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Health Insurance Terms Glossary

Advance Premium Tax Credit (APTC): A federal subsidy that will pay a portion of an individual's or family's health insurance premium. To be eligible for the APTC, you must be lawfully present in the United States, a current tax filer with the IRS and earn between 100% and 400% of the Federal Poverty Level (FPL). In 2013 this equates to $11,490-$45,960 for an individual or $23,550-$94,200 for a family of four.

Coinsurance: Coinsurance is usually a percentage that you (the insured) must pay. A common coinsurance split is 80/20, meaning that the insurance company pays 80% of your medical bills and you pay 20%. For example, if you went to the ER, and your bill was $1,000, you would pay $200 and your insurance company would pay $800. Coinsurance usually does not apply until you (the insured) have met your deductible.

Copayment: A copayment (also referred to as a "copay") is a fixed amount of money that you (the insured) must pay at the time a medical service is provided (when you visit the doctor, for example, the front desk will ask you to pay your copayment). Copayments are usually required for basic doctor visits and prescription medications. Copayment amounts will be outlined in your insurance plan language so you will know what your copayments are before you enroll.

Cost Sharing Reductions (CSRs): A subsidy that is applied to reduce the out-of-pocket cost for individuals and families who make less than 250% of the Federal Poverty Level. This equates to $27,925 for an individual and $57,625 for a family of four.

Deductible: A deductible is the amount of money that you (the insured) would need to pay before you can use any benefits from your health insurance plan. For example, if a person has a $1,000 deductible, that person will have to pay $1,000 for medical care before their insurance company pays anything. The deductible is an annual amount, something that you need to pay every year. There are certain things, such as doctor's visits and prescriptions that will be available before you meet the deductible. For example, that same person would not need to pay $1,000 for medical care or services before their insurance started paying for their prescription. Your deductible amount and what is exempt from the deductible will be outlined in your insurance plan language so you will know what your annual deductible is before you enroll.

Enrollment Assister: Enrollment Assisters are individuals who have been trained by Nevada Health Link to help enroll Nevada's uninsured and under-insured in QHPs on NevadaHealthLink.com. They will be able to sit down with people, one-on-one, to help them through the entire enrollment process.

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Essential Health Benefits: Essential Health Benefits are certain benefits that all QHPs must provide. The essential health benefits for Nevada include: ambulance services and care, emergency service, hospitalization, maternity and newborn care, mental health and substance abuse disorder treatment, prescription drugs, rehabilitation and habilitation services and devices, lab services, preventive and wellness services and chronic disease support, pediatric services, including dental and vision.

Health Maintenance Organization (HMO): A medical group plan that provides physician, hospital and clinical services to participating members in exchange for a periodic flat fee. The goal of an HMO is to keep people healthy by using Primary Care Providers (PCP) as the health gate keepers. A client with this type of plan must visit his/her PCP first for all health related conditions (the PCP can refer the client to a specialist if needed).

Household Income: For purposes of the premium tax credit, your household income is your modified adjusted gross income (MAGI) plus that of every other individual in your family for whom you can properly claim a personal exemption deduction and who is required to file a federal income tax return.

Individual Mandate: A requirement by law that certain people purchase or otherwise obtain a good or service. In this case, it means that people must have health insurance coverage. The U.S. law now says t

Individual shared responsibility payment (tax penalty): is required with your tax return if you (or any of your dependents) do not maintain coverage and do not qualify for an exemption. *To learn more visit our Tax Penalty and Exemption page on NVPCA.org under the Health Insurance Tab.*

Minimum Essential Coverage (MEC) An employer sponsored or privately purchased health insurance plan that covers the 10 Essential Health Benefits and meets a minimum actuarial value of at least 60%. This includes privately purchased or employer-sponsored plans, Medicare, Medicaid, Nevada Check Up and TRICARE.

Modified adjusted gross income (MAGI): is the adjusted gross income on your federal income tax return plus any excluded foreign income, nontaxable Social Security benefits (including tier 1 railroad retirement benefits), and tax-exempt interest received or accrued during the taxable year. It does not include Supplemental Security Income (SSI).

Out-of-Pocket Cost: For health insurance, the term out-of-pocket cost(s) refers to money you (the insured) pay out of your own pocket for medical care you've received.

Out-of-Pocket Maximum: Out-of-Pocket Limit (also known as Out-Of-Pocket Maximum) is the maximum amount of money you may pay for medical services in a calendar year. Out-of-pocket limit may and may not include deductible depending on insurers' definition of the term. The maximum amount of money you may spend for health care services also may vary whether they are receive in or out-of-network.

Premium: The premium is the amount you (the insured) will pay for your insurance plan. The premium, like many bills, is typically a monthly payment.

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Primary Care Provider (PCP): Primary care providers are our "family doctors" and where most people enter the health care system. It makes sense to have a primary care provider who knows you and your family and can care for you through both sick times and healthy times. They refer patients in need of more complex health care to other providers (like specialists or hospitals).

Provider Network: A provider network is a group of providers (a group of hospitals, doctor, X-ray centers, outpatient survey centers, therapist and labs, for example) that agree to accept certain insurance policies and plans. Every insurance plan offered through Nevada Health Link will list its provider network members, so you will know what doctors and hospitals are covered before you enroll.

Qualified Health Plan (QHP): A QHP is an insurance plan that is certified by Nevada Health Link. In order to be certified, the plan must provide essential health benefits (see definition above) and follow established limits on cost sharing (such as deductibles and co-payments).

Summary of Benefits: Insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage (includes deductible, copayment and coinsurance details). People will receive the summary when enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan.

Total Tax Household Size: You may count yourself, your spouse (if applicable) and any dependents that you are allowed to claim on your tax return. Individuals living in your household who may not be claimed on your taxes may not be included in this number.