Glossary: Medicare Drug Coverage (Part D) Mini-Course & Podcast Series

- **Appeal**—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare drug plan. You can appeal if Medicare or your plan denies one of these:
  - Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
  - Your request for payment for a health care service, supply, item, or prescription drug you already got
  - Your request to change the amount you must pay for a health care service, supply, item or prescription drug

  You can also appeal if Medicare or your plan stops providing or paying for all or part of a service, supply, item, or prescription drug you think you still need.
- **Catastrophic coverage**—The level of coverage you get after you spend the annual maximum out-of-pocket amount for drugs covered under your Medicare drug plan (Part D). It assures that you pay only a small coinsurance percentage or copayment for covered drugs for the rest of the year.
- **Claim**—A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.
- **Coinsurance**—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).
- **Conditional payment**—A payment made by Medicare for services for which another payer is responsible.
- **Coordination of benefits (COB)**—A process for determining which plan or insurance policy will pay first if 2 or more health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, federal law may decide who pays first.
- **Copayment**—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
- **Coverage determination (Part D)**—The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including whether a particular drug is covered, whether you've met all the requirements for getting a requested drug, how much you're required to pay for a drug, and whether to make an exception to a plan rule when you request it. The drug plan must give you a prompt decision (72 hours for standard requests, 24 hours for expedited requests). If you disagree with the plan's coverage determination, the next step is an appeal.

- **Coverage gap**—A period of time in which you pay higher cost sharing for prescription drugs until you spend enough to qualify for catastrophic coverage. The coverage gap (also called the "donut hole") starts when you and your plan have paid a set dollar amount for prescription drugs during that year.
- **Creditable drug coverage**—Drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard drug coverage. People who have this kind of coverage when they become eligible for Medicare, can generally keep that coverage without paying a penalty if they decide to enroll in Medicare drug coverage later.
- **Deductible**—The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay.
- **Drug list**—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering drug benefits. This list is also called a formulary.
- **End-Stage Renal Disease (ESRD)**—Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.
- **Exception**—A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its nonpreferred drug tier. You or your prescriber must request an exception, and your doctor or other prescriber must provide a supporting statement explaining the medical reason for the exception.
- **Extra Help**—A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.
- **Federal Black Lung Benefits Program**—A program authorized by the Black Lung Benefits Act, which provides monthly payments and medical benefits to coal miners totally disabled from pneumoconiosis (black lung disease) arising from their employment in or around the nation's coal mines.
- **Formulary**—A list of prescription drugs covered by a drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.
- **Generic drug**—A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.
- **Group health plan (GHP)**—In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.
- **Initial Enrollment Period (IEP)**—The first chance you have to enroll in Medicare. Your IEP starts 3 months before you first meet all the eligibility requirements for Medicare and lasts for a total of 7 months.
- **Late enrollment penalty**—An amount added to your monthly premium for Part A, Part B, or your Medicare drug coverage (Part D), if you don't join when you're first eligible. For Part A, the penalty is temporary. For Part B and Part D, you pay the penalty as long as you have Medicare. (There are some exceptions.)
- **Liability insurance**—Insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.

- **Medicaid**—A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- **Medicare**—The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).
- **Medicare Advantage Plan (Part C)**—A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include:
    - Health Maintenance Organizations
    - Preferred Provider Organizations
    - Private Fee-for-Service Plans
    - Special Needs Plans
    - Medicare Medical Savings Accounts Plans

  If you've enrolled in a Medicare Advantage Plan:
    - Most Medicare services are covered through the plan.
    - Most Medicare services aren't paid for by Original Medicare.
    - Most Medicare Advantage Plans offer drug coverage.
- **Medicare Cost Plan**—A type of Medicare health plan available in some areas. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare (your Cost Plan pays for emergency services or urgently needed services).
- **Medicare drug coverage (Part D)**—Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare. Also see Medicare drug plan (Part D).
- **Medicare drug plan (Part D)**—Part D adds drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer drug coverage that follows the same rules as Medicare drug plans.
- **Medicare Medical Savings Account (MSA) Plan**—MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. You can use the money in this account to pay for your health care costs, but only Medicare-covered expenses count toward your deductible. The amount deposited is usually less than your deductible amount so you generally will have to pay out-of-pocket before your coverage begins.
- **Medicare Part A (Hospital Insurance)**—Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- **Medicare Part B (Medical Insurance)**—Covers certain doctors' services, outpatient care, medical supplies, and preventive services.

- **Medicare Private Fee-for-Service (PFFS) Plan**—A type of Medicare Advantage Plan (Part C) in which you can generally go to any doctor or hospital you could go to if you had Original Medicare, if the doctor or hospital agrees to treat you. The plan determines how much it will pay doctors and hospitals, and how much you must pay when you get care. A Private Fee-for-Service Plan is very different than Original Medicare, and you must follow the plan rules carefully when you go for health care services. When you're in a Private Fee-for-Service Plan, you may pay more or less for Medicare-covered benefits than in Original Medicare.
- **Medicare Savings Program (MSP)**—A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.
- **Network**—Facilities, providers, and suppliers that have a contract with your plan to provide services (for non-emergency care). In some plans, you must get non-emergency care within their network. Others offer non-emergency coverage out of network, but typically at a higher cost.
- **No-fault insurance**—Insurance that may pay for health care services you get if you're injured or your property gets damaged in an accident, regardless of who's at fault for causing the accident. Some types of no-fault insurance include automobile plans, homeowners' plans, and commercial insurance plans.
- **Original Medicare**—A fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).
- **Out-of-pocket costs**—Health or prescription drug costs that you must pay on your own because they aren't covered by Medicare or other insurance.
- **Part D-Income Related Monthly Adjustment Amount (IRMAA)**—If your modified adjusted gross income as reported on your Internal Revenue Service (IRS) tax return from 2 years ago is above a certain amount, you'll pay an Income Related Monthly Adjustment Amount, also known as Part D-IRMAA. This is an extra charge added to your premium.
- **Premium**—The periodic payment to Medicare, an insurance company, or a health care plan for health or drug coverage.
- **Primary payer**—The insurance policy, plan, or program that has primary responsibility for paying a claim.
- **Prior authorization**—Approval that you must get from a Medicare drug plan before you fill your prescription in order for the prescription to be covered by your plan. Your Medicare drug plan may require prior authorization for certain drugs.
- **Programs of All-Inclusive Care for the Elderly (PACE)**—A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of still living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.
- **Secondary payer**—The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.
- **State Pharmaceutical Assistance Program (SPAP)**—A state program that provides help paying for drug coverage based on financial need, age, or medical condition.

- **Step therapy**—A coverage rule used by some Medicare drug plans that requires you to try one or more similar, lower cost drugs to treat your condition before the plan will cover the prescribed drug.
- **Tiers**—Groups of drugs that have a different cost for each group. Generally, a drug in a lower tier will cost you less than a drug in a higher tier.
- **True out-of-pocket (TrOOP) costs**—Expenses that count toward your Medicare drug plan's out-of-pocket threshold.
- **Workers' compensation**—An insurance plan that employers are required to have to cover employees who get sick or injured on the job.

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April 2023

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