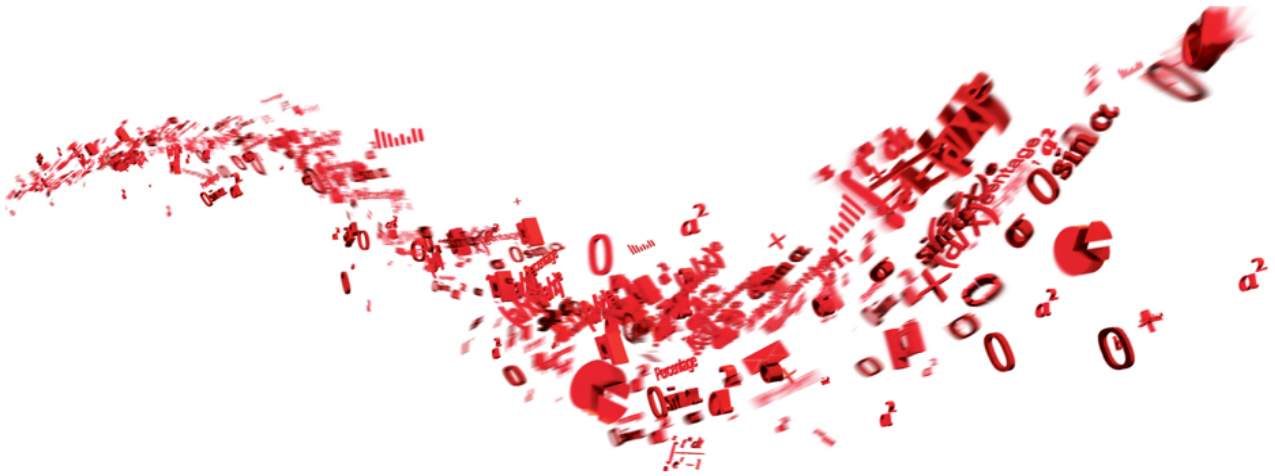

Benefit Counselor Learning Guide 2018

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BASELINE KNOWLEDGE STUDY GUIDE
Benefits 101 Overview

Understanding Benefit Products

Our industry groups products into core and voluntary benefits. Core benefits are those that are offered by the employer to the employee and are partially or fully subsidized by the employer. Voluntary benefits are those that are offered to the employee and are fully paid for by the employee. Most voluntary benefits are portable. This means that an employee can maintain the benefit after they leave the job, most times at the same cost. Each client may have a slightly different combination of core and voluntary benefits. Here is a list of benefits that many of our clients offer, both core and voluntary:

- Medical
- Dental
- Vision
- Flexible Spending Account
- Hospital Indemnity
- Accident Insurance
- Accidental Death and Dismemberment
- Basic Term Life
- Supplemental Term Life
- Dependent Term Life
- Permanent Life
- Short-Term Disability
- Long-Term Disability
- Critical Illness Insurance
- Long-Term Care Insurance
- Employee Assistance Program
- Wellness Program
- Pre-Paid Legal Services
- Identity Theft

The benefit enrollment session is an opportunity to position both core and voluntary products as a part of an employee's overall benefits package. Most employees believe that if they pay a portion of the premium for any plan, it is a voluntary plan. This belief is not correct.

Voluntary Products for each enrollment have been selected by the client based on anticipated need and interests of their employees.

Medical

Many companies offer several medical plan options. Here are some of the most common:

Health Maintenance Organization (HMO): An HMO is an organization that provides health services to individuals known as subscribers or members. The HMO generally contracts with a group of doctors and other medical practitioners to provide services at agreed-upon costs, prepaid on behalf of the members. Members select a Primary Care Physician (PCP) to coordinate their care. Members must rely exclusively on the HMO for all their medical needs in order to qualify for payment. No claim forms need to be completed and visits to physicians who are not in the HMO network will generally not be covered.

Preferred Provider Organization (PPO): Like HMOs, a preferred provider organization (PPO) is a managed healthcare system. However, there are several important differences between HMOs and PPOs.

A PPO is a group of doctors and/or hospitals that provides medical services only to a specific group or association. The PPO may be sponsored by a particular insurance company, by one or more employers, or by some other type of organization. PPO physicians provide medical services to the policyholders, employees, or members of the sponsor(s) at discounted rates and may set utilization control programs to help reduce the cost of medical care. In return, the sponsor(s) attempts to increase patient volume by creating an incentive for employees or policyholders to use the physicians and facilities within the PPO network. This plan offers in and out of network options. Seeing an in network provider, a co-pay will be required. Co-pays for specialists are most often higher than for family physicians.

If the member goes out of network, deductibles and co-insurance will apply, which are paid by the member out of his or her pocket.

Rather than prepaying for medical care, PPO members pay for services as they are rendered. The PPO sponsor (employer or insurance company) generally reimburses the member for the cost of the treatment, less any co-payment percentage. In some cases, the physicians may submit the bill directly to the insurance company for payment. The insurer then pays the covered amount directly to the healthcare provider, and the member pays his/her co-payment amount. The price for each type of service is negotiated in advance by the healthcare providers and the PPO sponsor(s).

Point of Service Plan (POS): A Point of Service (POS) plan is a type of managed healthcare system that has characteristics of the HMO and the PPO. Like an HMO, you pay no deductible and usually only a minimal co-payment when you use a healthcare provider within your network. You also must choose a primary care physician who is responsible for all referrals within the POS network. If you choose to go outside the network for your healthcare, POS coverage functions more like a PPO. You will likely be subject to a deductible (around $300 for an individual or $600 for a family), and your co-payment can be a substantial percentage of the physician's charges (usually ranging from 20 - 60%).

Minimum Essential Coverage (MEC): Any insurance plan that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance you must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called “qualifying health coverage”). Examples of plans that qualify include: Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP. MEC plans are a viable solution, but are not what most think of as traditional health insurance. They cover only certain wellness and preventive services specified by the ACA. Hence, the cost is less than traditional group health insurance and can be paid by the employer, the employee or co-funded.

Consumer-Driven Health Plan: This plan allows individuals to choose their own health care providers, manage their own expenses, and improve their own health with respect to factors that they can control. Typically a CDHP involves a tax-exempt health account to be used for health care up to a certain amount. It may involve a high-deductible health insurance policy that pays for expenses over the deductible. Funds that are not spent for health care may be saved for future years or retirement. These plans may include a support system (usually on the intranet) to help individuals choose providers, get reasonable prices, track their expenses, and improve their health.

