

INSURANCE DECISIONS

Comparing Health Insurance Plan Costs

Detailed practice, calculation, decision-making, and assessment

GRADES 9-12	TIME 2 x 42 min	GROUPING I / pairs / whole	PRODUCT Decision
YOUR CHALLENGE Use premiums, deductibles, copayments, coinsurance, networks, and out-of-pocket maximums to compare fictional health plans across different use levels.			

Insurance Is a Risk-Management Tool

A health plan's premium is only one part of total cost. A person may also pay deductibles, copayments, and coinsurance. Covered services, network rules, prior authorization, drug coverage, and the out-of-pocket maximum can change the decision. This lesson is financial education, not medical advice.

Term	Meaning in this packet
Premium	Amount paid each month for coverage.
Deductible	Amount paid for certain covered services before the plan begins sharing costs.
Copayment	Fixed amount paid for a covered service.
Coinsurance	Percentage of the allowed cost paid by the member.
Network	Providers and facilities contracted with the plan.
Out-of-pocket maximum	Most paid in a plan year for covered cost sharing under the plan's rules; premiums generally do not count.
IMPORTANT All companies, plans, prices, people, and claims in this packet are fictional. Real policies contain definitions, limits, exclusions, conditions, and location-specific rules that must be checked before making a decision.	

Part 1 - Read the Cost-Sharing Terms

Match each term to when and why it is paid.

Term	Plain-language meaning	Example	Question
Premium	Monthly cost to keep coverage	\$240/month	
Deductible	Amount paid for certain covered care before plan sharing begins	\$1,500	
Copayment	Fixed amount for a covered service	\$30 visit	
Coinsurance	Percentage paid for a covered service	20%	
Out-of-pocket maximum	Yearly cap on covered in-network cost sharing, subject to plan rules	\$6,000	

Which cost is paid even when the person receives no care? Which costs may not count toward the out-of-pocket maximum?

Part 2 - Calculate Annual Premium and Cost Sharing

Use the simplified classroom assumptions exactly as stated.

Task	Plan terms	Calculation	Student cost
Annual premium	\$240/month		
Service before deductible	\$600 allowed; deductible not met		
Service after deductible	\$800 allowed; 20% coinsurance		
Three visits	\$30 copay each		

Calculate each amount. Explain why annual premium should be added when estimating total yearly spending.

Part 3 - Compare Two Fictional Plans

Assume all listed services are covered and in-network. Ignore subsidies, tax effects, and separate drug deductibles.

Feature	Plan A	Plan B	Decision effect
Monthly premium	\$240	\$330	
Deductible	\$2,000	\$750	
Coinsurance after deductible	20%	10%	
Primary-care copay	\$35	\$20	
Out-of-pocket maximum	\$6,500	\$4,000	
Network	Local doctors listed	Preferred doctor not listed	

Calculate annual premiums and the maximum simplified yearly exposure: annual premium + out-of-pocket maximum. Why does network status matter?

Part 4 - Estimate Simplified Yearly Costs

Use this classroom rule: annual premium + stated copays + deductible/coinsurance amounts shown.
Cap covered cost sharing at the stated maximum.

Scenario	Plan A calculation	Plan A total	Plan B calculation	Plan B total
Low use: 3 primary visits				
Medium use: deductible met + \$2,000 subject to coinsurance + 4 visits				
High use: out-of-pocket maximum reached				

Complete both plans. For low use, assume visits use only the copay and do not count toward the deductible. For medium use, add the full deductible, coinsurance on \$2,000, and four copays.

Part 5 - Write a Health-Plan Comparison Brief

Sam wants predictable costs and to keep a preferred doctor. The doctor is listed only for Plan A. Expected use is uncertain.

Decision check	My evidence
Annual premium	
Low-use total	
Medium-use total	
High-use maximum exposure	
Deductible difference	
Network concern	
Prescription/authorization facts to verify	
Recommendation with limitation	

Write 150-200 words. Do not give medical advice. Explain what changes if keeping the preferred doctor is a nonnegotiable requirement.

Reality check: obtain the current Summary of Benefits and Coverage, provider directory, drug formulary, and plan documents before an actual enrollment decision.