Key Health Care Terms and Examples

In-Network, Preventive Care, Sick Visits

Health care providers or facilities that are part of a health plan's **network** – and with which the plan has negotiated a discount.

In-network **preventive care** – such as annual exams and age-appropriate screenings and vaccinations – are free.

Non-preventive care – or **sick visits** – detect or treat a diagnosis and will require you to pay "out of pocket" a percentage of the bill while in the deductible (100%) or coinsurance (20%) phase.

Deductible

Amount you pay out-of-pocket before the plan begins to cover cost of care.

ANNUAL IN-NETWORK MEDICAL DEDUCTIBLES

Individual	Family
Option A – $600	Option A – $1,250
Option B – $1,200	Option B – $2,500
Option C – $2,300	Option C – $4,600

Coinsurance

Amount you pay for a covered health care service, expressed as a percentage of total cost, once you've met your annual deductible.

For instance, you pay 20% of medical charges – and the Firm pays 80%.

Out-of-Pocket Maximum

Maximum amount you could pay for medical services in a plan year. Once this amount is met, the plan pays 100% of cost of your care.

ANNUAL IN-NETWORK MEDICAL OUT-OF-POCKET MAXIMUMS

Individual	Family
Option A – $2,000	Option A – $5,000
Option B – $3,000	Option B – $7,500
Option C – $5,500	Option C – $11,000

Example 1: Individual Enrolled in Medical Plan Option C*

Alex is enrolled in Medical Plan Option C, covering just themself. That means their in-network annual ***deductible*** is $2,300 and ***out-of-pocket maximum*** is $5,500 – *combined across medical and prescription costs.*

In January, Alex sees their in-network doctor for an annual checkup and flu shot. Since both are considered ***preventive care*** services, the cost of the care was covered at 100% and they paid nothing for the visit.

Unfortunately, Alex broke their arm in February, landing in the ER. The total cost was $1,000 for the medical care and an additional $200 for prescriptions. They had to pay the full $1,200 because they had not yet met the $2,300 deductible, leaving $1,100 of the deductible unmet.

Alex's arm break required surgery in March, performed by an in-network surgeon at an in-network hospital. The total charge was $2,000. Of that, they paid $1,100, the remaining deductible. Now that Alex had met the deductible, the plan begins sharing in the cost of care for the remaining $900 – called ***coinsurance***: The plan covers 80% ($720) and Alex the remaining 20% ($180).

Alex has paid a total of $2,480 out-of-pocket to date. If they seek additional medical care in-network or fill prescriptions, they'll be responsible for 20% of the charges, while the plan covers 80%. If they incur $5,500 total in charges for in-network care – hitting the out-of-pocket maximum – the plan will then cover the full cost of in-network services for the remainder of the year. Deductibles and out-of-of pocket maximums reset on January 1 each year.

Example 2: Family Enrolled in Medical Plan Option A*

Logan is enrolled in Medical Plan Option A, covering their partner and two children. The family's in-network ***deductible*** is $1,250, and family ***out-of-pocket maximum*** $5,000 (for medical costs only). Since Option A (and B because they are PPOs) have separate medical and prescription accumulators, Logan's family also has a separate $150 family medication deductible and $6,125 family medication out-of-pocket maximum.

In March, Logan got strep throat, requiring a ***sick visit*** to the doctor. The visit cost $100 and an antibiotic prescription $50. They were responsible for paying the full medical and prescription costs since they had not hit either deductible.

Unfortunately, Logan's two children also contracted strep. Each sick visit cost $100 per child and each prescription $50. Logan was responsible for paying the cost for the sick visits since the children hadn't met their medical deductible. However, they reached their $150 family medication deductible, so Logan and the plan would share any additional prescription costs (known as coinsurance).

In August, all four family members have annual checkups with their in-network primary care physician. Since the visits are considered preventive care, the cost of the care was covered at 100% and Logan paid nothing.

In November, Logan has their third baby (congratulations). The total cost of OB-GYN visits and the hospitalization (both in-network providers) total $8,500. What Logan and the plan pays breaks down as follows:

	Logan	Medical Plan
$800 deductible remainder ($1,250 minus $450 Logan has paid this year for sick visits)	$800	$0
$5,000 out-of-pocket maximum (coinsurance)	$1,000 (20%)	$4,000 (80%)
$2,700 remainder of bill	$0	$2,700 (100%)

Note: For **Options A and B**: If an individual family member reaches their individual deductible amount, the plan will start to share in the cost of care for just that individual (coinsurance). The same applies for the out-of-pocket maximum: If an individual within a family reaches the individual out-of-pocket maximum amount, the plan will cover costs at 100% for just that family member. For **Option C**: The family must meet the entire combined medical and prescription drug deductible before the plan will pay coinsurance.

* *The cost of care amounts used in the two scenarios – excluding deductibles, out-of-pocket maximums, coinsurance percentages and preventive care – are illustrative and do not reflect actual costs for care under the Firm's medical plan.*