Section Four

Additional Resources

Low Income Subsidy—LIS

NEED HELP PAYING FOR YOUR PRESCRIPTION DRUGS?

If you have Medicare, you may qualify for help in paying for your prescription drug plan.

To qualify you must have an income below 150% of the Federal Poverty Line and have limited assets.

To ask questions or to find out if you may qualify, call Volunteers Assisting Seniors at (402) 444-6617

Glossary of Terms

APPROVED CHARGE (ALLOWABLE CHARGE)	The amount Medicare or other insurers will use as a basis for determining how much they will pay for a service or piece of equipment.
ASSIGNMENT	The physician or supplier who "accepts assignment" under Medicare Part B agrees to accept Medicare's approved charge as payment in full. That means that after Medicare pays 80 percent of the approved amount, a doctor who accepts assignment can bill the patient for only the additional 20 percent of the approved charge.
BENEFIT PERIOD	Tracks the number of days covered by Medicare as an inpatient in the hospital or skilled nursing facility. Each benefit period has a new deductible.
CLAIM	A claim is what is submitted to your insurance company. This is a summary of what services were provided and when. It is the bill that is sent to the insurance company.
COINSURANCE	The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.
CONTINUOUS COVERAGE	Means there is no gap in medical coverage for more than 63 days. This will allow beneficiaries to overcome waiting periods set by Medicare Supplement plans.
COPAYMENT	In some Medicare health and prescription drug plans, the amount you pay for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount you pay. For example, this could be $10 or $20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.
COST SHARING	The amount you pay for health care and/or prescriptions. This amount can include copayments, coinsurance, and/or deductibles.
CREDITABLE COVERAGE	Coverage that is equal to or better than Medicare coverage.
DUAL ELIGIBLE	This is a beneficiary who is eligible for both Medicare and full Medicaid benefits.
DURABLE MEDICAL EQUIPMENT (DME)	Certain medical equipment that is ordered by a doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Glossary of Terms Continued

END-STAGE RENAL DISEASE (ESRD)	Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.
EXCESS CHARGES	The amount that a doctor or provider bill exceeds the Medicare-approved charge. Doctors are limited to 15 percent, medical suppliers have no limit. Also known as balance billing.
FORMULARY	A plan's list of covered prescription medications. This will also list any tiers or restrictions on the medications.
GUARANTEE ISSUE OPPORTUNITY	Certain life changing events trigger this opportunity in regards to Medicare Supplement Insurance. During this time an insurance policy will be issued to anyone, regardless of health.
HOME HEALTH CARE	Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
HOSPICE	A public agency or private organization that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families.
INPATIENT	Health care that you get when you are admitted to a hospital or skilled nursing facility.
LIFETIME RESERVE DAYS	Days 91-150 of a benefit period. They are not renewable. Once you use them, they are not available for future benefit periods.
MEDICALLY NECESSARY	Physician's determination that specific treatment is required. Medicare and insurance policies typically will pay only for services that are "medically necessary." Medicare or your insurance company may not agree with your doctor's opinion.
MEDICARE ADVANTAGE PLAN	A plan offered by a private company who contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plans, and are not paid for under Original Medicare.
NON-PARTICIPATING PROVIDER	These are providers who have contracted with Medicare but they do not have to accept Medicare assignment as payment in full. They are required to have a provider number. They bill Medicare directly, but the payment will be sent to the beneficiary to pay the provider.
OUTPATIENT	A patient who receives care at a hospital or other health facility without being admitted to the facility. Outpatient care also refers to care given in other locations such as outpatient clinics.
PARTICIPATING PROVIDER	These are providers who have contracted with Medicare to accept Medicare assignment. They are required to obtain a Medicare number and to work with Medicare directly.

Glossary of Terms Continued

PARTICIPATING PROVIDER	These are providers who have contracted with Medicare to accept Medicare assignment. They are required to obtain a Medicare number and to work with Medicare directly.
PRE-EXISTING CONDITION	A condition for which medical advice was given or treatment recommended within the past 6 months.
PRIMARY CARE DOCTOR	A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she may talk with other doctors and health care providers about your care and refer you to them. In many HMOs, you must see your primary care doctor before you can see any other health care provider.
PROVIDER	Someone who provides medical services or supplies, such as a physician, hospital, x-ray company, home health agency or pharmacy.
REFERRAL	A written order from your primary care doctor for you to see a specialist or get certain services. In many HMOs, you need to get a referral before you can get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.
REHABILITATION	Rehabilitative services are ordered by your doctor to help you recover from an illness or injury. These services are given by nurses and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.
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 you if you move out of the plan's service area.
SKILLED NURSING FACILITY (SNF)	A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.
SPECIALIST	A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.
SPEECH-LANGUAGE THERAPY	Treatment to regain and strengthen speech skills.
UNDERWRITING	The process an individual must go through before being insured. Allows companies to look at health history, medical records and pre-existing conditions.

Frequently Used Numbers

Federal Employee Health Benefits Program	1-888-767-6738
Coordination of Benefits Office	1-800-999-1118
Medicare	1-800-633-4227
Medicaid (Omaha)	1-402-595-1178
Railroad Retiree Board	1-402-221-4641
SHIIP	1-800-234-7119
SMP	1-800-234-7119
SSA	1-866-716-8299
TRICARE	1-888-874-9378
Veterans' Affairs	1-800-733-8387
Volunteers Assisting Seniors (VAS)	1-402-444-6617

FACT: It is estimated that $1 out of every $10 spent on public insurance programs is lost to fraud. The Nebraska helps people identify and report possible Medicare or Medicaid fraud, error and waste. To discuss possible fraud issues or for more information contact the SMP program at 1-800-234-7119.

Volunteers Assisting Seniors
1941 South 42 Street, Suite 312
Omaha, NE 68105
Phone: (402) 444-6617
www.vas-nebraska.com