Balance Billing - Balance billing is a medical billing practice increasingly instituted by health care providers to cover the cost of services rendered. If your doctor uses balance billing, she would bill you for any amount not covered by your insurance. So if her bill was for $1,000, and your insurance only covered $600, with balance billing, you would be responsible for the other $400. Balance billing may arise when you use services of out-of-network providers under a PPO or HDHP arrangement. It is illegal for health care providers affiliated with Medicare to practice balance billing. It is also illegal in most states for providers who are "in-network" to engage in balance billing, regardless of which insurance company they are affiliated with. Out-of-network providers, however, are usually permitted to do so.

BlueCard Network - The Blue Cross and Blue Shield Association (BCBSA) program that provides access to health care services from participating providers throughout the United States to members of any Blue Plan while traveling or residing outside of California. Your level of coverage depends on your plan.

Brand-Name Formulary - Prescription drugs marketed with a specific brand name by the company that manufactures it, usually the company which develops and patents it. When patents run out, generic versions of many popular drugs are marketed at lower cost by other companies.

California State Association of Counties - Excess Insurance Authority (CSAC - EIA) - Is a member directed joint powers authority (JPA) comprised of California public agencies dedicated to controlling losses and providing risk management and employee benefit solutions. Members own and run the program. Participants includes city, county and special district membership with over 200 employees.

Co-Insurance - The percentage of covered expenses an insured individual shares with the carrier, (i.e., for an 80/20 plan the health plan member's co-insurance is 20%.) If applicable, co-insurance applies after the insured pays the deductible.

Co-Pay - A flat fee for specified medical services (required by some insurers) that a subscriber must pay out-of-pocket at the time the service is rendered. For example, you pay a $30 copayment for a doctor visit or a $500 copayment for a hospital stay.

Deductible - The amount you must pay each year for your medical expenses before your insurance policy starts paying.

Dependent - Spouse, Domestic Partner and/or unmarried children (whether natural, adopted or step) of an insured.

Effective Date - The date your insurance is to actually begin. You are not covered until the policies effective date

Explanation of Benefits (EOB) - The insurance company's written explanation to a claim, showing what they paid and what the client must pay. Sometimes accompanied by a benefits check.

Exclusive Provider Organization (EPO) - A healthcare benefit arrangement that is similar to a Preferred Provider Organization (PPO) in administration, structure, and operation, but which does not cover out-of-network care. An EPO includes insurance carriers' contracted PPO providers. In an EPO, no Primary Care Physician referral is required to visit a specialist.

Formulary - A list of prescription drugs approved for coverage under a prescription drug plan.

Generic Drug - A "twin" to a "brand name drug" once the brand name company's patent has run out and other drug companies are allowed to sell a duplicate of the original. The dispensing of a drug that is the generic equivalent of a drug listed on a pharmacy benefit management plan's formulary. In most cases, generic substitution can be performed without physician approval. Generic drugs are cheaper, and most prescription and health plans reward clients for choosing generics.

High Deductible Health Plan (HDHP) - This plan has a higher deductible which gives the member a lower premium rate, but just as regular PPO plans, once the deductible is met the policy benefits start paying as noted on the plan summary.

The Health Insurance Portability and Accountability Act (HIPAA) - passed by the U.S. Congress in 1996, offers people rights and protections regarding their health care plans. Because of HIPAA, there are limits on preexisting condition exclusions, people cannot be discriminated because of health factors, there are special enrollment requirements for people who lose other group plans or have new dependents, small employers are guaranteed group health plan availability, and all group plans have guaranteed renewal if the employer wishes to renew. In summary these rights and protections include:

- Portability. This is the ability for a person to get new health insurance if a change is desired or needed.
- Availability. This refers to whether or not health insurance must be offered to a person and his or her dependents.
- Renewability. This refers to whether or not a person is able to renew his or her health plan.

Health Maintenance Organization (HMO) - Health Maintenance Organizations represent "pre-paid" or "capitated" insurance plans in which individuals or their employers pay a fixed monthly fee for services, instead of a separate charge for each visit or service. The monthly fees remain the same, regardless of types or levels of services provided, Services are provided by physicians who are employed by, or under contract with, the HMO. HMOs vary in design.

HMO Plan - In an HMO plan, members choose a primary care physician (PCP) who coordinates each assigned member's care. The PCP refers patients to specialists and provider services as needed. HMO plans often require members receive a referral from their PCP before seeing a specialist.

Health Insurance Subsidy - Established to help defray the cost of health, dental and vision insurance coverage, this is an account funded by Santa Barbara County's 401(h) program for Retirees who are enrolled in the County-sponsored health insurances. Each month, an amount equal to $15 per year of service is deducted from the total amount of your health, dental and vision premiums.

