Medicare Glossary Of Terms

Plain-language definitions of the Medicare words and phrases you will meet while choosing and using your coverage.

Medicare comes with a vocabulary all its own, and the jargon can feel overwhelming. This glossary defines the terms you are most likely to encounter, grouped by topic and written in plain English. Keep it nearby as you compare plans, read mail from your insurer, or talk with a licensed agent.

The Parts Of Medicare

Part A is hospital insurance. It helps cover inpatient hospital stays, skilled nursing care, hospice, and some home health services. Most people who worked and paid Medicare taxes long enough owe no premium for Part A.

Part B is medical insurance. It helps pay for doctor visits, outpatient care, lab work, and preventive services. Part B carries a monthly premium that CMS sets each year, and higher earners may pay more.

Part C is Medicare Advantage. These private plans bundle Part A and Part B, and usually Part D, into one package. They often add extra benefits but use provider networks.

Part D is prescription drug coverage. It is offered through private plans, either as a standalone drug plan or built into a Medicare Advantage plan. Each Part D plan has its own list of covered medications.

Enrollment And Timing Terms

Your Initial Enrollment Period is the seven-month window around your 65th birthday. It begins three months before your birthday month and ends three months after. Enrolling on time helps you avoid gaps and penalties.

The Annual Enrollment Period runs each fall. During this window you can join, switch, or drop Medicare Advantage and Part D plans for the coming year. Changes generally take effect on January 1.

A Special Enrollment Period is a window triggered by a life event. Losing employer coverage, moving out of a plan's service area, or other changes can open one. These periods let you adjust coverage outside the usual schedule.

The Medicare Advantage Open Enrollment Period runs early in the year. It gives current Advantage members one chance to switch plans or return to Original Medicare. A late enrollment penalty may apply if you delay certain coverage without a valid reason.

Cost-Sharing Terms

A premium is the amount you pay for coverage, usually every month. You may owe premiums for Part B, Part D, and any Medigap or Advantage plan you choose. Some plans advertise a very low premium, though other costs may apply.

A deductible is the amount you pay before your plan begins to share costs. Parts A, B, and D each can carry their own deductible. These amounts are set annually, so confirm the current figures with a licensed agent.

A copay is a fixed dollar amount you pay for a service, such as a doctor visit. Coinsurance is a percentage of the cost you pay instead of a flat fee. Both are forms of cost-sharing that continue after you meet a deductible.

The out-of-pocket maximum is the yearly cap on what you pay for covered services. Once you reach it, the plan covers the rest for the year. Original Medicare has no such cap on its own, which is one reason many people add other coverage.

Coverage And Plan Types

Original Medicare refers to Part A and Part B together, managed by the federal program. It lets you see any provider who accepts Medicare, with no network. Many people pair it with a Medigap policy and a Part D plan.

Medigap, also called Medicare Supplement, is private insurance that helps pay costs Original Medicare leaves behind. It can cover deductibles, copays, and coinsurance depending on the plan letter you choose. Medigap uses no network, so it travels well nationwide.

Medicare Advantage is the all-in-one alternative to Original Medicare. These plans include your Part A and Part B benefits and usually add drug coverage. They often include extra benefits but require you to use their networks.

Extra Help is a program that lowers Part D costs for people with limited income. Medi-Cal is California's Medicaid program, which works alongside Medicare for those who qualify for both. Together these programs form an important safety net.

Prescription Drug Terms

A formulary is a plan's list of covered medications. Drugs are arranged in tiers, and each tier carries a different cost. Checking that your medications appear on a plan's formulary is a key step in choosing coverage.

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A tier is a cost level within the formulary. Lower tiers usually hold generic drugs with smaller copays, while higher tiers hold pricier brand-name and specialty drugs. Two plans can place the same drug on different tiers.

Prior authorization means your plan must approve certain drugs before it will cover them. Step therapy asks you to try a lower-cost drug first before moving to a costlier one. These rules are meant to manage cost and safety.

