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – A federal law that allows workers to remain covered under the employer's group health plan for a period of time after: the death of a spouse, job loss, having work hours reduced, getting a divorce, or other specified reasons. You have to pay both your share and the employer's share of the premium.

Continuing Care Retirement Communities (CCRC) – Offer housing and a range of health care, social, and other services for substantial initial costs plus monthly fees.

Contract Supplier - If you live in, or are visiting certain regions in certain states when you need certain types of Durable Medical Equipment (DME) you must use a contract supplier in order for Medicare to cover your DME. If you do not use a contract supplier Medicare will not pay for your DME.

Coordination of Benefits (COB) – A clause in an insurance policy stating the policy will not pay the costs of a covered expense when another insurer pays it or that each insurer will pay part of the costs of the covered service, not to exceed the total actual cost. It is used to prevent the policyholder from receiving duplicate payments for a covered service when he or she is insured by more than one policy.

Copayment (also known as co-pay) – A specified dollar amount you pay for a medical service after satisfying any deductible. For example: A Medicare Advantage Plan may have a \$10 copayment for each primary care physician office visit.

Costs – Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same. Hospitals often charge more for a given service than it actually costs in order to recoup losses incurred from providing other services where costs exceed feasible charges.

Cost Sharing – The cost for medical care that you pay yourself, including co-payment, coinsurance, or deductible.

Coverage Gap (also known as the donut hole) - Once you and your Part D drug plan have spent \$2,970 (in 2013) for covered drugs, you will be in the Coverage Gap. Previously, you had to pay the full cost of your prescription drugs while in the Coverage Gap. The Affordable Care Act provides that in 2013, you receive a 52.5% discount on covered brand-name prescription medications in the Coverage Gap and a 21% discount on generic drugs in the Coverage Gap.

Coverage Restrictions (also known as Utilization Management Tools) – restrictions drug plans may place on certain covered services to restrict their usage. See: prior authorization, quantity limits, and step therapy.

Covered Services – Medicare law permits payment only for services that are “reasonable and necessary for the diagnosis or treatment of an illness or injury.” Therefore, Medicare can pay for services only as long as they are medically necessary.

CPT – “Physicians Current Procedural Terminology” A listing of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on claims submitted to Medicare and are shown on the person with Medicare’s MSN.

Creditable Coverage – Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period or prescription drug coverage that is considered to be as good or better than the Medicare Part D prescription drug coverage benefit.

Crossover - A billing arrangement between your Medicare supplemental insurance and Original Medicare whereby your supplemental plan is automatically billed for its share of the cost of your health care services after Medicare claims have been processed

Custodial Care – Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial

care includes help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as Activities of Daily Living or ADLs.) Medicare generally does not cover custodial care.

D

Daily Benefit – The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

Deductible – An initial amount of medical expense for which the person with Medicare is responsible before Medicare or an insurance policy will pay.

Denial of Coverage – A decision by Medicare or another insurance that your claim for benefits will not be approved and paid. Common reasons for a denial: the service is not an approved service; the service is not being provided in an appropriate setting; the service is not provided by an approved participating provider; or the service is not medically necessary.

Diagnosis Related Groups (DRGs) – DRGs are used to determine the amount that Medicare reimburses hospitals for inpatient services. They are part of the Prospective Payment System Categories of illnesses, one of which is assigned to a Medicare patient who is being admitted to a hospital. The hospital is reimbursed a fixed amount based on the DRG code for the patient.

Discharge Plan – A coordinated plan for post-hospitalization/skilled nursing facility care intended to identify an individual's need for medical and social services and resources available to help prevent re-hospitalization.

Disenroll – To end one's health coverage with a health plan.

Donut Hole – See: Coverage Gap.

Drug Class – Group of drugs that treat the same symptoms or have similar effects on the body. For example, people with Medicare often use statin class drugs, which are used for reducing cholesterol. Drugs in this class include (but are not limited to) Lipitor, Zocor, Pravachol, Zetia, and Vytarin.

Dual Eligibles – People who have both Medicare and Medicaid.

Duplication of Coverage – Coverage of the same health services by more than one health insurance policy.

Durable Medical Equipment (DME) – Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, oxygen equipment, or hospital beds. DME is paid for under Medicare Part B, and the person with Medicare pays 20 percent coinsurance in the Original Medicare plan.

Durable Medical Equipment Medicare Administrative Contractor (DME MAC) - A private insurance company that contracts with Medicare to process durable medical equipment (DME) claims. NHIC is the DME MAC for New York State.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DME POS) – See: Durable Medical Equipment (DME)

DME POS Competitive Bidding – A program that changes the amount Medicare pays suppliers for certain types of durable medical equipment and supplies and makes changes to who can supply these items. This program will be in place in parts of New York State (and for mail-order diabetic supplies nationally) starting on July 1, 2013.

Duration of Benefits – Time period or maximum amount of dollars for which an insurance policy will pay benefits.

E

Effective Date of Coverage – The starting date of insurance coverage which can be any of the following: 1) Date of the application, 2) Date of the insurance company’s approval, 3) Date the policy is issued.

Election – A person’s decision to join or leave the Original Medicare Plan or a Medicare Advantage plan.

Eligibility/ Medicare Part A – People with Medicare are eligible for premium-free Medicare Part A (hospital insurance) if: they are 65 or older and receiving Social Security or Railroad Retirement Board benefits, under 65 and have received Social Security disability benefits for 24 months, under 65 and have End-Stage Renal Disease or been diagnosed with Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig’s Disease.

Eligibility/ Medicare Part B – Automatically eligible for Part B if you are eligible for Part A, also eligible for Part B if not eligible for Part A premium-free, but are age 65 or older and a resident or citizen or lawful alien admitted for permanent residency. You must have lived in the United States continuously during the five years immediately before the month during which you enroll in Part B.

Elimination Period (Also known as a deductible or waiting period) – This applies to “hospital indemnity,” long-term care, or other “indemnity” type policies. It is the number of days before any benefit will be paid. **Emergency Care** – Care given for a medical emergency when you believe that your health is in serious danger.

Employer Group Health Plan (EGHP) – A health plan that gives health coverage to employees, former employees and their families.

End Stage Renal Disease (ESRD) – Medical condition in which a person’s kidneys no longer function, requiring the individual to receive dialysis or a kidney transplant to sustain his or her life.

Enrollment – Procedure by which eligible persons can sign up for the Medicare program and receive Medicare (Part A and Part B) coverage. It is handled by the Social Security Administration.

Enrollment Period – Period during which individuals may enroll in an insurance policy, Medicare Part A and Part B, Part D drug plan or Medicare Advantage plan. See: Fall Open Enrollment Period; Annual Coordinated Election Period; Medicare Advantage Disenrollment Period; General Enrollment Period; Initial Enrollment Period; and Special Enrollment Period.

Episode of Care – The health care service given during a certain period of time, during a hospital stay or home health service.

Evidence of Coverage (EOC) – A resource that explains your plan (Medicare Advantage Plan, Part D Plan) benefits, premiums, and cost-sharing; conditions and limitations of coverage; and plan rules. The EOC is typically mailed with the plan's Annual Notice of Change (ANOC), which is a notice informing you of plan changes that will take effect the following year.

Exception – A formal written request submitted to a Medicare Part D plan by your prescriber to ask that a non-formulary drug be covered; to request that a coverage rule (such as prior authorization) be waived; or to request that the tier level of your drug be changed to lower the cost.

Excess Charges – A limited amount above the Medicare-approved amount charged by doctors and other health care providers who do not accept assignment.