Health Reimbursement Arrangement (HRA) - Similar in function to a Health Savings Account, this account is funded by Santa Barbara County's 401(h) program to help those Retirees who chose not to enroll in the County-sponsored health insurances. SBC funds your HRA account with a set monthly amount ($4 per year of service). You can use this cash supplement to pay your out-of-pocket medical expenses, such as co-pays or coinsurance for office visits, prescription drugs, and other services. You must submit eligible receipts in order to receive the cash supplement. This benefit is administered by a third-party administrator, ***WageWorks*** (formerly ***Creative Benefits***).

In-Network - Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider because normally the plan will pay more of the benefit when using a contracted provider, and secondly the contracted provider cannot bill the member for any amount above the contracted rate. Providers not contracted with the carrier can "balance bill" the members, which in turn cost the member much more.

Inpatient - Treatment that is provided to a patient who must be admitted for an overnight stay in a hospital or other inpatient facility.

Independent or Individual Practice Association (IPA) – An organization which contracts with individual providers or groups of providers to arrange for the provision of their professional services to enrollees of a Health Maintenance Organization (HMO).

Lifetime Maximum - The maximum amount a health plan will cover for an insured individual during his or her lifetime (for example, $5 million).

Medicare - A federal government hospital expense and medical expense insurance plan primarily for elderly, disabled persons and those who have end-stage renal disease (permanent kidney failure).

- **Medicare Part A -** Covers basic hospitalization services automatically for most eligible persons
- **Medicare Part B -** Covers physician visits and other outpatient expenses that Medicare Part A does not cover. Medicare Part B is voluntary. You have to enroll in Part B and pay a monthly premium.
- **Medicare Part C -** Also known as Medicare Advantage Plans or Medicare+ Choice plans. Medicare Part C is another way to get your Medicare benefits. It combines Part A, Part B, and sometimes Part D (prescription drug) coverage. Medicare Advantage Plans are managed by private insurance companies approved by Medicare.
- **Medicare Part D -** Medicare-approved plans that you purchase to provide additional coverage for prescription drugs. SBCERS' Medicare plans include an enhanced Pharmacy benefit approved by Medicare. If you are enrolled in one of SBCERS' Medicare plans, you have prescription coverage and there is no need to purchase additional Medicare Part D pharmacy coverage from another insurer.

Medicare Coordination of Benefits (COB) - If you have Medicare and SBCERS' health insurance coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills, and then sends them to the "secondary payer" to pay. In some cases, there may be a third payer. Whether Medicare pays first depends on a number of things. Be sure to tell your doctor and other providers that you have health insurance coverage in addition to Medicare. This will help them send your bills to the correct payer to avoid delays. If you have questions about who pays first or if your insurance changes, call the Medicare Coordination of Benefits Contractor (COBC) at 1-800-999-1118. TTY users should call 1-800-318-8782.

Medicare Eligible - The first day of the month in which you turn 65 years old (exceptions apply for disabled persons).

Non-Formulary - Drugs that are not on your plan's formulary drug list.

Out-of-Network - This phrase usually refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Out-Of-Pocket Maximum - A predetermined limited amount of money that an individual must pay before an insurance company will pay 100 percent for an individual's health care expenses.

Outpatient - Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility.

Pooling - The practice of underwriting a number of small groups as if they constituted one large group.

Pre-Existing Condition - A medical condition that is excluded from coverage by an insurance company, because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company. An insurance company cannot apply these restrictions for more than 12 months. Prior creditable coverage may be used to decrease the time period applied to each member.

Preferred Provider Arrangement (PPA) - A contract between a healthcare insurer and a healthcare provider or group of providers who agree to provide services to persons covered under the contract. Examples include preferred provider organizations (PPOs) and exclusive provider organizations (EPOs).

Point of Service (POS) Plan - A heath plan which allows the subscriber to choose HMO, PPO or indemnity coverage at the point of service (time the services are received). Subscribers pay less for in-network care. For out-of-network care, subscribers usually pay a deductible and coinsurance.

Preferred Provider Organization (PPO) - A network or panel of physicians and hospitals that agrees to discount its normal fees in exchange for a high volume of patients. PPO members usually pay more when they receive care outside the PPO network.

Primary Care Physician (PCP) - An internist, pediatrician, family physician, general practitioner, or in some instances an obstetrician/ gynecologist who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized physicians for specialist care. If you are enrolled in an HMO, you usually must choose a PCP from a list of participating providers. The PCP coordinates your care and makes referrals to specialists as needed.

Retiree - In this publication, the term **"Retiree"** refers to any person who has retired from service or disability with the County of Santa Barbara and/or their survivors and who are currently receiving a monthly benefit from SBCERS.