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Glossary

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z ALL

TERM	DEFINITION
Annual Deductible	The amount you must pay for your health care or prescriptions before Original Medicare, your pr your Medicare Health Plan, or your other insurance begins to pay. These amounts can change ev If "Under Review" appears, it means that the coverage is still being discussed by Medicare and th
Any Willing Doctor	A doctor, hospital, or other health care provider that agrees to accept the plan's terms and condi and that meets other requirements for coverage
Approval Status	If Medicare has approved the coverage and costs offered by the company for the year 2010. "As organization" means the company has a current contract with Medicare, but Medicare is still disc costs offered by the company for 2010.
Assignment	An agreement by your doctor or other supplier to be paid directly by Medicare, to accept the pay approves for the service, and not to bill you for any more than the Medicare deductible and coins
Average annual drug costs	The average amount you might expect to spend each year for prescription drugs, depending on y
Benefit Period	The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) s begins the day you go to a hospital or SNF. The benefit period ends when you haven't received a care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one b a new benefit period begins. You must pay the inpatient hospital deductible for each benefit perio the number of benefit periods.
Catastrophic Coverage	Once you reach your plan's out-of-pocket limit during the coverage gap, you automatically get "c Catastrophic coverage assures that once you have spent up to your plan's out-of-pocket limit for pay a small coinsurance amount or a copayment for the rest of the year.
Choose Any Doctor/Any Hospital	There are no networks - you can go to any doctor, supplier, hospital or other facility that particip accepting new Medicare patients.
Cobrand	Refers to the partner relationships established between Medicare Prescription Drug Plans and oth drug plans enter into agreements with other organizations to help market their drug plans. These between the drug plan and the partner organizations and are outside of the contract with Medica
Coinsurance	An amount you may be required to pay as your share of the cost for services after you pay any d is usually a percentage (for example, 20%). In a Medicare Prescription Drug Plan or Medicare He coinsurance will vary depending on how much you have spent.
Company Name	Name of company that contracts with Medicare to offer a Medicare Prescription Drug Plan or a Me number next to the name is for Medicare's use only.)
Copayment	An amount you may be required to pay as your share of the cost for a medical service or supply, prescription. A copayment is usually a set amount, rather than a percentage. For example, you n a doctor's visit or prescription.
Cost Sharing	The amount you pay for health care and/or prescriptions. This amount can include copayments, deductibles.
Coverage Gap	Medicare drug plans may have a "coverage gap," which is sometimes called the "donut hole." Thi and your plan have spent a certain amount of money for covered drugs, you have to pay all cost drugs (up to a limit). Your yearly deductible, coinsurance or copayments, and what you pay in th toward this out-of-pocket limit. The limit doesn't include the drug plan's premium. **Note:** If you get extra help paying your drug costs, you won't have a coverage gap. However, yo pay a small copayment or coinsurance amount.

Deductible	The amount you must pay for health care or prescriptions, before Original Medicare, your Medicare drug plan, your Medicare Health Plan, or your other insurance begins to pay. For example, in Original Medicare, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.
Demonstration/Pilot Program	Special projects that test improvements in Medicare coverage, payment, and quality of care. Some follow Medicare Advantage rules, but others don't. Demonstrations are usually for a specific group of people and/or are offered only in specific areas. There are also pilot programs for people with multiple chronic illnesses designed to reduce health risks, improve quality of life, and provide savings.
Disenroll	Ending your health care and/or prescription drug coverage with a health plan or drug plan.
Drug Coverage	This tells you that a plan offers drug coverage and provides information about the coverage.
Drug Restrictions	The plan may have certain coverage rules (including quantity limits, prior authorization, and step therapy) on the prescription drug coverage provided.
Employer or Union Retiree Plans	Plans that give health and/or drug coverage to employees, former employees, and their families. These plans are offered to people through their (or a spouse's) current or former employer or employee organization.
Enhanced Alternative Plan	A plan that can offer a more comprehensive level of coverage, with lower cost and/or additional coverage of certain drugs not included in the standard or basic levels of coverage. Premiums may be higher for these plans.