Exclusion – An expense or condition that the policy does not cover and toward which it will not pay. Common exclusions may include preexisting conditions, such as heart disease, diabetes, or hypertension. Because of such exclusions, persons who have a serious condition or disease are often unable to secure insurance coverage, either for general conditions or the particular disease. For Medicare supplement insurance, federal law may exclude coverage for pre-existing conditions only for a maximum of six months after coverage begins.

Expedited Appeal – A fast appeal of a Medicare private health plan or drug plan's denial of coverage in which a beneficiary may receive a decision within 72 hours.

Explanation of Benefits (EOB) – An Explanation of Benefits is sent to you to describe what benefits were paid or not paid by your employer-sponsored retiree plan or by your Medigap or other private health insurance. Usually, the reasons for claim denial are listed on the EOB.

Extra Help (Also known as the Low-Income Subsidy (LIS)). – A Medicare program that helps people with low income and resources pay Medicare Part D Prescription Drug plan costs, such as premiums, deductibles and coinsurance.

F

Fall Open Enrollment Period – From October 15 through December 7 each year, the time when you can make changes in the way you receive Medicare – Original Medicare or a Medicare Advantage Plan – and/or your Medicare drug plan (Part D). The plan changes will be effective January 1st of the following year.

Federal Employee Health Benefit (FEHB) Program – Health Insurance for full-time permanent civilian employees and retirees of the United States Government, offered through private health plans.

Federally Qualified Health Center (FQHC) – Health centers that have been approved by the government for a program to give low-cost health care. Medicare pays for some health services in FQHCs that it generally does not cover, such as routine check-ups. FQHCs include community health centers, Tribal health clinics, migrant health services, and health centers for homeless individuals.

Federal Poverty Level (FPL) - The federally set level of income that an individual or family can earn below which it is recognized that they cannot afford necessary services. The FPL is used to determine eligibility for Extra Help and the Medicare Savings Programs. The FPL changes every year and varies depending on the number of people in a household.

Fee-for-Service – Method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the method of billing by providers in Original Medicare.

Fee Schedule – A listing of accepted charges or established allowances for specified medical, dental, or other procedures or services. It usually represents either a physician or third party's standard or maximum charges for the listed procedures.

Fiscal Year (FY) – The Federal Government's budget (or fiscal) year runs from October 1 to September 30 of the following calendar year.

Food & Drug Administration (FDA or USFDA) – is responsible for protecting and promoting [public health](#) through the [regulation](#) and supervision of [food safety](#), [tobacco products](#), [dietary supplements](#), [prescription](#) and [over-the-counter pharmaceutical drugs](#) (medications), [vaccines](#), [biopharmaceuticals](#), [blood transfusions](#), [medical devices](#), and [veterinary products](#).

Formulary – A list of certain drugs and their proper dosages. In Medicare health and drug plans, doctors may have to order or use only drugs listed on the health plan's formulary.

Fraud – To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the actual service provided.

Free Look (Medigap) – A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled.

Freedom of Information Act – A law that requires the U.S. Government to give out certain information to the public when it receives a written request. FOIA applies only to records of the Executive Branch of the Federal Government.

Friendly Visitor – Volunteers who visit the homebound to sit and talk or sometimes to run errands and shop for them.

Fully Capitated – Plan is given a set amount which includes all reimbursement for all long term care services as well as medical services such as doctor office visits, hospital care, pharmacy and other health related services

G

Gag Rule Laws – Special laws that make sure that health plans let doctors tell their patients complete health care information. This includes information about treatments not covered by the health plan. These laws make it illegal to include “gag” clauses in doctor contracts, which limit a doctor's ability to give information to patients about treatment choices for a health problem.

Gaps in Coverage – The costs or services that are not covered under the Original Medicare Plan such as prescription drugs, deductibles, and coinsurances.

Gatekeeper – In a managed care plan, this is another name for the primary care doctor (PCP). This doctor gives you basic medical services and coordinates proper medical care and referral.

General Enrollment Period - January 1 to March 31 of each year in which eligible persons can sign up for Medicare Part B coverage to start in July.

Generic Drug – A copy of a brand name drug that is regulated by the Food & Drug Administration to be identical in dosage, safety, strength, how it is taken, quality, performance and intended use (*Definition from the U.S. Food & Drug Administration*). Generics generally work just as well as the brand-name version, but are less expensive because they are not patented.

Grace Period – A specified period after a premium payment is due on an insurance policy, in which the policyholder may make such payment, and during which the provisions of the policy continue, usually 30 days.

Grievance – A complaint about the way your health care plan is giving care. A grievance is not the same as an appeal. See: Medicare Appeal.

Group Insurance – A group policy is a written contract between an insurer and a “middle man,” usually an employer or group, which provides benefits to the insured persons holding individual certificates of insurance stating the provisions of the coverage given to each insured individual or family.

Guaranteed Renewable – The insurance company agrees to continue insuring the policyholder for as long as the premium is paid. The premiums for the policy cannot be raised for a given policyholder because of the benefits received, but premiums can be raised for all policyholders. For example, Medigap/Medicare Supplement plans are guaranteed renewable.

H

Health and Human Services, Department of (HHS) – An executive department of the federal government that has the ultimate authority for the Medicare and Medicaid programs.

Health Benefit Exchange – See: Health Insurance Exchange.

Health Care Proxy – This legal document designates and authorizes a person (the “proxy”) to make decisions regarding medical treatment for another only when that person becomes temporarily or permanently incapable of communicating their own care or treatment wishes. The Health Care Proxy document can be revoked at any time. See: Advance Directive; Power of Attorney.

Health Insurance Claim Number (HICN) – The unique alphanumeric Medicare entitlement number assigned to a person with Medicare and which appears on the Medicare card.

Health Insurance Exchange – a set of government-regulated and standardized health care plans, from which individuals may purchase health insurance eligible for federal subsidies. Under the federal

Affordable Care Act, New York State has established a state-based exchange called the New York Health Benefit Exchange. Open enrollment for health insurance purchased through the Exchange will begin in October 2013 for coverage that begins on January 1, 2014.

Health Insurance Information, Counseling, and Assistance Program (HIICAP) – A statewide program developed to enable New York seniors to become educated health care consumers. HIICAP is part of the national SHIP (State Health Insurance Assistance Program).

Health Insurance Information, Counseling, and Assistance Program (HIICAP) Consortium – A consortium of private and public organizations that coordinate resources to educate people with Medicare and their families about Medicare and other health insurance.

Health Insurance Portability and Accountability Act (HIPAA) – Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits. HIPAA also provides rules for disclosure of medical record information.

Health Maintenance Organization (HMO) – An organization that, for a prepaid fee, provides a comprehensive range of health maintenance and treatment services (including hospitalization, preventive care, and nursing). Medicare HMOs are a common type of Medicare Advantage plan.

HMO with a Point of Service Option (HMO-POS) – A Managed Care Plan, generally less restrictive than an HMO. A person with this type of plan may have additional coverage for certain types of services outside of the plan network for an additional cost.

Healthy NY (New York) - New York State-sponsored health insurance for working individuals, sole proprietors, and small employers. Healthy NY coverage will be discontinued as of December 31, 2013 for currently enrolled individuals and sole proprietors.

Homebound – Normally unable to leave home. Leaving home takes considerable and taxing effort. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like a trip to the barber or church service. A doctor must certify this condition.

Home Health Agency – A home health agency is a public or private agency that specializes in giving skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

Home Health Care – Health care services provided in the home on a part time basis for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis. When skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage should not be denied based on the absence of potential for improvement or restoration.

Home Health Resource Group (HHRG) – HHRGs are used to determine the amount Medicare will reimburse home health agencies for services. The home health agency is paid a set amount based on the HHRG to which a patient is assigned.

