# Definitions of Common Health Insurance Terms

- **Coinsurance** is your share of the costs of a covered health care service, calculated as a percentage (for example, 10%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the allowed amount for a procedure is $100 and you've met your deductible, your coinsurance payment of 10% would be $10. The health plan pays the rest of the allowed amount.)
    - **Applied after the deductible is met**
    - **2019 coinsurance is typically 10%, meaning you pay 10% and the health plan pays 90%***

- **Copayment (copay)** is a fixed amount (for example, $25) you pay for a covered health care service, such as an office visit or prescription drug. Even after you reach the annual out-of-pocket maximum, you continue to pay copays for the remainder of the year.
    - **2019 copayment for physician and specialist visits is $25**
    - **Prescription drugs are subject to different copayments depending on the drug's tier**
    - **Emergency room visits is $150 copayment (waived if admitted)**
    - **Advanced radiology (e.g., MRIs) copay is $50 for Arise, Dean and GHC-SCW**

- **Deductible** is the amount that you pay annually for covered health care services before your plan begins to pay. For example, if your deductible is $250, your plan won't pay anything (except preventive services) until you've met your $250 deductible for covered health care services that are subject to the deductible.
    - **2019 deductibles are $250/single and $500 family***

- **Maximum out-of-pocket maximum (MOOP)** is the annual amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. This amount may be higher than the out-of-pocket limits stated for your plan. It is not typical to have costs that exceed the annual out-of-pocket limit defined above.

- **Out-of-pocket maximum** (OOP) is the most you could pay during a calendar year for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This does not include copayments.
    - **2019 annual out-of-pocket maximum is $500/single and $1,000/family***

- **Prescription Drug Tiers** determine your portion of the drug cost. A typical drug benefit includes three or four tiers:
    - Tier 1 usually includes generic medications.
    - Tier 2 usually includes preferred brand name medications.
    - Tier 3 usually includes non-preferred brand name medications.
    - Tier 4 usually includes specialty medications (3-Tier programs do not have a unique tier for specialty medications)

  A medication may be placed in tier 3 or 4 if it is new and not yet proven to be safe or effective; or there is a similar drug on a lower tier of the formulary that may provide the same benefit at a lower cost.

*WPS PPO has higher out-of-pocket costs when the member sees an out-of-network provider.