Estimated Annual Cost	When using this tool, this is an estimate of the average amount you might expect to spend each year for your health and/or drug coverage. The estimates include the following: Plan benefits (coverage) Costs for premiums, copayments, deductibles, coinsurance Costs not covered by your insurance Your out-of-pocket costs are based on actual health and/or drug coverage use by people with Medicare, and they may differ depending on your age and health status. Also, if you have limited income and resources, your expenses may be lower.
Estimated Annual Drug Costs	This is an estimate of the average amount you might expect to pay each year for your prescription drug coverage. This estimate includes the following costs, as applicable: Monthly premiums Annual deductible Drug copayments/coinsurance Drug costs not covered by prescription drug insurance If you entered your drugs into the Medicare Plan Finder, then this estimate includes the cost of those drugs. If you selected "I don't take any drugs," then this amount includes only the cost of the monthly premiums that you would pay for the plan. It does not include any drug costs. If you selected "I don't want to add drugs now," then this estimates includes the average drug costs for people with Medicare and may differ depending on your age and health status. Your expenses may be lower if you have limited income and resources.
Favorites	Your "favorites" are plans that you're interested in. When you're trying to decide which plan to join, you can create a list of plans you're interested in so that you can return to the Medicare Prescription Drug Plan Finder later and still be able to see those plans. To add or remove plans from your list of "favorites", click the "Add" or "Remove" buttons on the right side of screen under the "favorites" column.
Formulary	A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.
Full Benefit Dual Eligibles	People who qualify for both Medicare and Medicaid.
Full Extra Help	People who qualify for the full low-income subsidy for Medicare prescription drug coverage. People who get full Extra Help pay $0 for their monthly Medicare drug plan premium, $0 deductible, and no more than $2.50 (generic) or $6.30 (brand) for their prescriptions.
Full Subsidy Eligible	A person who either gets help from their state Medicaid program paying their Part B premiums (belong to a Medicare Savings Program) or who gets Supplemental Security Income (SSI) benefits. If you are full subsidy eligible, you get the full amount of extra help.
Full Year Cost at Network Retail Pharmacies	The total costs for your selected drugs when you use a network retail pharmacy. Actual amounts may vary depending on the number of months left in the year.

Full Year Cost with enrollment today	The total costs for your selected drugs if your enrollment starts at the beginning of next month. Costs calculations account for months that have already passed.
Full Year Cost with January enrollment	The total costs for your selected drugs if your enrollment starts in January.
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. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.
Guaranteed Issue Rights	Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, and can't charge you more for a policy because of past or present health problems.
Guaranteed Issue Rights	Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a policy, or place conditions on a policy, such as exclusions for pre-existing conditions, and can't charge you more for a policy because of past or present health problems.
Health Benefits	This tells you that the plan offers health coverage and that your costs may vary depending on the services offered.
Health Maintenance Organization (HMO)	A type of Medicare Health Plan that is available in most areas of the country. Plans must cover all Medicare Part A and Part B services. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency.
High-Deductible Medigap Policy	A type of Medigap policy that has a high deductible but a lower premium. You must pay the deductible before the Medigap policy pays anything. The deductible amount can change each year.
I don't get any Extra help	You don't qualify for extra help.
If I Qualify for Extra Help, will My Full Premium be Covered?	When using the Medicare Prescription Drug Plan Finder, if $0 appears under the premium column, it means that the extra help you get will cover the premium for that plan. If an amount of $1 or greater appears under the premium column, it means you will have to pay part of the premium because the extra help won't cover all of it. You would be responsible for paying this monthly amount if you choose to enroll in that plan.
Independent Reviewer	An independent reviewer, also known as an independent review entity (IRE), is an outside organization that has a contract with Medicare. If you appeal a decision about your coverage or if your plan doesn't make a timely appeals decision, the IRE may review your case. The IRE has no connection to the plan. Look at the materials your plan sends you each year, such as the Evidence of Coverage (EOC), for more details about the appeals process. Click here for more information on Medicare appeals: **www.medicare.gov/basics/appeals.asp**
Initial Coverage Limit	Once you have met your yearly deductible, and until you reach the plan's out-of-pocket maximum, you pay a copayment (a set amount you pay) or coinsurance (a percentage of the total cost) for each covered drug.
In-Network	Doctors, hospitals, pharmacies, and other healthcare providers that have agreed to provide members of a certain insurance plan with services and supplies at a discounted price. In some insurance plans, your care is only covered if you get it from in-network doctors, hospitals, pharmacies, and other healthcare providers.
