Health Insurance Glossary

Actuarial Value: The percentage of total average costs of benefits the plan will cover. This does not include other costs to consumers such as premiums.

Affordable Care Act (ACA): The healthcare reform bill signed into law in 2010. It is intended to provide coverage to millions of uninsured Americans and lower healthcare costs. Also known as the Patient Protection and Affordable Care Act (PPACA) or Obamacare.

Benefits: The health care items covered under a health insurance plan. These are defined by the insurance company when the coverage is purchased.

Children's Health Insurance Program (CHIP): Insurance paid for by the State and Federal governments. Under this program in Wisconsin, all children can have low cost insurance regardless of their parents' income. Wisconsin's CHIP is BadgerCare+.

Claim: Request by a person asking their insurance company to pay for services obtained from a health care professional.

Co-payment: A set amount a patient may have to pay when they receive care. Insurance covers the remaining cost of the services.

Deductible: The amount that a person must pay for health care expenses before their insurance will cover the costs.

Dependent: A person or persons who rely on the policy holder for support. This may include the spouse or children of the insured policy holder.

Donut Hole: Plans with Medicare Prescription Drug coverage cover the costs of any prescription up to a certain dollar amount. From this amount on, all costs are covered by the patient, until a yearly limit is reached. After the yearly limit is reached, the coverage gap closes and drugs are paid for by insurance again.

Essential Health Benefits: Under the ACA, all insurance plans sold on the Health Insurance Marketplace must offer a minimum benefits package including: emergency services, hospitalization, maternity and new born care, mental health and substance use services, prescription drugs, rehabilitative services, preventative and wellness services, chronic disease management, and pediatric services including oral and vision care.

Federal Poverty Level (FPL): A measure of a family's income that is measured yearly. The FPL is used to determine eligibility for State and Federal benefits.

Grandfathered Plans: Plans purchased before March 23, 2010 do NOT have to cover preventive care for free, guarantee your right to appeal or protect your choice of doctors. They MUST however, end lifetime limits, cancellation of coverage for illness and cover adult children up to age of 26.

Guaranteed Issue: A requirement that health plans must permit you to enroll, regardless of health status, age, gender or other factors that may cause a higher use of health services.

Health Insurance: A contract you pay for with "premiums" that requires your health insurer to pay some or all of the costs for care.

Health Insurance Marketplace/Exchange: a key part of the health reform law that creates a website where consumers can compare and purchase their own health insurance.

Individual Mandate: A new law in 2014 requiring everyone to have health insurance. People who choose not to purchase health insurance are subject to a tax penalty (fee).

Individual Subsidies: Tax credits (discounts) that are given to individuals who need help purchasing health insurance through the Health Insurance Marketplace. Subsidies vary based on the individuals standing in the FPL from 100%FPL to 400%FPL.

Lifetime Limit: A maximum amount of benefits your insurance will cover over your lifetime. Under the ACA, insurance companies will no longer be able to impose a lifetime limit.

Medicaid: Public insurance through the state for parents and pregnant women who fall under a certain income level. Children are eligible no matter what the family's income. In Wisconsin, this is called BadgerCare*+*.

Medicare: A federal health insurance program providing health coverage for Americans age 65 and older. It has been expanded to cover people with permanent disabilities.

Metal Tiers: The plans sold on the Health Insurance Marketplace come in four different cost levels: Bronze level plans are at 60% actuarial value, Silver 70%, Gold 80% and Platinum 90%.

Network: A group of doctors, hospitals and other providers that contract with an insurance company to provide services for less than their usual rate.

Open Enrollment Period: A period of time when a person can sign up for new insurance. Usually this occurs once a year.

Out-of-pocket costs: Expenses not paid for by insurance. Often includes co-payments, deductibles, and any other service not covered by insurance.

Premium: The basic cost of your health insurance. Usually you/your employer make payments monthly.

Pre-Existing Condition: A medical condition that is not covered by an insurance company because it existed before the individual bought the coverage. They often include heart disease, asthma, diabetes, acne and pregnancy. Under the ACA, insurance companies cannot deny coverage to those that have preexisting conditions.

Preventive Services: Routine health services such as checkups, screenings and counseling designed to prevent disease and other health problems.

Provider: The term used for healthcare professionals such as doctors and hospitals who provide health care services to patients.

Summary of Benefits and Coverage (SBC): Insurance companies are required to provide each customer with an easy to understand list of what is included under the coverage they have bought. This lists are must be provided at renewal, when coverage is applied for, before coverage begins if changes occur, or any time at the consumers request.

Wellness Programs: Programs intended to improve and promote health and fitness that are usually offered through an employer, but can also be offered by an insurance company. Benefits can include premium discounts, gym memberships and other incentives.

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