Hospice – Comprehensive care for people who are terminally ill that includes pain management, counseling, respite care, prescription drugs, inpatient care and outpatient care, and bereavement services for the terminally ill person's family.

Hospital Indemnity Insurance – Insurance that pays a fixed cash amount for each day a person is in the hospital up to a certain amount of days. Some policies may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

Hospital Issued Notice of Non-coverage (HINN) – Hospitals provide Hospital-Issued Notices of Non-coverage to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is not medically necessary; not delivered in the most appropriate setting; or is custodial in nature.

I

Indemnity Policy – Type of insurance policy, which pays a fixed amount per day for covered services received, generally a fixed amount per day of covered hospitalization.

Independent Review Entity (IRE) – An independent entity with which Medicare contracts to handle the second level of appeals of a denial of coverage (except for hospital care) if you are in a Medicare Advantage Plan or a Medicare Part D Prescription Drug Plan.

Individual Health Insurance – An individual policy of insurance is a written contract between an insurance company and an insured person. It is separate from Medicare.

Individual Insurance Policy – The individual copy of the master contract that contains a policy number assigned only to the subscriber. That policy number should be used when contacting the insurance company for information.

Inflation Protection – A policy option that provides a percentage or dollar amount increase in benefit levels to adjust for inflation or allows the policyholder to purchase additional units of coverage to keep up with inflation

In-Home Supportive Services (IHSS) – Personal care services and non-medical services to help functionally impaired persons of all ages, with limited resources, stay at home. Title XX of the Social Security Act authorizes payment to those individuals who qualify for IHSS.

Initial Coverage Election Period – The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare Advantage plan during your Initial Coverage Election Period.

Initial Coverage Limit – The initial period of Part D insurance coverage after a beneficiary has met any deductible requirement and before expenditures reach the coverage gap.

Initial Enrollment Period (IEP) – Your IEP starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months. This IEP is the first chance a person has to enroll in Part A or B if they do not get it automatically, without paying a penalty.

Initial Preventive Physical Exam (IPPE) – See: “Welcome to Medicare” preventive visit

In-Network – Part of a managed care plan’s network of providers. If you use doctors, hospitals, pharmacies, home health agencies, skilled nursing facilities and equipment suppliers that are in your private health plan’s or Medicare private drug plan’s network, you will generally pay less than if you use out-of-network providers.

Inpatient – A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health services.

Institutionalization – Admission of an individual to an institution, such as a nursing home, where he or she will reside for an extended period of time or indefinitely.

Insurance Contract – The master copy of a policy which is submitted to the State Department of Financial Services for approval and sale. It is assigned a form number, which is listed in the bottom left corner of the cover. This number should be used when seeking information from the State Department of Financial Services.

Insured – The individual or organization protected in case of loss or covered service under the terms of an insurance policy.

Insurer – A company which, for a set premium, agrees to reimburse the insured for a loss covered by an insurance policy.

L

Length of Stay – The time a patient stays in a hospital or other health facility.

Lifetime Maximum – The Affordable Care Act prohibits health plans from putting a lifetime dollar limit on most benefits you receive. The law also restricts and phases out the annual dollar limits a health plan can place on most of your benefits — and does away with these limits entirely in 2014.

Lifetime Reserve Days – When you are in the hospital for more than 90 days in a single benefit period, Medicare pays for 60 additional reserve days that you can only use once in your lifetime. They are not renewable once you use them.

Limited Benefits Policy – Type of insurance policy, which only pays benefits for a specific type of illness or health care services, named in the policy.

Limiting Charge – The maximum amount doctors and other health care providers who don’t accept assignment can charge for a covered service. The Federal limit is 15 percent over Medicare’s approved payment amount. New York State’s limit is 5 percent, except for home and office visits, where the limit is 15 percent over Medicare’s approved payment amount.

Lock-In- Limits your ability to change the way you receive your Medicare health and prescription drug (Part D) coverage to the Annual Coordinated Election Period (AEP) and Medicare Advantage Disenrollment Period (MADP).

Long-Term Care (LTC) – The medical and social care given to individuals who have severe chronic impairments over a long period of time. Long-term care can consist of care in the home, by family members assisted with voluntary or employed help (such as provided by home health care agencies), adult day health care, or care in institutions.

Long-Term Care Insurance – A policy designed to help alleviate some of the costs associated with long-term care. Often, benefits are paid in the form of a fixed dollar amount (per day or per visit) for covered long-term care expenses and may exclude or limit certain conditions from coverage.

Long-Term Care Ombudsman - An independent advocate for nursing home and assisted living facility residents who provides information about how to find a facility and how to get quality care and addresses complaints and advocates for improvements in the long-term care system.

Loss – The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

Loss/Benefit Ratio – The percentage of premiums collected that is returned in benefits to the policyholder by an insurer. See: Medical Loss Ratio.

Low Income Subsidy (LIS) – See: Extra Help.

M

Mammogram – A special X-ray of the breasts. Medicare covers the cost of a screening mammogram once a year for women over 40 who are enrolled in Medicare.

Managed Care Plans – A health care plan that involves a group of doctors, hospitals and other health care providers who have agreed to provide care to people with Medicare in exchange for a fixed amount of money every month.

Marketing Fraud - When Medicare private plans deceive you—through marketing materials or through a person misrepresenting the plan—about what the plan offers and how much it costs.

Maximum Out-of-Pocket (MOOP) – Medicare Advantage plans limit how much customers pay out of their own pocket for all Part A and Part B (hospital and medical) covered services. The Maximum Out-Of-Pocket expenses are capped at \$6,700 for in-network benefits for 2013. MOOP does NOT include the Part D costs and monthly premiums.

Medicaid – Federally assisted, state-administered program to finance health care services for low-income persons of all ages.

Medicaid Buy-in – A state-run Medicaid program that allows people with disabilities under the age of 65 to work and still get the comprehensive benefits of Medicaid. The program allows people who are not eligible for traditional Medicaid—because their income or assets are too high—to “buy in” to the program for a small percentage of their income. New York State has a Medicaid Buy-In program.

Medicaid Managed Long-Term Care (MMLTC) - an arrangement in which the state Medicaid program makes a single managed care plan responsible for a range of long-term care services and pays the plan a set monthly fee, called capitation, regardless of the amount of care delivered.

Medicaid Re-Design Team (MRT) – By Executive Order on January 5, 2011, Governor Andrew M. Cuomo commissioned the Medicaid Redesign Team to reconstruct and refinance New York State’s Medicaid system. These MRT stakeholders are working to implement the provisions in the Affordable Care Act that affect Medicaid including: simplifying the application process between Medicaid and the Health Insurance Exchanges (Health Benefit Exchange in New York State) beginning in January 2014; and expanding Medicaid coverage to more low income residents.

Medicaid Spend-Down (also known as Medicaid Excess Income or Surplus Income Program) – A state-run Medicaid program for people whose income is higher than would normally qualify them for Medicaid, but who have high medical expenses that reduce their incomes to the Medicaid eligibility level. In New York State you must be under age 21, age 65 or older, certified blind or certified disabled, pregnant or a parent of a child under age 21 to become eligible for Medicaid Spend-Down.

Medicaid Waiver 1115 - a federal waiver amendment developed by the New York Medicaid Re-Design Team (MRT) that will allow the state to reinvest in its Medicaid health care infrastructure and implement national health care reform.

Medical Loss Ratio (MLR) – As required by the Affordable Care Act, certain health insurers must provide rebates to their customers for each year that the insurers do not meet a set financial target called a medical loss ratio (MLR). A MLR measures the share of a health care premium dollar spent on health care quality improvement, as opposed to administrative costs. The ACA sets the minimum required MLR at 80% for the individual and small group markets and 85% for the large group market.