HRA: A Health Reimbursement Arrangement (or Account) is an account set aside by your employer with tax-free funds to reimburse you for qualified medical expenses. Balances at the end of a calendar year may carry over to the next calendar year, but the account is not portable if you leave your job. Although HRAs are usually a benefit that is part of a high-deductible health plan, it is not a requirement. Employers can offer HRAs with any kind of health plan, although there are limitations to how an employer can contribute funds to an HRA.

HSA: A Health Savings Account is an account that you set aside, in combination with a high-deductible health plan, to pay for qualified medical expenses. Any funds that you deposit to the account from your paycheck are tax-free. Your employer can also contribute to your HSA, either through a matching program or through other options, but the account is yours and is portable if you leave your job. Unlike HRAs, HSAs are only available in combination with a high-deductible health plan.

Dental

Many companies offer several dental plan options. Here are some of the most common:

Dental Maintenance Organization (DMO): This plan may require employees to select a dentist in advance. The dentist has agreed to participate in network and accept reimbursement from the dental carrier. Employees must use an in-network dentist. This leads to lower out of pocket expenses. This plan works the same way as an HMO.

Dental Preferred Provider Organization (DPO): This plan allows employees to choose an in or out of network dentist. The employee receives a higher level of benefits when he/she uses a participating dentist. Deductibles and co-insurance may apply.

Discount Plan: This plan offers a discount on the cost of services, usually a flat percentage amount, as long as the employee uses a participating dentist. The cost to the employee is small because the discount is relatively small.

Most plans include four types of service: preventative, basic, major, and orthodontic:

- **Preventative:** includes routine examinations, cleanings, x-rays. Usually covered at 100%.
- **Basic:** includes fillings, extractions, periodontal work, and oral surgery, usually paid at 70-100%.
- **Major:** Includes crowns and bridges. Usually paid at 50-60% of Reasonable and Customary charges.
- **Orthodontic:** includes charges related to braces. There may be restrictions (e.g., adults may not be covered). A cap or maximum lifetime allowance usually applies.

Vision

Most plans provide only limited vision plans. Stand-alone vision plans may operate within a network or allow participants to use any provider with reasonable and customary limits. Typically, for a small co-pay, a participant can receive one eye exam and a dollar amount towards eye wear once every 12 months. Out-of-network benefits are usually handled on a reimbursement basis. There are also "materials only" discount plans that provide annual discounts (these are useful for contact lens users).

Flexible Spending Accounts (FSAs)

A Flexible Spending Account or FSA allows employees to set aside pre-tax dollars via salary deduction to pay for certain expenses. This is made possible through an employer participating in a flexible benefits plan which is qualified under codes section 125 and 132 of the Internal Revenue Service. The three types of FSA accounts available cover out-of-pocket medical expenses, dependent care, and parking or public transportation to and from work.

An employee is allowed to participate in any or all of the three different FSA plans depending on personal needs and which of the three an employer sponsors. An employee would elect to have a specific amount of their pre-tax income deducted from their paycheck each pay period. This money would not be included in their gross earnings or taxable income. They employee can then use these pre-tax dollars to pay for eligible expenses, either medical, dependent care or parking/transit based on which of the three, separate accounts they elect to participate in. By contributing pre-tax dollars to an FSA plan, an employee can lower their taxable income, thereby paying less in taxes and increasing take home pay.

The maximum that can be contributed to a medical FSA is regulated by the IRS, for 2017 the maximum contribution is $2,600. The IRS allows up to $5,000 annually for dependent care. Dependent care includes daycare for children 13 or under or for adults as long as the care is necessary in order for the employee and their spouse to be employed. Eligible medical expenses could include co-pays, deductibles, orthodontia, eyeglasses, contacts and more. Over-the-counter drugs can be eligible expenses with a prescription only.

It is important to note that when planning an FSA allotment, one should not overestimate expenses as dependent care and Transit FSA plans are "use it or lose it." All of the money that was committed to the account must be used during that calendar year or the employee will not receive a refund of what is left in the account following the plan year. For the medical FSA, the employer has the option of allowing either a $500.00 rollover into the next year or a 2 ½ month grace period in order to use up the funds, but not both. In general, an employee can end up saving 20-32% or more on their out-of-pocket costs for eligible expenses!

Hospital Indemnity

Hospital Indemnity plans are considered supplemental health coverage, meaning that they do not coordinate or reduce by benefits received under major medical insurance. Major medical insurance will pay the hospital and doctor directly while a hospital indemnity plan will pay benefits directly to the insured. Therefore benefits are paid regardless of any other coverage.

Common areas that are covered in a hospital indemnity plan are daily hospital confinement, intensive care, inpatient physician's attendance, surgery, anesthesia, transportation, etc. When any of these services are provided a predetermined cash benefit payment is triggered. These payments will continue to be paid accordingly as they apply.

Accident Insurance

Accident Insurance is a form of health insurance against loss by accidental bodily injury. This benefit can help defray the cost of out-of-pocket medical expenses for accidental injuries such as doctor fees, co-payments, deductibles, x-rays, crutches and wheelchairs as well as lump sum benefits for accident related disabilities. Benefits are often paid on a schedule of benefits and can be paid out for accidents that occur either on or off the job.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment is a benefit offered by employers that will pay a death benefit in the event an employee dies in an accident. A percentage of the benefit amount is normally paid in the event of a loss of limb, eyesight, or hearing. Sometimes an accidental death and dismemberment rider is included with a basic term life insurance policy and provides a double indemnity in the event of the death of an employee. When AD&D is included with basic term life, the cost is paid by the employer. If AD&D is a benefit by itself (stand-alone policy), then generally the employee must pay for it.

Basic Term Life

Basic Term Life pays a death benefit to a beneficiary if the covered employee dies. This plan is often provided by the company at no cost to the employee. There are two primary approaches:

- Flat amount: The employer provides a specific dollar amount, usually based on job title, years of service or other criteria.
- Multiple of salary: Most often one x salary is provided rounded up the next $1000.

Company-provided term insurance is usually convertible to an individual policy once an employee terminates or retires. Converted policies, however, are usually whole life policies based on the employee's attained age, thus making them cost prohibitive to many. In recent years, some basic term life group plans will allow “portability” with proof of good health.

Supplemental Term Life

Supplemental Term Life is a benefit that allows employees to purchase additional term life insurance. The options available to employees can be based on a flat amount of insurance, multiple of salary, or a combination of the two. Because this is term insurance, it is fairly inexpensive for employees to purchase. In order to avoid adverse selection, companies often restrict the dollar amount of coverage that an employee can purchase without the employee providing evidence of insurability.

