Farmers' Health Cooperative of Wisconsin

ASA Agri-Services Agency

Glossary of Terms

Deductible: A pre-determined, fixed dollar amount you must pay each calendar year for health care expenses before your insurance begins to pay for services.

Copayment: A pre-determined, fixed dollar amount you must pay for certain health care services. For example, you may pay a $20 "copayment" for each office visit, regardless of the type or level of services provided during the visit. Copayments do not apply toward the satisfaction of the deductible or out-of-pocket maximum.

Coinsurance: The percentage of cost you must pay for services, after the deductible has been satisfied. For example, the insurance pays 80% of the cost for services; you pay 20% of the cost.

Out-Of-Pocket Maximum: The maximum amount of money you must pay each calendar year toward costs for services. Once you've met the maximum, the insurance carrier will pay 100% of the cost for services for the remainder of the year. This maximum includes the deductible, but does not include copayments.

Plan Lifetime Maximum: The maximum amount an insurance carrier will pay for health care services for you while you are covered under the Certificate.

Pre-existing Conditions: Any physical or mental condition; disease; or ailment that is believed to have existed prior to the start of your insurance policy. Pre-existing conditions are excluded from coverage until you have satisfied the appropriate waiting period, unless you have "Prior Coverage Credit".

Prior Coverage Credit: The time you were covered by another health insurance plan, provided there is not a break in coverage greater than 63 days between the termination of the previous coverage and the start of your new coverage.

Dependent children: Your unmarried children (whether natural, adopted or step) who are chiefly dependent on you for support.

In-network Providers: Physicians, hospitals or other health care professionals who are part of the health plan's network of providers with which it has negotiated a discount. Your share of costs for services is lower when you use in-network providers.

Out-of-Network: Physicians, hospitals or other health care professionals who do not hold a contract with the health plan's network. Services are not discounted and your share of costs for services is higher, as you may be responsible for amounts over the usual, customary and reasonable schedule of allowances for the services provided.

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Brand-name drug: Prescription drugs marketed with a specific brand name by the company that manufactures it, usually the company which patents and makes it. When patents run out, “generic” versions of many popular drugs are developed and marketed.

Generic Drug: A "twin" to a "brand name drug" that is created and sold once the brand name company's patent has run out. The generic version must have the same core components of the “brand name” version. Drug companies other than the “brand name” manufacturer are allowed to make and sell the generic version and typically sell them at a much cheaper price.

Formulary: Many insurance plans use a “formulary” list to describe which prescription medicines will be covered and how much the insurance company will pay for them and how much you will be required to pay for each drug purchased. The list is generally broken into **3 separate tiers:**

1. The first tier indicates covered “**generic**” medications. These typically require you to pay the least amount for each drug purchased.

2. The second tier is often called “**preferred brands**”. These are the brand name drugs the insurance company will cover at a lower cost to you than “non-preferred brands”.

3. The third tier is often called “**non-preferred brands**”. These are the brand name drugs the insurance company will cover, but at a higher cost to you than “preferred brands”. Prescription medications typically fall into the “non-preferred” tier because of the availability of a similar medication listed in the “preferred brand” tier and/or the overall cost of the medication.

*If you do not see a medication listed on the formulary list, the medication is likely not covered. Contact your insurance carrier whenever you don’t see a drug listed to verify if it would be covered by your insurance plan.