Medical Underwriting – The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for preexisting conditions and how much to charge you for that insurance. As required by the Affordable Care Act, starting in 2014, insurers can no longer use health status to determine eligibility, benefits, or premiums.

Medically Necessary – Procedures, services or equipment that meets medical standards and is necessary for the diagnosis and treatment of a medical condition. Medical necessity must be established (via diagnostic and/or other information presented on the claim under consideration) before the insurer will make payment.

Medicare – Title XVIII of the Social Security Act, federal health insurance program for people 65 and older and some under 65 who are disabled. Medicare has two parts. Part A is Hospital Insurance and primarily provides coverage for inpatient care. Part B is Medical Insurance and provides limited coverage for physician services and supplies for the diagnosis and treatment of illness or injury. You can receive Medicare health insurance coverage directly through the federal government (see Original Medicare) or administered through a private company (see Medicare Advantage).

Medicare Advantage Plan (also known as Part C or health plan) – Medicare program developed as a result of the Balanced Budget Act of 1997, which provides people with Medicare with many different health insurance options. Plans must cover all Medicare Part A and Part B health care and may include prescription drug coverage. Plans may also cover extras, like dental care, eyeglasses or hearing aids.

Medicare Appeal – Procedure in which a person with Medicare who disagrees with the denial of payment for a claim by Medicare can challenge the decision made. See Appeals Process.

Medicare Approved Amount – See: Approved Amount.

Medicare Administrative Contractor (MAC) – A private company that contracts with CMS to process both Medicare Part A and Part B claims, and make payments to providers on behalf of Medicare. The MAC replaces Medicare Part A intermediaries and Part B carriers.

Medicare Advantage Disenrollment Period (MADP) – (January 1 through February 14) when you can leave your Medicare Advantage Plan and change to Original Medicare with or without also selecting a standalone Medicare drug plan. You cannot make changes during this time if you have Original Medicare. And you cannot switch from one Medicare Advantage Plan to another during this time.

Medicare Cost Plan – a type of Health Maintenance Organization (HMO) that works in much the same way as a Medicare Advantage Plan if you use in-network providers. But if you go to an out-of-network provider, the services are actually covered under Original Medicare

Medicare Fraud and Abuse – Medicare fraud is defined as making false statements or representation of material facts to obtain some benefit or payment for which no Medicare entitlement exists. Medicare abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Medicare as Secondary Payer (MSP) – Situations, defined by law, in which Medicare payment may be made only after another source has either paid or denied payment of medical items and/or services.

Medicare Medical Savings Account (MSA) Plan – Combines a high deductible Medicare Advantage plan with a Medical Savings Account for medical expenses. These plans do not offer prescription drug coverage.

Medicare Part A (Hospital Insurance) – Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

Medicare Part B (Medical Insurance) – Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services.

Medicare Part D (Medicare Prescription Drug Coverage) – Coverage for prescription drugs which is available through private stand-alone plans for people on Original Medicare or through Medicare Advantage plans for their members.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also called the Medicare Modernization Act or MMA) – the federal law establishing Part D prescription drug coverage and other changes.

Medicare Savings Programs (MSP) Also known as “Medicare Buy-In” programs - Help pay your Medicare premiums and sometimes also coinsurance and deductibles. There are three main Medicare Savings Programs, with different eligibility limits: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) program. The Qualified

Disabled Working Individual (QDWI) program is a less common MSP for people who are under 65, have a disabling impairment, and continue to work.

Medicare Secondary Payer (MSP) – Medicare pays second on a claim for medical care, after an employer group health plan has paid, for example.

Medicare Select – A type of Medigap/Medicare Supplement plan that may require you to use doctors and hospitals within its network to be eligible for benefits.

Medicare Summary Notice (MSN) – A notice mailed to beneficiaries from Original Medicare that lists services received from doctors, hospitals or other health care providers. It details what the provider billed Medicare, Medicare's approved amount for the service, the amount Medicare paid, and what the beneficiary is responsible to pay. An MSN is not a bill.

Medication Therapy Management Program (MTMP) - the application of a distinct CMS approved service or group of services that optimizes drug therapy with the intent of improved therapeutic outcomes for individual patients.

Medigap/Medicare Supplement – Type of insurance policy with coverage specifically designed to fill the major benefit gaps in Medicare Part A and Part B (deductibles and coinsurance). Medigap policies only work with the Original Medicare Plan.

Mental Health – Services that may be provided by a psychiatrist (MD), clinical psychologist (PhD) or clinical social worker (LCSW/LMSW). Unlike medical services, paid at 65% of allowed amount in 2013, but will be covered at the same 80% as medical services beginning in 2014.

N

National Coverage Determination (NCD) – A decision about particular treatments that [Medicare](#) will or will not cover for particular conditions. Medicare contractors are required to follow NCDs.

National Association of Insurance Commissioners (NAIC) – The organization that prepares model provisions and guidelines for insurance companies and state legislatures.

National Committee for Quality Assurance (NCQA) – A non-profit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Sets (HEDIS) data reporting system.

Network – A group of doctors, hospitals, pharmacies and other health care experts hired by a health plan to take care of its members.

Non-covered – Health care costs that Medicare does not cover at all.

Nonforfeiture Benefits – A policy feature that returns at least part of the premiums if the policyholder cancels or lets the policy lapse. For example, the "Reduced Paid-Up Benefit" provides reduced benefits for the original term of the policy, and the "Shortened Benefit Period" provides full benefits for a reduced period of time.

Non-Participating Provider - In Original Medicare, this is a provider that does not always accept assignment. Non-participating providers may charge up to 15 percent of Medicare's approved amount

for the service or item on top of the Medicare coinsurance. In addition, the provider can request full payment up front and will then submit the bill to Medicare for patient reimbursement.

Notice of Discharge and Medicare Appeal Rights (NODMAR) – A written discharge notice given to Medicare Advantage plan enrollees that states if a person with Medicare chooses to stay in the hospital, he/she will be responsible for services provided beginning on the third day after the notice has been received; the notice also explains the Medicare appeal process.

Notice of Medicare Non-Coverage (NOMNC) – If you are enrolled in a Medicare Advantage Plan, a notice that tells you when care you are receiving from a home health agency (HHA), skilled nursing facility (SNF) or comprehensive outpatient rehabilitation facility (CORF) is ending and how you can contact a Quality Improvement Organization (QIO) to appeal.

Nursing Home – Also referred to as a long-term care facility or skilled nursing facility. A residence for persons who need some level of medical assistance and/or assistance with activities of daily living. If certain health criteria are met, Medicare covers a limited stay in a Medicare-certified skilled nursing facility for rehabilitation therapies. Not all nursing homes are Medicare approved/certified facilities.

Nursing Home Policy (sometimes referred to as Long-Term Care policies) – Type of limited health insurance policy, which generally pays indemnity benefits for medically necessary stays in nursing facilities. See: Long-Term Care Insurance.

NY Bridge Plan – New York State’s Pre-existing Condition Insurance Plan (PCIP), providing individual coverage to eligible New Yorkers with a pre-existing health condition who have not had health coverage for at least six months. The NY Bridge Plan began offering coverage in 2011 and will end in 2014, when the new federal Health Insurance Exchanges (Health Benefit Exchange in New York State) will take its place.

New York State Health Benefit Exchange – See: Health Insurance Exchange.

O

Observation Status - a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether a patient requires further treatment as a hospital inpatient (Medicare Part A applies) or if they are to be treated on an outpatient basis (Medicare Part B applies).

Occupational Therapy – Activities designed to improve the useful functioning of physically and/or mentally disabled persons.