Dependent Life

Dependent Life is a benefit that allows employees to purchase additional term life insurance on the lives of their spouses and/or dependent children. Typically, the options are based on a flat amount of insurance coverage. Some companies offer dependent life as a combination spouse/child life insurance election; other companies offer spouse life and child life as separate options.

Permanent Life (also known as Universal Life or Whole Life)

Permanent Life Insurance refers to a policy that pays a lump sum death benefit and in some cases, may pay an accelerated death benefit upon the diagnosis of a terminal illness. Permanent life policies offer a cash value benefit; the premium does not increase as you age and you can keep the policy for your whole life provided the premiums are paid.

Short-Term Disability

Short-Term Disability is a benefit that provides income protection for employees for a short period of time. The benefit period usually lasts between 13-26 weeks (about the same timeframe as the federal Family/Medical Leave Act (FMLA) entitlement). If the employer provides both short and long term disability plans, the short-term usually expires at the same time the long-term plan commences. This benefit can be State-provided, company-provided or offered to employees as a voluntary benefit.

On some company-provided plans, employers require that all or some available sick time be used prior to the benefit becoming available. Although some companies provide a 100% salary replacement STD plan, most employers do not want to offer too rich a benefit for fear that those employees who constantly miss work due to illness have no urgent desire to return to work.

In states like New Jersey, New York, Hawaii, Rhode Island and California where there is a State Disability Plan, these plans work as a supplement to the State plan, to the effect that the total benefit cannot exceed a certain percentage of weekly pay. For example, in NJ, the benefit is approximately 60% of weekly pay to a maximum weekly amount, after a waiting period.

Long-Term Disability

Most Long-Term Disability plans provide disability benefits up to age 65. The typical benefit is 50-60% of monthly base pay although the benefit level can be higher. The waiting period is anywhere from 13-26 weeks and usually coincides with any short-term disability plans in effect at the time.

The plan can either be company-provided or made available as a voluntary benefit. The length of the benefit is usually subject to medical review periodically during the duration of the disability. Employees should be encouraged to read the plan summary carefully.

Critical Illness Insurance (also known as Critical Care)

Critical Illness Insurance provides a contract in which an insurer makes a lump sum cash payment if the policyholder is diagnosed with one of the covered critical illnesses listed on the insurance policy and they have satisfied any pre-existing clauses from the date the insurance was first purchased. Typical illnesses covered are heart attack, stroke, cancer, kidney failure, and organ transplants. This will vary from contract to contract.

Long-Term Care (LTC)

Long-Term Care offers a variety of services which help meet both the medical and non-medical need of people with a chronic illness or disability who cannot care for themselves for long periods of time. It is common for long-term care to provide custodial and non-skilled care, such as assisting with normal daily tasks like dressing, bathing, and toileting. LTC may also include medical care that most people do for themselves, such as diabetes monitoring. LTC can be provided at home, in the community, in assisted living, or in nursing homes. LTC may be needed by people of any age, even though it is a common need for senior citizens.

The median age of the United States population is at an all-time high. Adults over the age of 65 have surpassed the number of teenagers, and people in their 50s and 60s can expect to live longer than previous generations. As life expectancy continues to rise in the U.S., more and more Americans between the ages of 40 and 84, especially those in their mid 50s, are preparing for their golden years by purchasing long-term care insurance. With costs rising with age, it is important for employees to fully understand long-term care insurance and when it should be purchased to best prepare them for the future.

Employee Assistance Program (EAP)

An Employee Assistance Program is a confidential program that is designed to help employees stay healthy and maintain a sense of well being. This program provides employees with access to professionals in the fields of psychology, social work, and counseling who allow them to get information, referrals, or solutions to personal issues. Some examples of areas in which employees can get help are stress, depression, parenting, marital problems, substance abuse, financial issues, or legal problems.

Wellness Program

A Wellness Program is designed to promote a healthy lifestyle among employees through on-site exercise facilities and classes or seminars on nutrition, exercise, health education, health risk assessments, smoking cessation, etc. Other venues are telephone or web based. These plans are often designed to promote employee health and reduce overall healthcare costs.

Pre-Paid Legal Services

A Pre-Paid Legal benefit refers to an individual or group employee benefit legal plan in which members pay a monthly fee in exchange for access to a range of legal services on-call. Pre-paid legal plans typically offer certain services for a fixed monthly charge such as legal advice and consultation, review of contracts, having a lawyer write a letter on a client's behalf, or the drafting of wills and other legal documents. Legal service plans may also cover legal representation in court and the filing of motions, but most plans require a client to pay extra for such services or cover a limited number of hours in court time.

Identity Theft Insurance

Identity Theft Insurance provides reimbursement to crime victims for the cost of restoring their identity and repairing credit reports. Some companies now include it as part of their homeowner’s insurance policy. Others sell it as either a stand-alone policy or as an endorsement to a homeowner’s or renter’s insurance policy.

Identity theft insurance provides reimbursement for expenses such as phone bills, lost wages, notary and certified mailing costs, and sometimes attorney fees with the prior consent of the insurer.

BASELINE KNOWLEDGE STUDY GUIDE
HDHPs & Healthcare Accounts

Understanding the shift to Consumer Directed Health Care

Suppose the average employee visits his doctor with an average case of strep throat or back pain and pays a $20 health insurance co-pay as he or she checks out. What do you think the office visit actually costs?

If you're that average employee, you might guess $40 or $50. As an insurance broker, benefits expert, or insurance underwriter, you'd know the answer is closer to $80.
.
And there lies part of the challenge for employers trying to control their health insurance costs. Employees generally don't know the true costs of health care, and many lack information or incentive to become involved in holding down those costs.

To change that situation, employers today are beginning to shift more of the responsibility (and risk) for health care to their employees. And they're wielding some new tools to do it.

Many health insurance companies have developed health plans to increase consumer awareness of costs and quality of their health care.

The new kids on the block in medical expense insurance are Consumer-Driven Health Plans (CDHPs). This title refers to these newer, more recently developed health plans that give consumers more options to direct how health care dollars are spent.

Sometimes called "Consumer-Directed Health Plans," or "Consumer Choice Health Plans," there are a number of health plans that fall into this category.

Under the consumer-directed umbrella are High-Deductible Health Plans (HDHPs), which require workers to pay many medical bills themselves, up to a certain point.

Along with the HDHPs, some employers are offering Health Reimbursement Arrangements (HRAs).
Other employers are offering Health Savings Accounts (HSAs), a new way for workers to pay for unreimbursed medical expenses such as deductibles, co-payments and services not covered by insurance.

