

Glossary of Important Terms



Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing their teeth.

Aid paid pending: You can continue receiving certain Healthy Connections Medicaid services while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called “aid paid pending.”

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge your plan’s action if you think they made a mistake. You can ask your plan to change a coverage decision by filing an appeal. Chapter 9 of your member handbook explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan’s cost sharing amount for services. Healthy Connections Prime does not allow providers to “balance bill” you. Call your plan’s Member Services if you get any bills that you do not understand.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care coordinator/care manager: The main person who works with you, with your Medicare-Medicaid plan, and with your care providers to make sure you get the care you need.

Care plan: A plan developed specifically for you about what health services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.. You are an important member of the care team and can also include other family members or friends.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, your network providers, or your network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

Comprehensive Assessment: A review aimed at getting a deeper look at your medical needs, social needs, and capabilities. Your plan will get information from you, your providers, and family/caregivers when appropriate. This assessment will be done by qualified and trained health professionals, such as nurses, social workers, and care coordinators/care managers.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coordinated and Integrated Care Organization (CICO): Another name for a Medicare-Medicaid Plan.

Copayment (or Copay): A fixed amount you pay as your share of the cost each time you get a service or supply. For example, you might pay \$2 or \$5 for a service or a prescription drug.

Cost sharing: Amounts you have to pay when you get services or drugs. Cost sharing includes copayments and coinsurance.

Cost sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs (Formulary)* is in one of cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug. However, your plan may have \$0 copay for all tiers of drugs.

Coverage decision: A decision about what benefits your plan cover. This includes decisions about covered drugs and services or the amount your plan will pay for your health services. Chapter 9 of your *Member Handbook* tells you how to ask your plan for a coverage decision.

Covered drugs: The term your plan uses to mean all of the prescription drugs they cover.

Covered services: The general term your plan uses to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by your plan.

Disenrollment: The process of ending your membership in your plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). An example of a cause of involuntary disenrollment is when you no longer qualify for Healthy Connections Medicaid.

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem to a neutral hearing officer and show that a decision your plan made is wrong.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about your plan or one of their network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators/care managers to help you manage all your providers and services. They all work together to provide the care you need.

Healthy Connections Medicaid: South Carolina's Medicaid program. For more information, see the definition of "Medicaid" below.

Healthy Connections Prime: A demonstration program jointly run by South Carolina and the federal government to provide better health care for people who have both Medicare and Healthy Connections Medicaid.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a life-limiting or terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. ~~An enrollee~~A member who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. Your plan must give you a list of hospice providers in your geographic area.

Independent Review Entity (IRE): An organization that is hired by the Centers for Medicare & Medicaid Services (CMS) to conduct a Level 2 appeal review for a service or item that is covered by Medicare-only or by both Medicare and Health Connections Medicaid. If your plan denies approval for such a service or item during a Level 1 appeal, the denied appeal is sent to the IRE to conduct a Level 2 review. The IRE is not connected to your plan and is not a government agency. Please see Chapter 9 of your *Member Handbook* for more information about Level 2 appeals.

Initial coverage stage: The stage before your total Part D drug expenses reach the initial coverage limit. This includes amounts you have paid, what your plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

Initial health screen: A review of your medical history and current condition. It is used to figure out your health and how it might change in the future.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

List of Covered Drugs (Drug List): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income subsidy (LIS): See “Extra Help.”

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2 of your *Member Handbook* for information about how to contact Medicaid ~~in your state~~.

Medically necessary: Services that are reasonable and necessary:

- For the diagnosis or treatment of your illness or injury; **or**
- To improve the functioning of a malformed body member; **or**
- Otherwise medically necessary under Medicare law.

In accordance with Healthy Connections Medicaid law and regulation, services are medically necessary if:

- They are essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity; **and**
- They are provided at an appropriate facility at the appropriate level of care for the treatment of your medical condition; **and**
- They are provided in accordance with generally accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease

(generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see “Health plan”).

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including your plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Healthy Connections Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dual eligible beneficiary.” Also see the definition of “member” below.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program (called “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Healthy Connections Medicaid. Healthy Connections Prime includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Healthy Connections Medicaid may cover some of these drugs.

Member (member of a plan, or plan member): A person with Medicare and Healthy Connections Medicaid who qualifies to get covered services, who has enrolled in a plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the State.

Member Handbook and Disclosure Information: A document from your health plan, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what your plan must do, your rights, and what you must do as a member of your plan.

Member Services: A department within your plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 of your *Member Handbook* for information about how to contact Member Services.

Model of care: How a health plan delivers services to members. Each plan might define their model of care differently. Please refer to the plan websites and handbooks for more information on their individual models of care.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for your plan's members. These are called "network pharmacies" because they have agreed to work with your plan. In most cases, your prescriptions are covered only if they are filled at one of your plan's network pharmacies.

Network provider: "Provider" is the general term for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide you with health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services. They are called "network providers" when they agree to work with your plan and accept their payment and not charge their members an extra amount. While you are a member of a plan, you must use its network providers to get covered services. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that helps you if you are having problems with your plan. The ombudsman's services are free. The Healthy Connections Prime Advocate is the ombudsman for people enrolled in Healthy Connections Prime. Please see Chapter 2 of your *Member Handbook* for information on how to contact the Healthy Connections Prime Advocate.

Organization determination: When the plan or one of its providers makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are also called "coverage decisions." Chapter 9 of your *Member Handbook* explains how to ask your plan for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers in amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in your plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with your plan to coordinate or provide covered drugs to members of your plan. Most drugs you get from out-of-network pharmacies are not covered by your plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by your plan and is not under contract to provide covered services to members of the plan. Chapter 3 of your *Member Handbook* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. See the definition for “cost sharing” above. Please note that, depending on your plan, there may be a small copayment for a few services or items covered by Medicaid but not by Medicare.

Part A: See “Medicare Part A.”

Part B: See “Medicare Part B.”

Part C: See “Medicare Part C.”

Part D: See “Medicare Part D.”

Part D drugs: See “Medicare Part D drugs.”

Primary Care Provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many plans, you must see your primary care provider before you see any other health care provider. See Chapter 3 of your *Member Handbook* for information about getting care from primary care providers.

Prior authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from your plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4 of your *Member Handbook*. Some drugs are covered only if you get prior authorization from your plan. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include but are not limited to: arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2 of your *Member Handbook* for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that your plan covers per prescription.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4 of your *Member Handbook* to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members. You may be involuntarily disenrolled if you move outside of your plan's service area.

Skilled nursing facility (SNF): A nursing home with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Medicaid agency: The South Carolina Department of Health and Human Services (SCDHHS) is designated as the single state agency for the administration of the Medicaid program (called "Healthy Connections Medicaid") in South Carolina. SCDHHS is a cabinet-level agency under the Governor of the State of South Carolina.

Step therapy: A coverage rule that requires you to first try another drug before your plan will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

إذا كانت لغتك الأساسية غير اللغة الانكليزية فإن خدمات المساعدات اللغوية متوفرة لك مجاناً. اتصل على الرقم:
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