Off-Label Use – the practice of prescribing pharmaceuticals for a reason other than the use approved by the U.S. Food and Drug Administration (FDA). See: Food and Drug Administration.

Ombudsman – A “citizens’ representative” who protects a person’s rights through advocacy, providing information and encouraging institutions or agencies to respect citizens’ rights.

Opt-Out - Doctors can “opt-out” of Medicare by notifying the Medicare Administrative Contractor that they will not accept Medicare payments and informing their patients in writing before providing services. Doctors who have “opted-out” can charge as much as they want, and their patients have to pay

the entire bill themselves. The only time a doctor who has opted out can receive payment from Medicare is when the doctor provides a patient emergency or urgent care services.

Original Medicare Plan (Traditional Medicare) – the pay-per-visit federal health insurance program created in 1965 that provides coverage for medically necessary services from any doctor, hospital, or other health care provider who accepts Medicare regardless of location. Persons with Original Medicare share costs by paying deductibles and coinsurances. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance)

Out-of-Network – Not part of a [managed care plan's network](#) of health care [providers](#). If you get services from an out-of-network doctor, hospital or pharmacy, you will likely have to pay higher out of pocket for the services you received.

Out-of-Pocket Costs – Health care costs that you must pay because Medicare or other health insurance does not cover them.

Outlier Case – Outlier cases are atypical cases which involve longer hospital stays or higher treatment costs.

Outpatient – A patient who receives care outside of a facility or at a hospital or other health facility without being admitted to the facility.

Outpatient Hospital Services – Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay. This includes: blood transfusions, certain drugs, hospital billed laboratory tests, mental health care, medical supplies such as splints and casts, emergency services or outpatient clinics, including same day surgery and X-rays or other radiation services.

Outpatient Prospective Payment System (OPPS) – The way that Medicare pays for most outpatient services at hospitals or community mental health centers.

Over-the-Counter (OTC) Drug A drug that you can buy without a prescription, at your local pharmacy or drug store. These drugs are not covered by Medicare Part D.

P

Palliative Care – a multidisciplinary area of healthcare that focuses on relieving and preventing the suffering of patients and is appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life.

Partially Capitated – Plan receives a set amount for Medicaid services only. See: Capitated

Participating Facility – Health care facility, which participates in the Medicare program and accepts Medicare payment for services received in the facility.

Participating Physician/Supplier Agreement – An agreement, by an individual physician or supplier, to always accept assignment on claims for Medicare-covered items and services.

Patient Assistant Program - A program offered by a pharmaceutical company that offers lower-cost or free prescriptions to people with low incomes.

Patient Protection Affordable Care Act (PPACA) – See: Affordable Care Act.

Patient Representative – A member of the hospital staff who serves as a link between patient, family, physicians and other hospital staff. The representative should be available to answer questions about hospital procedures, help with special needs or concerns and help solve problems (i.e., explaining hospital notices, etc.). There is no charge for services provided by the patient representative.

Period of Care (Hospice) – A set period of time that hospice services are provided. Additional periods of care are possible if the patient is evaluated and still found to be hospice appropriate. Hospice has unlimited periods of care.

Personal Care - Assistance with bathing, cooking, dressing, eating, grooming, or personal hygiene. Providers of personal care (home health aides) are not required to undergo medical training. Medicare only covers personal care if you are homebound and receiving skilled care.

Personal Comfort Items – For inpatients in a hospital, such items as a television, telephone, etc.

Physical Therapy – Services provided by specially trained and licensed physical therapists in order to relieve pain, maintain function, and prevent disability, injury or loss of body part. Note: A beneficiary's lack of restorative potential alone cannot serve as a reason to deny a Medicare claim for therapy. The beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question must also be considered. See: Skilled Nursing Care.

Physician Assistant (PA) – A person who has two or more years of advanced training and has passed a special exam. They work with a doctor and can do some of the job that a doctor can do.

Point of Service Option (POS) – Gives managed care plan members the right to partial coverage for certain services they get outside of the managed care plan network.

Power of Attorney – A legal document which gives a person (usually a spouse, other relative, or friend) the power to act on behalf of another. A power of attorney primarily authorizes the person you designate to make financial decisions for you. In New York State, it cannot be used to make health care decisions. The person giving the power of attorney must be competent, and does not lose the legal right to act on his own behalf. See: Health Care Proxy.

Pre-Authorization (Also called pre-approval.) – An approval that must be asked for from a managed care plan or primary care doctor for care, treatment, or other medical services needed. See: Prior Authorization.

Pre-existing Condition – Health conditions or problems that were identified and treated before health insurance was purchased. The definition and waiting period before these conditions are covered varies from policy to policy. However, there is a maximum six-month waiting period for Medigap policies and treatment must have been received in the preceding six months for the condition to be considered “pre-existing.”

Preferred Provider Organization (PPO) – Type of Medicare Advantage plan under which you can get coverage for providers both in **and** out of network; although, it usually costs the member more to see an out-of-network provider.

Premium – Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder in exchange for a designated amount of insurance coverage.

Premium Penalty - An amount that you must pay in addition to the regular monthly premium for late enrollment in Part B or Part D. The Part B penalty is an additional 10 percent of the premium for each year you delay enrollment that you did not have coverage from a current employer. Part D imposes a premium penalty of 1 percent for every month of delayed enrollment without creditable drug coverage.

Pre-existing Condition Insurance Plan (PCIP) – See: NY Bridge Plan.

Prescription Drug Plan (PDP) – Stand-alone drug plan offered by private companies (contracted with Medicare) available to beneficiaries on Original Medicare or on a Medicare Private Fee-for-Service plan without Part D.

Preventive Services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, colorectal cancer screenings, yearly mammograms, annual wellness visits, and flu shots). Medicare [covers many preventive services](#) without charging you the Part B coinsurance or deductible.
Primary Care Physician (PCP) – A doctor who is trained to give you basic care. This includes being the first one to check on health problems and coordinating your preventive health care with other doctors, specialists and therapists. In some Medicare managed care plans, you may have to see your primary care doctor before you can see any other health care professional.

Primary Payer – The insurance company that pays first on a claim. This could be Medicare or other insurance.

Prior Authorization - Also called pre-authorization or pre-approval. Approval may be required before a medical service is provided under a Medicare Advantage plan or a prescription drug is covered under a Part D plan. For a service or medication to be covered a provider must get special permission from the plan. When prior authorization is required, an insurer can deny coverage for services already provided or for proposed services that are deemed not to be medically necessary.

Private Fee-For-Service Plan (PFFS) – a type of managed care plan that allows a Medicare beneficiary to receive services from any doctor or hospital regardless of location as long as that provider accepts the plan's terms and conditions. The insurance plan, rather than the Medicare program, determines how much the person with Medicare pays for services.

Program of All-Inclusive Care for the Elderly (PACE) – Serves individuals who are age 55 or older who are certified by their state to need nursing home care to be able to live safely in the community at the time of enrollment and who live in a PACE service area.

Prospective Payment System (PPS) – A standardized payment system to help manage health care reimbursement whereby the incentive for hospitals to deliver unnecessary care is eliminated. Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each hospital stay. In some cases the Medicare payment will be more than the actual cost of providing services for that stay; in other cases, the payment will be less than the hospital's actual cost. In special cases, the hospital may receive additional payment for unusually high costs. Also see "Outlier Cases."

Provider – A doctor, hospital, other health care professional, or health care facility.

Q

Qualified Disabled Working Individual (QDWI) - A less common Medicare Savings Program (MSP) administered by each state's Medicaid program. It pays the Medicare Part A premium for people who are under 65, have a disabling impairment, continue to work, and are not otherwise eligible for Medicaid.