While employers may seize upon such plans as a strategy for shared economic survival—theirs and their employees—it has been a challenge to understand the plans and communicate the provisions to their workers.

Understanding Tax-Advantaged Arrangements for Health Care Expenses

Tax-advantaged arrangements for health care expenses have been around for more than 20 years, starting with Flexible Spending Accounts (FSAs) in the 1980s and Archer Medical Savings Accounts (MSAs) in 1997. The Treasury Department approved Health Reimbursement Arrangements (HRAs) for tax exempt status in 2002.

FSAs have become common in many organizations, although Medical Savings Accounts (MSAs) never caught on widely. The newcomers on the block are Health Savings Accounts (HSAs), approved in the 2003 Medicare prescription drug bill, and Health Reimbursement Accounts (HRAs).

Flexible Spending Account (FSA)

The FSA is a stand-alone vehicle that enables employees to pay out-of-pocket health care costs with pre-tax dollars. Most FSAs are contributions through salary reduction arrangements: employees get less take-home pay but the "missing" money goes directly into their FSA and is theirs to use on qualified expenditures. Non-medical withdrawals are not permitted on a Health Care FSA; although employers also can set up—and employees can contribute to — separate FSAs for Dependent Care.

The accounts have had a "use it or lose it" provision; any unused funds at year's end were forfeited to the employer. New options are available to employers, so long as an employer chooses to participate, one option extends the deadline to March 15 of the following year, the other option allows for a $500 Rollover.

The entire amount that is to be contributed to an FSA in a calendar year is actually available at the beginning of the year, even before all the employee's paycheck deductions have been made. Thus an employee who endured a root canal in January could be reimbursed then instead of waiting until July for the "correct" number of dollars to mount up.

Health Reimbursement Arrangement (HRA)

An HRA is an employer-paid health arrangement that reimburses employees for qualified medical expenses. Only employers can set up and contribute to HRAs. However, employers need not actually Pay any money until—or unless—an employee actually files a reimbursement request. Employers like HRAs because of this feature, and because they maintain control over the money.

HRAs can roll forward, meaning if not all the money is used in one year; it can be carried forward into the next.

The employer determines which qualified medical expenses are covered, and the coverage is usually restricted in some way. Because the employer owns the HRA, the employer can set limits, such as the total amount that can be built up in the account. When an employee leaves the company, the account balance may be forfeited back to the employer. Or, an employer can choose to give all or a portion to the employee. The choice is the employer's.

However, HRAs are subject to COBRA provisions. COBRA (Consolidated Omnibus Budget Reconciliation Act) gives qualified former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage. HRAs do not need to be associated with High-Deductible Health Plans (HDHPs), although employers generally link them with a health plan having an employee out-of-pocket deductible greater than the annual contribution to the HRA.

Health Savings Account (HSA)

With HSAs, people can set up tax-favored accounts to pay for medical expenses not covered by insurance or other reimbursements. Eligible individuals can establish and contribute to these accounts only when they have a High-Deductible Health Plan (HDHP) and, in general, no other health insurance (other than dental, vision, disability and long-term care).

With an HDHP, workers pay lower premiums which—in theory—frees up money so they can make pre-tax contributions to their HSA. Contributions can be deducted from taxes. Because employers also are saving money on premiums, they often choose to contribute as well, generally a few hundred dollars to each account.

Withdrawals for medical expenses are not taxed, and account earnings are tax-exempt. A withdrawal can be used for non-medical expenses; however an individual doing so would incur a tax penalty. The individual can accumulate unused balances, and the account belongs to him or her. An HSA also is portable, meaning employees can take the account along with them if they switch jobs.

Why would workers be interested in high deductibles and HSAs? When they're getting small pay increases but have been absorbing higher costs for health insurance premiums, in effect shrinking the raise. If employers can illustrate how workers could have more take-home pay under an HDHP with an HSA, employees might be receptive. In theory, at least, the advantage for employees would be coupled with an advantage to employers who could slow the rise in their health care premium costs—or at least make them more predictable.

Some observers see HRAs and HSAs as a way to increase consumers' interest in their own health care—changing their behavior and thus controlling costs. However redistributing health care costs and responsibilities is a huge culture shift for American employees, so employers are moving cautiously, gleaning experience from early plans.

Debit Cards

Major Banks that are administering HSAs give clients a debit card, and many provide a checkbook as well. When an individual walks into the pharmacist, for instance, he generally can pay with the card. Health insurance companies are working on details of how such point-of-service payments also could be possible as the patient leaves a doctor's office or hospital. Employees seem to like the idea of using a debit card with their health care or with a flexible benefit plan. Employers have found that when they put a debit card into an HSA, HRA or FSA, the average participation goes up by 30 percent, and the average amount contributed goes up as well, by about 20 percent. Some experts predict that very soon, these eligibility/stored value cards will morph into even smarter cards containing the user's electronic health records.

Further Understanding Consumer Directed Health Care

What is a CDHP?

The concept of a CDHP is to return control of health care dollars to the person who uses them, the consumer. The consumer is given a financial incentive to control costs and as a result tend to become more directly involved in the selection and usage of health care services. CDHP's typically consist of three parts:

1. A health plan with a relatively high deductible level that provides financial security for more severe illnesses. Preventive care services are typically covered with only a small copayment.
2. A health fund that the consumer controls. Employers can make contributions into the health fund of their employees. Funds in the account can be used to pay for expenses before the deductible is met. Any unused funds typically roll over from year to year and can accumulate into a significant balance.
3. Information tools are provided to the consumer to help them make better health care decisions. These may include health and wellness information and information on providers and the cost of services.

How the Consumer Directed Plan works:

1. You have an annual deductible and the security of an out-of-pocket maximum.
2. Through contributions by the employer (if eligible) to your HRA, or your own contributions to a Health Flexible Spending Account (Health FSA), if elected, you also have the ability to save for future health care expenses.
3. Rather than paying a fixed co-pay when you receive care, you pay the negotiated cost of each visit until you meet your annual deductible, with the exception of in-network preventive care services.
4. All in-network preventive care is covered at 100%. This includes annual screenings, well-woman visits and routine immunizations.
5. After you meet the annual deductible, you pay coinsurance up to your out-of-pocket maximum.
6. Once you reach your out-of-pocket maximum, the plan pays 100% of the cost of covered services for the remainder of the year.

What are the advantages of a CDHP?