May Have Doctor/Hospital Network	You may have to get care and services from doctors or hospitals in the plan's network, or pay a higher cost to see out-of-network providers. In all plan types, you're always covered for emergency care.
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.
Medically Necessary	Services or supplies that are needed for the diagnosis or treatment of your medical condition and accepted standards of medical practice.
Medicare Advantage Plans	A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare.
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 Health and Prescription Drug Plans	A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.

	If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.
Medicare Health Plans	A plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare Health Plans include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).
Medicare Medical Savings Account (MSA) Plan	A type of Medicare Advantage 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 Prescription Drug Plan	A stand-alone drug plan that adds prescription 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 prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.
Medicare Savings Program	A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.
Medicare Special Needs Plan	A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or have certain chronic medical conditions
Medicare-approved Amount	In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.
Medigap Basic Benefits	All Medigap policies must cover a basic set of benefits. These basic benefits include most Medicare Part A and B coinsurance amounts, blood, and additional hospital benefits not covered by Original Medicare. Part A Hospital Coinsurance Days 61-90 of a hospital stay in each Medicare benefit period Days 91-150 of a hospital stay. Medicare will only pay for these 60 days once during your lifetime Additional Part A Hospital Benefits An extra 365 days of inpatient hospital care after you use your Original Medicare hospital benefits Part B Coinsurance Pays for the Part B coinsurance after you meet your annual deductible Part A and B Blood Coverage Pays for the first three pints of blood per calendar year Part A Hospice Coinsurance Pays for outpatient prescriptions drug and inpatient respite care coinsurance
Medigap Policy	Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage. Medigap policies only work with Original Medicare.
Monthly Premium	The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. In a few cases, a note will say "Under Review" instead of a premium amount. This means Medicare and the company are still discussing the amount.
Network pharmacies	Medicare drug plans have contracts with a number of pharmacies that are part of the plan's "network." If you don't go to a network pharmacy, your plan may not cover your prescription. Along with retail pharmacies, your plan's network may include preferred pharmacies, a mail-order program, and a 60- or 90-day retail pharmacy program.
Non-preferred pharmacy	A network pharmacy that offers covered drugs to plan members at higher out-of-pocket costs than what the member would pay at a preferred network pharmacy.
Open Enrollment Period (Medigap)	A one-time only 6-month period when Federal law allows you to buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older (or under age 65 in some states). During this period, you can't be denied a Medigap policy or charged more due to past or present health problems.
Optional Supplemental Benefits	Services not covered by Medicare that enrollees can choose to buy or reject. Enrollees that choose these benefits pay for them directly, usually in the form of premiums and/or copayments or coinsurance. These services can be grouped or offered individually and can be different for each Medicare Health Plan offered.
Original Medicare	Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.
Out-of-Network	Generally, an out-of-network benefit provides you with the option to get plan services outside of the plan's contracted network of providers. In some cases, your out-of-pocket costs may be higher for an out-of-network benefit.

Out-of-Pocket Costs	Health or prescription drug costs that you must pay on your own because they are not covered by Medicare or other insurance.
Out-of-Pocket Spending Limit	The most you will have to pay out-of-pocket for your Part A and Part B services during the year. All Medicare Advantage Plans have a limit on what you pay each year and each plan can have a different amount. Original Medicare doesn't have a limit on what you pay each year.