Qualified Medicare Beneficiaries (QMB) – A Medicaid program that pays the Medicare Part A premium, Part B premium, and Medicare deductibles and coinsurance amounts for services provided by Medicare providers for individuals who have Medicare Part A, and a low monthly income.

Qualifying Individual (QI) – A Medicaid program that pays the Medicare Part B premium for individuals who have Medicare Part A, and a low monthly income, but who are not otherwise eligible for Medicaid.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing complaints and grievances from people with Medicare about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare Advantage plans and ambulatory surgical centers. They also assist Medicare beneficiaries with the Medicare Appeals Process. The Island Peer Review Organization (IPRO) is the QIO in New York State. **Quantity Limit** - A restriction used by private health plans and Medicare Part D plans that limit coverage of a particular drug to a specific quantity (such as 30 pills a month).

R

Railroad Retirement – Persons who worked for a railroad company are entitled to their benefits at retirement (includes Medicare), similar to Social Security benefits.

Reasonable and Necessary Care – The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Reconsideration – The second level in the Medicare Part A and Part B appeals process.

Redetermination - The first level in the Medicare Part A and Part B appeals process that occurs when a person with Medicare receives a Medicare Summary Notice (MSN) with a denial of coverage and appeals that decision.

Referral – A written authorization from your primary care doctor for you to see a specialist or get certain services. In some Medicare managed care plans, this is a necessary step.

Respite Care – Short-term care given to a hospice patient by another caregiver, so that the usual caregiver can rest. A volunteer, an institution, or an adult day care center may provide the care.

Retiree Insurance - Health insurance provided by employers to former employees who have retired. Retiree insurance is always secondary to Medicare.

Retroactive Disenrollment - A way to discontinue enrollment in a Medicare Advantage or Medicare Part D Prescription Drug Plan that you mistakenly joined or joined due to marketing fraud, effective back to the date you joined. A person with Medicare will be disenrolled from the Medicare private health or drug plan as if they had never joined it.

Rider – A legal document which modifies the protection of an insurance policy, either extending or decreasing its benefits, or which adds or excludes certain conditions from the policy’s coverage.

S

Second Opinion – When another doctor gives his or her view about a patient’s diagnosis and treatment.

Secondary Payer – A payer of health benefits whose payments cannot be made until another primary party has processed the claim and issued a claim determination.

Self-pay – Consumers pay for all of their own health care costs.

Senior Medicare Patrol (SMP) – A federally funded nation-wide, long-term initiative to fight fraud, waste, error and abuse in Medicare and Medicaid.

Service Area – The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll a member if they move out of the plan’s service area.

Service Benefits – Type of benefits in a health insurance policy, which pays the costs of the services, covered by the policy rather than a fixed dollar amount per day to cover any services received.

Skilled Nursing/Therapy Care – Care that can only be provided by or under the supervision of licensed nursing personnel or professional therapists under the general direction of a physician. If a home health aide (someone who provides help with activities of daily living) or other person can perform the service, it is not considered skilled care.

Skilled Nursing Facility (SNF) – A Medicare approved facility which is staffed and equipped to furnish skilled nursing care and skilled rehabilitation services for which Medicare pays benefits.

Specified Low-Income Medicare Beneficiary (SLMB) – A Medicaid program that pays the Medicare Part B premium for individuals who have Medicare Part A and a low monthly income.

Social Security Administration (SSA) – The federal agency responsible for determining Medicare eligibility and handling the Medicare enrollment process.

Special Enrollment Period (SEP) – A period of time when a person with Medicare can enroll in or switch their Part D plan outside of the Annual Coordinated Election Period (October 15 – December 7) due to special circumstances. The term is also used in the context of enrolling in Medicare Part B following the end of a beneficiary’s coverage through their own or their spouse’s current employment.

Special Needs Plan (SNP) – Type of Medicare Advantage plan that provides specialized care for specific groups of people with Medicare, such as those with both Medicare and Medicaid, institutionalized beneficiaries or with certain chronic conditions.

Specific Disease Policy – Type of limited health insurance policy which only covers the expenses incurred for the specific disease named in the policy. The most common type is cancer insurance.

Speech/Language Pathology – The study, examination, and therapeutic treatment of defects and diseases of the voice, speech, spoken and written language.

Spend-down – When individuals deplete their income and assets and thereby meet Medicaid financial eligibility requirement.

Spousal Impoverishment Protection Law – Law which allows the at-home spouse of a Medicaid-eligible nursing home resident to keep a minimum amount of joint income and assets.

State Health Insurance Assistance Program (SHIP) – Federally-funded program to train volunteers to provide counseling on the insurance needs of senior citizens. In New York State, the SHIP program is known as HIICAP.

Step Therapy – A type of prior authorization in which a Medicare Part D plan requires a member to try less expensive drugs for the same condition before they will pay for a particular formulary drug.

Stop-Loss – a policy that takes effect after a certain amount has been paid in claims. Companies providing health insurance for their employees through a self-insured plan often subscribe to stop-loss policies in order to protect themselves against catastrophic claims.

Social Security Disability Insurance (SSDI) - Monthly benefits provided through the Social Security Administration for people who lose their ability to work because of a severe medical impairment (disability). People who receive SSDI for 24 months are eligible for Medicare.

Supplemental Insurance – Fills gaps in Original Medicare coverage by helping to pay for the portion of health care expenses that Original Medicare does not pay for, such as deductibles and coinsurances. Supplemental insurance includes Medigap plans and retiree insurance from a former employer and may offer additional benefits that Medicare does not cover.

Supplemental Security Income (SSI) – A federal program that pays monthly checks to people in need who are 65 years or older and to people at any age who are blind or disabled and in need. The purpose of the program is to provide sufficient resources so that anyone who is blind or disabled can have a basic monthly income. Eligibility is based on income and assets.

Suppliers – Persons or organizations, other than physicians or health care facilities that furnish durable medical equipment, prosthetics, orthotics or medical supplies. See: Durable Medical Equipment (DME).

Swing Beds – A unit of beds in a hospital designated for the Medicare program for both traditional hospital acute care and long term care and rehabilitation.

T

Tax-Qualified Long-Term Care Insurance Policy – A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

Therapy Caps - Limits on the amount of physical therapy, occupational therapy and speech/language pathology that Medicare will cover in a given year.

Third-Party Liability – A party other than a person with Medicare who is responsible for payment of part or all of a specific Medicare claim. Medicare Supplement Insurance (Medigap) coverage is one example.

Third-Party Notice – A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment.

Tiers – Different levels of drug coverage within the same Medicare Part D plan. Plans may have tiers for generic, preferred brand name, non-preferred brand name and specialty drugs.

Title XVIII – That portion of the Social Security Act, which clearly defines the provisions of Medicare.

Title XIX – That portion of the Social Security Act that clearly defines the provisions of Medicaid.

Transition Policy or Temporary First-Fill - Allows new members of Medicare private drug plans (Part D) to get temporary coverage of drugs they were taking before they joined if those medications are not covered by their new plan (or covered with restrictions).

TRICARE (formerly known as CHAMPUS) – TRICARE is the health care program for members of the military, eligible dependents and military retirees.

Twisting – The insurance sales practice of replacing an existing health insurance policy with a new one from a different company in order to receive the high first year sales commission.

U

Unassigned Claim – A claim on which the doctor or supplier refuses to accept Medicare’s approved charge as payment in full.

Underwriting – The process by which an insurer establishes and assumes risks according to insurability.

Urgent Care – Immediate medical attention for a sudden illness or injury that is not life threatening.

Usual, Customary, Reasonable (UCR) Charges – In “insurance language,” this is the maximum amount a company will pay on a claim as determined by their guidelines. See: Approved Amount.