The coverage gap, sometimes called the donut hole, is a phase in some drug plans where your share of costs can change. Rules around this phase are updated over time. A licensed agent can explain how the current structure affects your medications.

Provider And Network Terms

A network is the group of doctors, hospitals, and pharmacies a plan contracts with. Medicare Advantage plans use networks, while Original Medicare does not. Staying in network usually means lower costs.

An HMO plan generally asks you to use in-network providers and choose a primary care doctor. A PPO plan offers more flexibility to see out-of-network providers, often at a higher cost. The right structure depends on how you like to receive care.

A referral is approval from your primary doctor to see a specialist. Some plans require referrals, while others let you self-refer. Knowing your plan's rules prevents surprise bills.

Assignment means a provider agrees to accept the Medicare-approved amount as full payment. Providers who accept assignment help keep your out-of-pocket costs predictable. Confirming this before an appointment can save you money.

Documents And Help Terms

The Annual Notice of Change is a letter your plan mails each fall. It explains what will change in your coverage for the coming year, from premiums to drug lists. Reading it carefully is the first step in any yearly review.

The Evidence of Coverage is the detailed document describing exactly what your plan covers. It spells out costs, rules, and your rights as a member. Keep it handy as a reference throughout the year.

A licensed agent is a professional who is trained and authorized to help you compare and enroll in Medicare plans. A working with an independent agency means you can review options from several carriers. Because figures and rules change every year, an agent helps you confirm current details.

Guaranteed issue rights protect your ability to buy certain Medigap policies without medical underwriting. These rights apply in specific situations and time windows. Understanding when they apply can protect your future coverage choices.

More Terms Worth Knowing

Medical underwriting is the health review an insurer may use when you apply for coverage. Depending on the situation, it can affect your price or approval for a Medigap policy. During certain windows, underwriting does not apply. Knowing these windows can protect your options.

A benefit period, used with Part A, measures a span of inpatient care. It begins when you are admitted and ends after you have been out for a set number of days. Each new benefit period can bring its own deductible. This is different from a calendar year.

Creditable coverage means prior drug or health coverage that is at least as good as Medicare's standard. Keeping proof of creditable coverage can help you avoid a late penalty later. Employer plans often qualify, but it is worth confirming. A licensed agent can help you check.

A Special Needs Plan is a type of Medicare Advantage plan built for people with specific conditions or situations. Some serve people with both Medicare and Medi-Cal, while others focus on chronic conditions. These plans tailor benefits to a defined group. They are not right for everyone, so review the details carefully.

Frequently Asked Questions

What is the difference between a copay and coinsurance?

A copay is a fixed dollar amount you pay for a service, such as twenty dollars for a visit. Coinsurance is a percentage of the cost, such as twenty percent. Both are forms of cost-sharing that can apply after you meet a deductible.

What does out-of-pocket maximum mean?

It is the yearly cap on what you pay for covered services. Once you reach it, your plan covers the rest for the year. Original Medicare alone has no such cap, which is why many people add other coverage.

What is a formulary?

A formulary is your drug plan's list of covered medications, arranged in cost tiers. The tier a drug falls on affects how much you pay. Checking that your medications are on a plan's formulary is a key step before enrolling.

Is Medigap the same as Medicare Advantage?

No. Medigap supplements Original Medicare by helping pay costs it leaves behind, and it uses no network. Medicare Advantage replaces the way you get your benefits and uses a network. They are different approaches, and you generally choose one path.

Why do the dollar figures keep changing?

Medicare premiums, deductibles, and other amounts are updated every year. That is why this glossary describes them generally rather than listing exact numbers. Always confirm the current figures with a licensed agent before you decide.

What is the Annual Notice of Change?

It is a letter your plan sends each fall explaining what will change for the coming year. It covers premiums, drug lists, and network updates. Reading it is the first step in reviewing your coverage.

Talk It Through, at No Cost

This guide is educational. Plan details and figures change, so confirm current specifics with a licensed local agent. Call (714) 922-0043 or visit hsocal.com to book a free 45-minute review.

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