- Contributions to the health fund are tax exempt.
- The higher deductible health plan has a lower premium than a traditional plan so the employee's premium contribution is reduced, saving money.
- If used judiciously, the health fund will be conserved and increase from year to year, even to the point of covering the entire out-of-pocket exposure.
- Most employers contribute to their employees' health fund; so that the employee's out-of-pocket exposure with the higher deductible plan may not be significantly higher than the traditional plan.
- Access to information tools to make better health care decisions and to improve health status.

What are the disadvantages of a CDHP?

- CDHPs require consumers to become more involved with their health care. To maximize value consumers need to shop around and find the appropriate mix of usage, quality, and price for their health care dollar.
- CDHPs have higher out-of-pocket exposure than more traditional plans. This should be partially offset by employer contributions to the health fund.

What is a High-Deductible Health Plan (HDHP)?

With a High-Deductible Health Plan (HDHP), you have the security of comprehensive health care coverage. Like a traditional plan, you are responsible for paying for your qualified medical expenses up to the in-network deductible; however, the deductible will be higher, and you can use HSA funds to pay for these expenses.

After the annual deductible is met, you are responsible only for a portion of your medical expenses through coinsurance or co-payments, just as with a traditional health plan.

How do I know if my health plan is a "qualifying (or qualified)"High-Deductible Health Plan (HDHP)?

The health insurer or your employer can verify the status of your coverage. In addition, the words "qualifying (or qualified) high-deductible health plan" will be included in the declaration page of your policy or in another official communication from the insurance company.

To be a qualified plan the deductible cannot be below the annually declared minimum and out-of-pocket maximums cannot exceed the annually declared maximum.

Deductibles and out-of-pocket maximums are adjusted annually for inflation by the IRS and US Department of Treasury.

A qualified HDHP with family coverage may have deductibles for both the family as a whole (aggregate deductible) and for individual family members (embedded deductibles). If either the deductible for the family (aggregate) or the deductible for an individual (embedded) is below the minimum annual deductible for family coverage, the plan is not a qualified HDHP.

What is covered under preventive care?

Preventive care includes annual physicals, well-baby check-ups, mammograms, pap smears, prostate specific antigen (PSA) tests, colon cancer screenings, and immunizations.

What is a Health Reimbursement Arrangement (HRA)?

An HRA is a reimbursement account setup and funded by your employer to cover eligible healthcare expenses as defined in the HRA Summary Plan Document. Unlike a healthcare FSA where the IRS defines the eligible services, your employer defines the services eligible for reimbursement from an HRA. Typically, an employer will reimburse deductible, coinsurance and co-pay expenses from your HRA but not services such as medical, dental or over the counter drugs. An HRA can also cover all or a portion of your prescription drug expenses. Check your employer's HRA Summary Plan Document to see what types of services are covered under the HRA being offered by your employer.

How the Health Reimbursement Account (HRA) works:

- You can use the balance in your HRA to pay for eligible health care expenses, such as doctor visits or prescription drugs.
- Any unused balance at year-end will roll over to the next year, and you can access the unused balance if you remain enrolled in an HRA-eligible medical plan and remain employed by the company.
- Your HRA is funded only by the company, if you meet eligibility requirements. You can't make contributions yourself.
- To pay for eligible medical expenses, simply show your Medical ID card at your doctor's Office or pharmacy, and then pay with your health care account Visa® debit card.
- You can also pay with cash, check or your own credit card and then request reimbursement from your HRA account.

Who funds the HRA?

The HRA must be funded entirely by your employer.

What expenses can I submit for reimbursement from my HRA?

Reimbursements may be made for any eligible expense as defined in IRS code section 213d. However, it is up to your employer as to what your benefit plan allows as an eligible expense. Please refer to your specific benefit material to determine what is considered an eligible expense under your specific HRA plan.

Do you have to substantiate eligible expenses?

Yes, the IRS requires that all HRA transactions be substantiated. Therefore, it is very important that you save your receipts for all your transactions.

What happens to my HRA balance at the end of the year?

Unused funds in the HRA account may roll over to the following year. Any funds remaining in the HRA account are used toward future medical expenses under the Consumer Driven Health Plan.

Can I have both an HRA and a Flexible Spending Account (FSA) at the same time?

Yes, your employer can offer both or either of these plans.

How will my HRA work with my FSA?

You cannot receive payment for the same qualified medical expense under both plans. It is up to your employer to determine if your HRA or FSA will pay first. If your HRA account pays first and has limitations on allowable services, the HRA funds must be exhausted. Then any applicable qualified medical expenses will apply to your FSA funds. If your FSA pays first, once your FSA funds are exhausted then any applicable qualified medical expense may apply to your available HRA funds.

Are insurance premiums an eligible expense?

Usually, they are not but an HRA is a special kind of reimbursement account so your employer may allow you to be reimbursed from your HRA for insurance premiums.

If I terminate employment or retire, can I receive the remaining balance in my HRA?

No. However, you can continue to submit claims for reimbursement that were incurred prior to your termination date before the end of the run-out period (defined in your Summary Plan Description).

For example: Your plan has a 90-day run-out period following termination. Your termination date is September 13th. Your physician sees you on September 12th, but you do not receive the Explanation of Benefits from your insurance carrier until October 31st. You can still submit this expense as it was incurred prior to your termination date, and prior to the end of the 90-day run-out period following your date of termination. Any expense incurred after September 13th is not eligible.

If I terminate employment or retire can I be reimbursed for expenses incurred after my termination date?

Typically, in order to be considered an eligible expense, the expense must be incurred prior to your termination date. However, you may be able to continue your HRA coverage under COBRA.

How do I enroll?

To enroll in an HRA, you must elect the option through your employer. With some plans, HRA coverage is automatically provided when you enroll in a specific health plan option, such as a deductible based PPO.

Is my family eligible to enroll in an HRA?

It depends. Typically, an HRA is offered as a reimbursement account to cover healthcare expenses incurred by you or your family members covered under the employer's insurance plan.

How do I contribute money to my HRA?

That's the best part of an HRA - you don't need to contribute any money to your HRA as the funds are provided by your employer to offset your out-of-pocket healthcare expenses.

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a special tax-advantaged savings account designated for medical expenses. An HSA allows you to pay for current eligible health care expenses and save for future qualified medical and retiree health care expenses on a tax-favored basis.

HSAs provide triple-tax advantages: contributions, investment earnings, and qualified distributions all are exempt from federal income tax, FICA (Social Security and Medicare) tax and state income taxes (for most states).

Unused HSA dollars roll over from year to year, making HSAs a convenient and easy way to save and invest for future medical expenses. You own your HSA at all times and can take it with you when you change medical plans, change jobs or retire.

Funds in the account not needed for near-term expenses may be able to be invested.