Overall Plan Rating	The Overall Plan Rating combines scores for the types of services each plan offers: **What is being measured?** **For plans covering health services**, the overall score for quality of those services covers **36 different topics in 5 categories:** **Staying healthy: screenings, tests, and vaccines:** Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy. **Managing chronic (long-term) conditions:** Includes how often members with different conditions got certain tests and treatments that help them manage their condition. **Ratings of health plan responsiveness and care:** Includes ratings of member satisfaction with the plan. **Health plan member complaints and appeals:** Includes how often members filed a complaint against the plan. **Health plan telephone customer service:** Includes how well the plan handles calls from members. **For plans covering drug services**, the overall score for quality of those services covers **17 different topics in 4 categories:** **Drug plan customer service:** Includes how well the drug plan handles calls and makes decisions about member appeals. **Drug plan member complaints and Medicare audit findings:** Includes how often members filed a complaint about the drug and findings from Medicare's audit of the plan. **Member experience with drug plan:** Includes member satisfaction information. **Drug pricing and patient safety:** Includes how well the drug plan prices prescriptions and provides updated information on the Medicare website. Includes information on how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition. **For plans covering both health & drug services,** the overall score for quality of those services covers **all of the 53 topics listed above**. **Where does the information for the Overall Plan Rating come from?** For quality of **health services**, the information comes from sources that include: Member surveys done by Medicare Information from clinicians Information submitted by the plans Results from Medicare's regular monitoring activities For quality of drug services, the information comes from sources that include: Results from Medicare's regular monitoring activities Reviews of billing and other information that plans submit to Medicare Member surveys done by Medicare **Why is the Overall Plan Rating important?** The Overall Plan Rating gives you a single summary score that makes it easy for you to compare plans based on quality and performance. Learn more about differences among plans by looking at the detailed ratings.
PACE (Programs of All-inclusive Care for the Elderly)	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 living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.
Part A (Hospital Insurance)	The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
Part B (Medical Insurance)	Medicare medical insurance that helps pay for certain doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.
Partial Dual Eligibles	People who are in a Medicare Savings Program run by their state.
Partial Extra Help	People who qualify for the partial low-income subsidy for Medicare prescription drug coverage. People who get partial Extra Help may pay a percentage of their monthly Medicare drug plan premium depending on their income and resources, $63 for their annual deductible, and may pay up to 15% coinsurance for the cost of their prescriptions.
Partial Subsidy Eligible	You get a partial amount of extra help.
Password Date	The password used to retrieve a Saved Drug List.
Pharmacy Network	Pharmacies that have agreed to provide members of certain plans with services and supplies at a discounted price. In some plans, your prescriptions are only covered if you get them filled at network pharmacies.

Plan members who qualify for extra help	These plan members qualify to get extra help from Medicare paying their prescription drug coverage costs. This extra help is also known as the "Low-Income Subsidy." People who qualify for this program get help paying their Medicare plan's monthly premiums, annual deductible, and prescription co-payments.
Plan Name	The name of the plan offered by the company that contracts with Medicare.
Point of Service (POS)	An HMO option that lets you use doctors and hospitals outside the plan for an additional cost.
Pre-existing conditions	A health problem you had before the date that a new insurance policy starts.
Preferred Pharmacies	If your plan has preferred pharmacies, you may save money by using them. Your prescription drug costs (such as a copayment or coinsurance) may be less at a preferred pharmacy because it has agreed with your plan to charge less.
Preferred Pharmacy	A network pharmacy that offers covered drugs to plan members at lower out-of-pocket costs than what the member would pay at a non-preferred network pharmacy.
Preferred Provider Organization (PPO)	A type of Medicare Advantage Plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Premium	The periodic payment to Medicare, an insurance company, a health care plan, or a drug plan for health care or prescription drug coverage.
Pricing Method	Insurance companies set their own premiums for Medigap (Medicare Supplement Insurance) policies. How they set the price affects how much you pay now and in the future. Medigap policies can be priced or "rated" in three ways: 1. Community-rated (or "no-age-rated") 2. Issue-age-rated 3. Attained-age-rated
Prior Authorization	Prior authorization means that you will need prior approval from an insurance plan before you fill your prescription. If a drug has prior authorization, you will need to work with the plan and your doctor to get an exception. Call your plan or visit their Web site to learn more about specific prior authorization requirements. Many prior authorization requirements can be resolved at the point of sale and don't require any additional information from your doctor. Knowing what the prior authorizations are before going to your doctor's office may save you time at the pharmacy counter.
Private Fee-for-Service Plan	A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that agrees to treat you under the plan and that accepts the plan's payment terms. The plan decides how much you must pay for services.
Qualified Medicare Beneficiary (QMB)	A Medicaid program for people with Medicare who need help paying for Medicare services. The person with Medicare must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A and Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.
Quality	Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person-and getting the best possible results.