Utilization Management Tools – See: Coverage Restrictions.

Utilization Review Committee – Committee in a health care facility which evaluates the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities. This includes a current and retroactive review of the appropriateness of admissions; services ordered and provided, length of stay, and discharge practices.

V

Viatical Settlement – Viatical settlement companies make lump sum payments to life insurance policy holders with catastrophic or life-threatening illnesses in return for having the policy’s death benefit assigned to that company.

Visit – An encounter between a patient and a health care professional which requires either the patient to travel from his home to the professional’s usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in the patient’s home. Doctors’ services can be covered in any of these settings under Medicare.

W

Waiting Period – The period of time that must pass after becoming insured before the policy will begin to pay benefits for a preexisting condition.

“Welcome to Medicare” preventive visit - An introductory visit within the first 12 months you have Medicare Part B. This visit includes a review of your medical and social history related to your health, education and counseling about preventive services, and referrals for other care, if needed. See: Annual Wellness Visit.

ACROYNMS

A

AAA	Area Agencies on Aging
AACR	American Association for Cancer Research
AAHA	American Association of Homes for the Aging
AAHP -	American Association of Health Plans
AAHSA	American Association of Homes & Services for the Aging
AAKP	American Association of Kidney Patients
AARP	American Association of Retired Persons
ABD	Aged, Blind & Disabled
ABH	Association of Behavioral Healthcare
ABN	Advance Beneficiary Notice of Noncoverage
ABR	American Board of Radiology
ABS	Annual Beneficiary Summary
AC	Actual Charge
ACA	Affordable Care Act (2010)
ACA	Amputee Coalition of America
ACF	Administration for Children & Families
ACO	Accountable Care Organization
ACO	Administrative Contracting Officer
ACR	Adjusted Community (Contract) Rate
ACRP	Adjusted Community Rate Proposal
ACS	American Cancer Society
ACSI	American Customer Satisfaction Index
ACTG	AIDS Clinical Trials Group
ACYF	Administration on Children, Youth & Families
ADA	Americans with Disabilities Act (of 1990)
ADAP	AIDS Drug Assistance Program
ADC	Adult Day Care
ADL	Activities of Daily Living
ADMS	Alcohol, Drug Abuse & Mental Health Services
ADP	(Medicaid) Alternative Disposition Plan
ADP	Advance Planning Document
ADT	Admission/Discharge Transfer

AEP	Annual Coordinated Election Period
AFDC	Aid to Families with Dependant Children (Title IV of the SS Act)
AG	Attorney General
AHA -	American Heart Association
AHA	American Hospital Association
AHB	American Health Benefit (Exchanges)
AHRQ	Agency for Healthcare Research & Quality
AIC	Amount in Controversy
AKF	American Kidney Fund
ALJ	Administrative Law Judge
ALOS	Average Length of Stay
ALP	Assisted Living Program
ALR	Assited Living Residence
ALS	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
ALS	Advanced Life Support
ALT	Average Length of Treatment
AMA	American Medical Association
AMA	Against Medical Advice
ANA	Administration for Native Americans
ANA	American Nurses Association
ANOC	Annual Notice of Change (Medicare Part D)
AOA	Administration on Aging
APC	Ambulatory Payment Classifications
APD	Advanced Planning Documents
APTD	Aid to the Permanently & Totally Disabled
AQL	Acceptable Quality Level
ARA	Alliance for Retired Americans
ARC	American Red Cross
ARRA	American Recovery and Reinvestment Act (of 2009)
ASA	American Society on Aging
AWV	Annual Wellness Visit
B	
BAE	Best Available Evidence (Part D)
BBA	Balanced Budget Act (of 1997)

BBRA	Balanced Budget Refinement Act of 1999
BC/BS	Blue Cross/Blue Shield
BCB	Beneficiary Confidentiality Board
BCBSA	Blue Cross/Blue Shield Association
BCF	Benefit Correction Form
BI	Buy In
BIC	Beneficiary Identification Code
BIPA	(Medicare, Medicaid and SCHIP) Benefits and Improvement Act (of 2000)
BMI	Body Mass Index
BP	Benefit Period
C	
CA	Cancer
CAH	Critical Access Hospital
CAHPS	Consumer Assessments of Health Plans Survey
CASPER	Certification and Survey Provider Enhanced Reporting
CBA	Competitive Bidding Area
CBO	Community Based Organization
CBO	Congressional Budget Office
CCRC	Continuing Care Retirement Community
CDC	Centers for Disease Control
CDPAP	Consumer Directed Care
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (now known as TRICARE)
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
CHC	Community Health Center
CHHA	Certified Home Health Agency
CHIP	Child Health Insurance Program
CLT	Certified Lab Technician
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CN	Claim Number (also C/N)
COA	Change of Address
COB	Coordination of Benefits
COBA	Coordination of Benefits Agreement

COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act (of 1985)
COLA	Cost of Living Adjustment
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitative Facility
CPAP	Continuous Positive Airway Pressure
CPD	Competitive Pricing Demonstration
CPI	Consumer Price Index
CPT	(Physicians) Current Procedural Terminology
CVD	Cardiovascular Disease
D	
DBA	Daily Benefit Amount
DC	Discharge
DD	Developmental Disabilities
DFS	Department of Financial Services (formerly NYS Insurance Department)
DHHS	Department of Health & Human Services (Federal)
DI	Disability Insurance
DIS	Disabled (Beneficiary)
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DME POS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOB	Date of Birth
DOEH	Date of Entitlement to Hospital Insurance (Medicare Part A)
DOES	Date of Entitlement to Supplementary Medical Insurance (Part B)
DOL	Department of Labor
DOS	Date of Service
DRG	Diagnosis Related Groups
DSS	Department of Social Services
DUR	Drug Utilization Review
DVA	Department of Veterans Affairs (see VA)
DWA	Disabled Working Aged
DWB	Disabled Widow's Benefits
DWI	Disabled & Working Individual (see QDWI)
DX	Diagnosis

E

EGHP	Employer Group Health Plan
EH	Extra Help (Medicare Part D)
EISEP	Expanded In Home Services for the Elderly
EMTALA	Emergency Medical Treatment and Active Labor Act
EOB	Explanation of Benefits
EOC	Episode of Care
EOC	Evidence of Coverage
EOMB	Explanation of Medicare Benefits
EPIC	Elderly Pharmaceutical Insurance Coverage (NYS)
ERISA	Employee Retirement Income Security Act (of 1974)
ESRD	End-Stage Renal Disease
EHP	Essential Health Benefits Package

F

F&A	Fraud & Abuse
FAQ	Frequently Asked Question
FBR	Federal Benefit Rate
FDA	Food & Drug Administration
FEHB	Federal Employees Health Benefits (Program)
FFS	Fee for Service
FHP	Family Health Plus
FMAP	Federal Medical Assistance Percentage
FOIA	Freedom of Information Act
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FRA	Full Retirement Age
FSA	Flexible Spending Accounts
FY	Fiscal Year

G

GAO	Government Accountability Office
GEP	General Enrollment Period (Medicare Part B)
GHP	Group Health Plan
GSA	Gerontological Society of America

H

HAC	Hospital Acquired Condition
HCBS	Home & Community Based Services
HCBWP	Home & Community Based Waiver Program
HCERA	Health Care and Education Reconciliation Act (of 2010)
HEDIS	Healthplan Employer Data Information Sets
HHQI	Home Health Quality Initiative
HHA	Home Health Agency
HHRG	Home Health Resource Group
HHS	(Department of) Health & Human Services (also DHHS)
HIB	Hospital Insurance Benefits (Part A)
HICN	Health Insurance Claim Number
HIICAP	Health Insurance Information, Counseling & Assistance Program
HINN	Hospital-issued Notice of Non-Coverage
HIPAA	Health Insurance Portability & Accountability Act (of 1996)
HIX	Health Insurance Exchange
HMO	Health Maintenance Organization
HMO-POS	Health Maintenance Organization with a Point of Service Option
HNY	Healthy NY (New York)
HRA	Health Reimbursement Accounts
HRSA	Health Resources and Services Administration
HSA	Health Savings Account