To be eligible to set up an HSA and to make contributions, you must be covered by a qualified “high-deductible health plan”, or HDHP.

How the Health Savings Account (HSA) works:

- You can use the balance in your HSA to pay for eligible health care expenses, such as doctor visits or prescription drugs.
- Once you meet the deductible, the CDHP option pays a percent of health care costs.
- Any unused balance at year-end will roll over to the next year, every year.
- There’s no use-it-or-lose-it rule.
- You keep your account even if you change jobs or health plans.
- If you meet eligibility requirements, the employer contributes to your HSA. You can also make contributions yourself.
- You can pay for eligible expenses at the time of service using your Visa® debit card.
- You can also pay at any time with cash, check or your own credit card and then file a claim online.

Who is eligible to open an HSA?

If you meet all the criteria listed below, you are eligible to open and contribute to an HSA. Eligible individuals" as those who:

1. are covered by a qualified high-deductible health plan (HDHP);
2. are not covered by another health care plan, such as a health plan sponsored by your spouse’s employer, Medicare or Tri-Care; and
3. Cannot be claimed as a dependent on another individual's tax return.

Who is eligible to contribute to an HSA?

After you open your HSA, making contributions helps you build a balance to assist with current and future health care expenses. Anyone, including your employer or family members, may contribute to your HSA. You can make contributions by payroll deduction (if available) or by after-tax contributions.

Payroll deductions: If your employer offers the option, you may specify a regular contribution to be deducted from your paycheck. This contribution will be made before Social Security, federal, and most state income taxes are deducted.

After-tax contributions: You may choose to make all or part of your annual account contributions to your HSA by making "after-tax" contributions to your account. These contributions may be deducted on your income tax return, using IRS Form 1040 and Form 8889. Employers may make contributions to your account as well; while you do not take a deduction for these contributions, they are excluded from your gross income.

You are eligible to make contributions to your HSA as long as you meet the definition of an "eligible individual" as listed in the question, "Who is eligible to open an HSA?" If you no longer participate in a high-deductible health plan or enroll in Medicare, you can no longer contribute new funds to your HSA account.

What is a qualified medical expense? What can I spend my HSA dollars on?

An HSA-qualified medical expense is any health care cost paid on behalf of an individual or his or her spouse or dependents as defined in the Internal Revenue Code (IRS Section 213[d]). These are the same as for a Health Care Flexible Spending Account (FSA).In general you can use your HSA funds to pay for any **qualified** medical expense. Qualified medical expenses are a defined term created by the IRS and include: medical care, prescription drugs, and payment for long term care.

What is the value of an HSA?

First, consider the following: unless you have a significant, catastrophic-type medical claim, it is unlikely that you will recoup the amount of money you pay in employee contributions for traditional plans (such as a PPO) or even Health Reimbursement Accounts (HRAs).

Example 1, assume you pay $250 a month for Family HDHP coverage, which equals $3,000 per year (12 x 250)

Example 2, assume you pay $550 a month for family PPO coverage, which amounts to $6,600 per year (12 x $550).

	Example 1	Example 2
3 Dr. Visits	$600	$60
4 Prescriptions	$300	$120
	$900	$180

In Example 1 you will have $900 in medical expenses, because you did not yet meet your deductible, However you can pay all those expenses with a Pre-Tax H.S.A. By choosing the HDHP plan in this case can save $300 a month in premium setting aside some of that into the H.S.A could have covered the expenses. In this case you spent $3,900 on Medical for the year, $3,000 in Premium, $900 in services.

In Example 2 you will have $180 in medical expenses, because you have co-payments for your services. The co-payments will likely be with after tax dollars, unless an F.S.A was used. In this case you spent $5,680 on medical for the year, $5,500 in premiums and $180 in services

Compare the numbers of your available plans. The HDHP usually offers lower premiums in exchange for the higher deductible, including the same coverage for significant health expenses as with the more expensive traditional plans. You pay for costs below the deductible with tax-free dollars and employer contributions, if offered, and keep and grow the funds you don't use each year.

How is money deposited to my HSA?

Money may be deposited to your HSA through payroll deduction, if your employer participates in such a program, or you may make deposits directly to your account. Deposits may be made periodically or in a lump sum, but only up to the contribution limits set by the IRS.

Payroll deductions: If your employer offers the option, you may specify a regular contribution to be deducted from your paycheck. This contribution will be made before Social Security, federal, and most state income taxes are deducted.

After-tax contributions: You may choose to make all or part of your annual account contributions to your HSA by making “after-tax” contributions to your account. These contributions, which you can make by writing a personal check, may be deducted on your income tax return, using IRS Form 1040 and Form 8889.

Employers may make contributions to your account as well; while you do not take a deduction for these contributions, they are excluded from your gross income.

Why establish an HSA? What are the advantages?

Yes, you can have both an HSA and an IRA.

Tax-advantaged:

1. Contributions you may make through payroll deposits are made with pretax dollars, meaning they are not subject to federal (or state, for most states) income taxes.
2. Contributions to your HSA made with after-tax dollars can be deducted from your gross income, meaning you pay less income tax at the end of the year.
3. The interest you earn on your HSA balance is not taxed.
4. Withdrawals from your HSA for qualified medical expenses are not subject to federal income tax. As long as you use your HSA funds for qualified medical expenses, you will not have to pay federal (or state, for most states) income taxes.
5. Employers may make contributions to your account; these contributions are excluded from your gross income.

Flexible: The money is yours; it grows and remains with you, even when you change medical plans, change employers or retire. There are no "use it or lose it" rules. Even if you are no longer eligible to make contributions, funds in your account may still be used to pay for qualified medical expenses tax-free. And after age 65, or in cases of disability, the funds in the account can be used for nonqualified expenses.

Portable: Accounts move with you when you change medical plans, change employers or retire.

Savings mechanism for future health needs: Unused funds can grow through interest and investment earnings and can be "banked" for future medical expenses.

Contributions can come from multiple sources: As long as you are covered by a qualified HDHP, you, your employer, family members, or anyone else may contribute to your HSA up to the maximum annual contribution limit.

How do HSAs differ from Health Care Flexible Spending Accounts (FSAs)?

Both HSAs and FSAs allow you to pay for qualified medical expenses with pre-tax dollars .One key difference, however, is that HSA balances can roll over from year to year, while FSA money left unspent at the end of the year or after a designated grace period is forfeited.

How is an HSA different from a savings account?

The funds in a regular savings account do not have the tax advantages of an HSA. Also, funds from an HSA can only be used for qualified medical expenses.

What are the differences between an HSA and FSA?

