Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Health Insurance Glossary

Allowed Amount

Maximum amount on which payment is based for covered healthcare services. This may be called “eligible expense,” “payment allowance," or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Appeal

A request for your health insurer or plan to review a decision or a grievance.

Balance Billing

When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Benefit Period

The length of time during which a benefit is paid.

Coinsurance

Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment (Copay)

A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible

The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won’t pay anything until you’ve met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Excluded Services

Healthcare services that your health insurance or plan doesn’t pay for or cover.

Facility Fee

A fee that may be charged by a Baylor Scott & White Health clinic when you receive services at the clinic from a Baylor Scott & White Health doctor. The facility fee covers the hospital's cost of maintaining the facility, including the facility, equipment, and support staff.

Fee-for-Service

Payment model where services are not bundled and are paid for separately.

Flexible Spending Accounts (FSA)

This account can pay certain medical expenses with pre-tax dollars with funding levels set by the employer and employee.

Formulary

A list of the prescription drugs that are covered by a specific plan.

Grievance

A complaint that you communicate to your health insurer or plan.

Health Insurance

A contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a premium.

Health Reimbursement Arrangement (HRA)

HRAs are funded solely by the employer as eligible expenses are processed. The employer sets the funding level, maximum contributions, and the maximum rollover amount from year to year.

Health Savings Account (HSA)

HSAs were designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis. The employer, employee, or both can fund the account. Funds are portable and roll over from year to year.

Home Healthcare

Healthcare services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn’t require an overnight stay.

HMO

Health Maintenance Organization plans provide a range of benefits for a set fee. The plan features a list from which to choose your primary care physician (PCP). Your PCP will refer you to specialists within the network when necessary. Out-of-network providers are usually not covered.

Indemnity Insurance

Policies where consumers choose their own provider and the plan reimburses providers for each service. Also known as fee-for-service.

Managed Care

A category of plans that direct members to a group of providers. HMOs, POS, and PPOs are all forms of managed care.

Medicaid

A medical assistance program for certain individuals and families with limited incomes and resources. Medicaid is jointly funded by the federal and state governments and managed by the states. It includes programs that help pay Medicare premiums and cost sharing.

Medicare

A federal government health program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (ESRD)

Network

The facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

Non-Preferred Provider

A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

POS

Point of service plans are sometimes offered in conjunction with HMOs, allowing members to see out-of-network providers after seeing their primary care physicians.

PPO

Preferred Provider Organizations often have an approved network of providers, although members can also seek care out of network for a higher copay.

Preauthorization

A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary, sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

Primary Care Physician

A physician who directly provides or coordinates a range of healthcare services for a patient.

Primary Care Provider

A physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of healthcare services.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

Step Therapy

Controlling costs by first treating a condition with the most cost-effective and safe approach before progressing to riskier, more expensive therapies.

Tiered Formulary

A drug plan formulary that divides drugs into groups or tiers. Each tier has a different level of cost sharing. For example, a generic version of a drug may have a lower copay than a brand-name version of the same drug. The details of the cost sharing vary from plan to plan.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.