I

IADL	Instrumental Activities of Daily Living
ICEP	Initial Coverage Election Period (Medicare Advantage)
IEP	Initial Enrollment Period
IEQ	Initial Enrollment Questionnaire
IHSS	In-home Supportive Services
IPPE	Initial Preventive Physical Exam
IPRO	Island Peer Review Organization
IRE	Independent Review Entity

J

JCAHO	Joint Commission for Accreditation of Health Organizations
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L

LCD	Local Coverage Determination
LEP	Late Enrollment Penalty (Medicare Part D)
LHCSA	Licensed Home Care Agency
LPN	Licensed Practical Nurse
LIS	Low Income Subsidy (AKA Extra Help) (Medicare Part D)
LPR	Lawful Permanent Resident (“Green Card” Holder)
LRD	Lifetime Reserve Days
LTC	Long Term Care
LTCF	Long Term Care Facility
LTCI	Long Term Care Insurance

M

MA	Medicare Advantage
MAC	Medicare Appeals Council
MAC	Medicare Administrative Contractor
MAP	Medicaid Advantage Plus
MADP	Medicare Advantage Disenrollment Period
MAGI	Modified Adjusted Gross Income
MAPD	Medicare Advantage Prescription Drug (Plan)
MBN	Medicare Benefit Notice
MCCAP	Managed Care Consumer Assistance Program
MCO	Managed Care Organization
MEDIC	Medicare Prescription Drug Integrity Contractor
MI	Medical Insurance (Part B or SMI)
MLR	Medical Loss Ratio
MLTC	(Medicaid) Managed Long Term Care
MLTCP	Managed Long Term Care Providers
MMA	Medicare Modernization Act
MMAAP	(AARP) Medicare/Medicaid Assistance Program
MMDDCCYY	Two-digit Month/Day/Century Year (i.e., 02/26/2001)
MMDDYY	MonthMonth/DayDay/YearYear
MOOP	Maximum Out of Pocket (Medicare Advantage)
MRC	Medicare Rights Center
MRT	Medicare Redesign Team (in New York State)

MSA	Medical Savings Accounts
MSN	Medicare Summary Notice
MSP	Medicare Savings Programs
MSP	Medicare Secondary Payer
MTMP	Medication Therapy Management Program
N	
NAIC	National Association of Insurance Commissioners
NASI	National Academy of Social Insurance
NCD	National Coverage Determination
NCI	National Cancer Institute
NCOA	National Change of Address (SSA & USPS)
NCOA	National Council on Aging
NCQA	National Committee for Quality Assurance
NCQHC	National Committee for Quality Health Care
NIA	National Institute on Aging
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NKF	National Kidney Foundation
NMEP	National Medicare Education Program
NODMAR	Notice of Discharge and Medicare Appeal Rights
NOMNC	Notice of Medicare Non-Coverage
NORC	Naturally Occurring Retirement Community
NYP\$	New York Prescription Saver (Discount Card)
NYS	New York State
NYS DOH	New York State Department of Health
NYSOFA	New York State Office for the Aging
NYSPLTC	New York State Partnership for Long-Term Care

O

OAC	OASIS Automation Coordinator
OBQM	Outcome Based Quality Monitoring
OEC	OASIS Educational Coordinator
OGC	(HHS) Office of the General Council
OIG	Office of the Inspector General
OMRDD	Office of Mental Retardation and Developmental Disabilities

OOP	Out Of Pocket
OP	Outpatient
OP	Overpayment
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy
OTC	Over the Counter
P	
PA	Prior Authorization
PA	Public Assistance
PA	Physician's Assistant
PACE	Program for All Inclusive Care for the Elderly
PCP	Primary Care Physician (or Provider)
PCIP	Pre-existing Condition Insurance Plan
PDP	Prescription Drug Plan
PEBS	Personal Earnings & Benefit (PEBES) Statement
PFSS	Private Fee-For-Service
PHR	Personal Health Record
PO	Post Office
POA	Power of Attorney
POS	Point of Sale
PPACA	Patient Protection and Affordable Care Act (of 2010)
PSO	Provider Sponsored Organization
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PT	Physical Therapy
Q	
Q&A	Questions & Answers
QDWI	Qualified Disabled & Working Individual
QI	Qualifying Individual
QIES	Quality Improvement Evaluation System
QIO	Quality Improvement Organization
QL	Quantity Limits (Medicare Part D)
QMB	Qualified Medicare Beneficiary

R

RDF	Renal Dialysis Facility
RFA	Reason for Assessment
RN	Registered Nurse
RHCF	Residential Health Care Facility
RNHCI	Religious Non-Medical Health Care Institution
ROC	Resumption of Care
RRB	Railroad Retirement Board

S

SAGE	Spending and Government Efficiency Commission in NYS
S&C	Survey and Certification
SCHIP	State Child Health Insurance Program
SEP	Special Enrollment Period
SFY	State Fiscal Year (April 1 to March 31)
SGA	Substantial Gainful Activity
SHI	Supplemental Health Insurance
SHIP	State Health Insurance Assistance Program (NY State HIICAP)
SHOP	Small Business Health Insurance Options Program
SLMB	Specified Low-income Medicare Beneficiary
SMI	Supplementary Medical Insurance (Medicare Part B)
SMP	Senior Medicare Patrol (Fraud and Abuse)
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SNT	Supplemental Needs Trust
SOB	Statement of Benefits
SPAP	State Pharmaceutical Assistance Program (NY State EPIC)
SS	Social Security
SSA	Social Security Act
SSA	Social Security Administration
SSA	State Survey Agency
SSANY	State Society on Aging of New York
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSN	Social Security Number

ST	Speech Therapy
ST	Step Therapy (Medicare Part D)
T	
TBD	To be determined
TBI	Traumatic Brain Injury
TDD	Telecommunications Device for the Deaf
TEP	Technical Experts Panel
TITLE I	Grants to States for old age & medical assistance for the aged
TITLE II	Federal old age, survivors & disability insurance benefits (OASDI)
TITLE IV	Grants to States for aid & services to needy families with children (AFDC)
TITLE X	Grants to States for aid to the blind (AB)
TITLE XIV	Grants to States for aid to the permanently & totally disabled (DI)
TITLE XIX	Grants to States for medical assistance programs (MAA) (Medicaid)
TITLE XVI	Grants to States for aid to the aged, blind and disabled (ABD) & Supplemental Security Income (SSI)
TITLE XVIII	Health Insurance (Medicare)
TITLE XX	State operated home health care entitlement program
TITLE XXI	State Child Health Programs
TPN	Total Parenteral Nutrition
TROOP	True Out-of-Pocket Costs (Part D)
TTY	Text Telephones
TWWIA	Ticket to Work & Work Incentives Act (of 1999)
U	
UCR	Usual, Customary, and Reasonable
UMW	United Mine Workers
UPS	United Parcel Service
USPS	United States Postal Service
V	
VA	Veterans Administration
W	
WC	Workers' Compensation

Y

Y2K	Year 2000
YOB	Year of Birth
YR	Year
YTD	Year-To-Date
YYYY	Year (i.e., mmddyyyy)

Z

ZIP+4	Nine-digit ZIP Code Plan
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