Both HSAs and FSAs allow you to pay for qualified medical expenses with pre-tax dollars. The most important difference between the FSA and the HSA is that you keep any remaining year-end balance in the HSA, whereas you lose any remaining balance in your FSA at the end of the year.

If you enroll in the HSA, you can still contribute to an FSA. However, when you participate in the HSA you are then eligible to participate only in a Limited FSA. A Limited FSA will only reimburse you for dental and vision costs. You cannot submit medical or prescription expenses for reimbursement from your Limited FSA.

Can my spouse and I have a joint HSA, like our regular checking account?

No, only one person can be named the account owner. If both you and your spouse have qualified HDHP coverage, you must each have your own account. If both you and your spouse have family coverage under qualified high-deductible health plans, the maximum total tax-deductible HSA contribution both of you can make (including employer contributions) is the IRS limit for family coverage. This contribution can be divided between you and your spouse however you wish. If you and/or your spouse are eligible to make catch-up contributions, you may each contribute your eligible catch-up contribution to your individual HSA.

Why is my employer offering an HSA in conjunction with a qualified HDHP?

Offering an HSA is an excellent way to help you save for future medical expenses and pay for current expenses with tremendous tax advantages.

Can I have more than one HSA?

Yes, you may have more than one HSA and you may contribute to them all, as long as you are currently enrolled in an HDHP. However, this does not give you any additional tax advantages, as the total contributions to your accounts cannot exceed the annual maximum contribution limit. Contributions from your employer, family members, or any other person must be included in the total.

Terms to know:

Consumer-driven health plan (CDHP)
A CDHP plan is a healthcare benefit that provides incentives and tools to help consumers understand the total cost of healthcare and make informed decisions that balance choice with cost. These plans typically include a high deductible and one or more spending accounts (Health Savings Account or Healthcare Reimbursement Account).

Healthcare reimbursement account (HRA)
An HRA is similar to a credit line. Your employer or health plan contributes a set dollar amount to this account each year to help pay for you and your family's covered medical and prescription expenses, including your deductible. HRAs may be known by different names, such as Personal Care Account (PCA), Healthcare Account (HCA), or Spending Account (SA). If any money remains in the HRA at the end of the year, your health plan may allow you to roll over some or all of those funds for use in the following year.

Healthcare savings account (HSA)
An HSA is a tax-sheltered savings account, similar to a 401(k) plan. You or your employer (or health plan) can contribute to this account each year. The account can be used to pay medical and prescription expenses for you and your eligible family members. Any money remaining in the HSA year stays in the account and is available to you for future healthcare expenses. An HSA is portable, which means you can take it with you if you change employers or health plans. In order to make contributions to this account, the IRS requires that the account holder be covered by a qualifying High-Deductible Health Plan (HDHP). Visit http://www.irs.gov/publications/p502/index.html for eligible expenses.

High-deductible health plan (HDHP)
An HDHP is a health plan that begins with a high deductible. This deductible must be paid by you before you or your eligible family members can receive healthcare coverage. For HSA plans, the HDHP includes an IRS-defined minimum deductible and maximum out-of-pocket limits.

Flexible spending account (FSA)
A Healthcare FSA enables you to set aside your own money on a pretax basis to pay for healthcare expenses incurred by you or any eligible dependents. When you pay for an eligible medical service or product (for example, your prescription cost share), the amount you pay will be reimbursed through available FSA funds. Any funds that are unused by the end of the FSA benefit period are forfeited. Visit http://www.irs.gov/publications/p502/index.html for eligible expenses.

Annual deductible
Your annual deductible is the amount you pay for most covered medical services each year before the Plan begins to pay its portion.

Coinsurance
Once your annual deductible is met, the plan shares in the cost of your covered medical services through coinsurance.

Out-of-pocket maximum
The out-of-pocket maximum is the most you will pay for most covered medical services in a calendar year.

Triple Tax Advantage
Additional tax advantage of the HSA: The HSA also has a triple tax advantage. Your contributions are Tax free and the money you use for eligible health care expenses is tax free. Also, if you have more than $1,000 in the HSA, you can invest it, and the money grows tax free helping you save for medical expenses down the road.

Imputed Income
The value of certain benefits is considered imputed income, which means you pay taxes on the value of that coverage.

You will have imputed income if your company-paid associate basic life insurance coverage is more than $50,000.

The value of coverage for a domestic partner or same-sex spouse and/or their children who are not your tax dependents is considered imputed income for purposes of medical, dental, vision, AD&D insurance, as well as the value of any bank contribution to your HRA, to the extent you are not paying the full value of such coverage on an after-tax basis. If you are enrolling a domestic partner or same-sex spouse and/or their children who qualify as your dependents under federal law for purposes of health care coverage, notify the Global HR Service Center.

Eligible employees based in the U.S. who elect to cover a same-sex domestic partner/same-sex spouse and/or same-sex domestic partner's/same-sex spouse's children through the company's medical (including HRA), dental, vision or AD&D plans will be eligible for a reimbursement to offset the additional required tax paid by the employee for that coverage.

Reimbursement will occur in the first quarter following the plan year for which the coverage was effective. Reimbursement is not available with respect to opposite-sex domestic partner coverage. In addition, certain participants have imputed income on a portion of their dependent life insurance coverage. If imputed income affects you, you will see it on your pay notification and W-2 form. For more information, call the Global HR Service Center or contact a tax adviser. Some states may have different rules for imputed income for state income tax purposes.

Key Points:

Health Savings Account (HSA) Maximum Contributions 2018
- Single Coverage: $3,450
- Family Coverage: $6,900
- Catch-up (55+): $1,000

Health Flexible Spending Account (FSA) Maximum Contributions 2018
- Single/Family Coverage: $2,650

Health Reimbursement Account (HRA) Maximum Contributions 2018
- The employer is allowed to determine contribution limits.

What is an Embedded Deductible?

An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. It's not usually used in high-deductible health plans which use aggregate deductibles instead, but is the most common type of family deductible in all other health plans.

How Does An Embedded Deductible Work?

With an embedded deductible, your health plan will keep track of two different types of health insurance deductibles for each family member: the individual deductible and the family deductible. The family deductible is usually two to four times larger than the individual deductible. When a family member has a health care expense, the money he pays toward his individual deductible is also credited toward the family deductible.

There are two ways coverage will kick-in and the health plan will begin paying for the health care expenses of any particular family member:

1. The family member has had enough personal health care expenses that he or she has met the individual deductible. In this case, the health plan begins paying for this person's expenses, but not the health care expenses of other family members.
2. Several different family members have each paid enough in individual deductibles that, added together, the family deductible has been met. In this case, the health plan begins paying the health care expenses for the entire family, even the family members that haven't paid anything at all toward their individual deductible.