Quantity Limitation	For safety and cost reasons, plans may limit the quantity of drugs that they cover over a certain period of time. If the drug has a quantity limit restriction, you should contact the plan for more details. If you take one pill per day and the drug has a 30 day/month quantity limit, the impact will be minimal (i.e., you may not be able to refill the prescription until a few days before running out of pills). If you currently take 2 pills per day and the quantity limit is 30 pills per month, you would need to work with the plan to get authorization for the higher quantity.
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, t he plan may not pay for your care
Saved Drug List	Your list of drugs that is saved with a unique ID number. This list can be retrieved at any time by entering the Saved Drug List ID and Password Date.
Service Area	The area where a health plan accepts members. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.
Skilled Nursing Facility	A nursing facility with the staff and equipment to give skilled nursing care and, in most cases skilled rehabilitation services and other related health services.
Specified Low - Income Medicare Beneficiary (SLMB)	A Medicaid program that pays Medicare Part B premiums for people who have Medicare Part A and limited income and resources.

Stars	Stars for each plan show how well the plan performs in a particular category. Star ratings range from 1 star to 5 stars, where a rating of 1 star means "poor" quality, 2 stars means "below average" quality, 3 stars means "average" quality, 4 stars means "above average" quality and 5 stars means "excellent" quality.
Step Therapy	In some cases, plans require you to first try one drug to treat your medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, a plan may require your doctor to prescribe Drug A first. If Drug A doesn't work for you, then the plan will cover Drug B. If a drug has step therapy restrictions, you will need to work with the plan and your doctor to get an exception.
Subsidy Status Unknown	Medicare doesn't have any information about your extra help status.
Summary Rating of Health Plan Quality	This summary rating gives an **overall score** on the health plan's quality and performance on **36 different topics** in **5 categories:** **Staying healthy: screenings, tests, and vaccines.** How often members got various screening tests, vaccines, and other check-ups that help them stay healthy. **Managing chronic (long-term) conditions.** How often members with different conditions got certain tests and treatments that help them manage their condition. **Ratings of health plan responsiveness and care.** How well members are satisfied with the plan. **Health plan member complaints and appeals.** Includes often members have made complaints against the plan. **Health plan telephone customer service.** How well the plan handles calls from members. The information described is based on member surveys, information from clinicians, or information from plans. In other cases it's based on results from Medicare's regular monitoring activities. **Why is the summary rating important?** A single overall rating makes it easy for you to compare health plans based on quality and performance. In addition to using the summary rating: You can look up how well the health plan is doing in each of the 5 categories that make up the summary rating. You can also look up how well the health plan is doing in the 36 individual topics that make up the ratings in those 5 categories.
Summary Rating of Prescription Drug Plan Quality	This summary rating gives an **overall score** on the drug plan's quality and performance on **17 different topics** in **4 categories:** **Drug plan customer service:** How well the drug plan handles calls and makes decisions about member appeals. **Drug plan member complaints and Medicare audit findings:** Includes how often members complain about the drug plan. **Member experience with drug plan:** How well members are satisfied with the plan. **Drug pricing and patient safety:** How well the drug plan prices prescriptions and provides accurate pricing information on the Medicare Web site. Includes information on how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition. This information is gathered from Medicare's regular monitoring activities, reviews of billing and other information that plans submit to Medicare, and Medicare's member surveys. **Why is the summary rating important?** The summary rating makes it easy to compare drug plans based on quality and performance. In addition to using the summary rating: You can look up the drug plan's rating in each of the 4 categories that make up the summary rating. You can also look up how well the drug plan is doing in the 17 individual topics that make up the rating in those 4 categories.
Supplemental Security Income	SSI is a monthly amount paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits provide cash to meet basic needs for food, clothing, and shelter. SSI benefits aren't the same as Social Security benefits.
Tiers	Drugs on a formulary are often organized into different drug "tiers," or groups of different drug types. Your cost depends on which drug tier your drug is in. For example, a plan may form tiers this way: Tier 1 - Generic drugs. Tier 2 - Preferred brand-name drugs. Tier 3- Non-preferred brand name drugs. Contact the plan to learn more about its specific tier structure.
Timely Appeals Decision	An appeals decision is considered to be timely when it meets Medicare's appeals timeframes. The specific timeframe depends on the type of appeal, and ranges from 24 hours to 7 days. Look at the materials your plan sends you each year, such as the Evidence of Coverage (EOC), for more details about the appeals process.