Pros and Cons of an Embedded Family Deductible

The problem with an embedded family deductible is that the only way you can meet the family deductible and get coverage for the entire family is by pooling the individual deductible expenses of several family members. (This is not true for an aggregate deductible.)

With an embedded deductible, even if a single family member has very high health care expenses, those expenses alone won't be sufficient to meet the family deductible. Why? Because as soon as that individual meets his lower individual deductible, his health insurance benefits kick in and begin paying. He may then be required to pay other types of cost-sharing like co-pays or coinsurance, but those other out-of-pocket expenses don't get credited toward the family deductible. Only the money he paid toward his individual deductible gets credited toward the family deductible. Since the individual deductible is smaller than the family deductible, one individual in the family can't possibly satisfy the entire family deductible himself.

The benefit of an embedded family deductible is that health insurance kicks-in for the sickest members of the family sooner than for other family members. Because these sick family members have higher health care expenses, they reach their individual deductible and health insurance starts paying for their health care expenses. It's thanks to the embedded deductible system that their insurance benefits kick in and start paying before the family deductible has been met.

What Is An Aggregate Deductible?

An aggregate deductible is the system most high-deductible health plans use for family deductibles. It works differently than the more common embedded deductible system used in non-HDHP health insurance.

How Does an Aggregate Deductible Work?

With an aggregate family deductible, the health plan doesn't begin paying for the health care expenses of anyone in the family until the entire family deductible has been met. Once the aggregate family deductible has been met, health insurance coverage kicks-in for the entire family.

There are two ways the aggregate deductible can be met:

1. As each member of the family uses and pays for health care services, the amount they pay out-of-pocket for those services is credited toward the family's aggregate deductible. After several family members have paid deductible expenses, the combined total of those expenses reaches the aggregate deductible. The health plan then begins to pay the health care expenses of the entire family.
2. One member of the family has high health care expenses. The amount he or she pays out-of-pocket for those expenses is large enough to meet the family's aggregate deductible. The health plan then begins to pay the health care expenses of the entire family, even though only one family member has paid anything toward the aggregate deductible.

What Expenses Count Toward the Family Aggregate Deductible?

The only expenses your HDHP will count toward your aggregate deductible are expenses for covered health plan benefits. For example, facelifts aren't usually a covered health plan benefit. If you get a face lift, the money you pay for it won't count toward your aggregate deductible.

Your health insurance company can't credit any of your out-of-pocket medical expenses toward your deductible if it doesn't know about them. Make sure you or your doctor file claims for each of your medical expenses, even if you know you must pay them yourself because you haven't met your deductible yet. This is how your health insurance company knows how much you've paid toward your deductible.

What Expenses Are Exempt From the Aggregate Deductible?

In the United States, the Affordable Care Act requires that health plans pay for preventive health care services without requiring any form of cost-sharing. This means your health insurance will pay for things like your flu shot, your kids' immunizations, and your yearly mammogram even if you haven't paid your deductible yet.

FAQs Further Clarify New Embedded Out-of-Pocket Requirement

As reported earlier, starting with the 2016 plan year, the self-only annual limitation on cost sharing for non-grandfathered plans ($6,850 for 2016)1 applies to each individual, even if the individual is enrolled in family coverage.

On May 26, 2015, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) issued new FAQs further clarifying this new rule, confirming that it applies to all non-grandfathered group health plans, including self-insured plans, large group health plans, and high deductible health plans. The Departments also provided the following example:

Assume that a family of four individuals is enrolled in family coverage under a group health plan in 2016 with an aggregate annual limitation on cost sharing for all four enrollees of $13,000. Assume that individual #1 incurs claims associated with $10,000 in cost sharing and that individuals #2, #3, and #4 each incur claims associated with $3,000 in cost sharing (in each case, absent the application of any annual limitation on cost sharing).

In this case, because the self-only maximum annual limitation on cost sharing ($6,850 in 2016) applies to each individual, cost sharing for individual #1 for 2016 is limited to $6,850, and the plan is required to bear the difference between the $10,000 in cost sharing for individual #1 and the maximum annual limitation for that individual, or $3,150. With respect to cost sharing incurred by all four individuals under the policy, the aggregate $15,850 ($6,850 + $3,000 + $3,000 + $3,000) in cost sharing that would otherwise be incurred by the four individuals together is limited to $13,000, the annual aggregate limitation under the plan, under the assumptions in this example, and the plan must bear the difference between the $15,850 and the $13,000 annual limitation, or $2,850.

For the FAQs, visit: **http://www.dol.gov/ebsa/pdf/faq-aca27.pdf**.

KEY INFORMATION- TERMS TO KNOW AND UNDERSTAND

All terms below are with brief descriptions and general information. Keep in mind that any carrier or company may modify plans to fit their needs.

Medical

HMO-Health Maintenance Organization, This is an *In-Network* Medical plan that has the participant coordinate their care through a *PCP*. Many services are often provided for a *Co-Payment*.

PPO-Preferred Provider Organization, This is a Medical plan that provides an *In-Network* list of providers where the participant can get higher coverage. However, PPO's allow the participant to go *Out-of Network*, but at an increased cost. PPO's often have A few *Co-payments* for Key services, and then allows all other services to fall under the *deductible* and *co-insurance* schedule.

CDHP-Consumer Driven Health Plan, This a broad category of medical plans that often has a higher deductible then standard *PPO* plans and they are paired with an account option, giving the participant more control over their medical costs. CDHP can include plans paired with *FSA's*, *HRA's* and *HDHP* paired with *HSA's*

HDHP-High Deductible Health Plans, This is a Medical plan that provides an *In-Network* list of providers where the participant can get higher coverage. However, HDHP's allow the participant to go Out-of Network, but at an increased cost. HDHP must have a deductible of at least $1,350 for an individual and $2,700 for family coverage. HDHP participants will often need to reach the deductible before most service are paid for, and then they have co-insurance up to their Out of Pocket Max. HDHP can be paired with HSA.'s.

EPO-Exclusive Provider Organization- This is an *In-Network* Medical plan that has the participant coordinate their own care. They will generally have co-payments for some services while using a deductible and co-insurance schedule for others. Somewhat of a hybrid between an HMO and a PPO.

PCP-Primary Care Physician, This is a general doctor that can often help treat and coordinate your care in any medical plan. PCP's are often required in HMO plans, both medical and dental.

In-Network-This is the list of doctors that most participants with a medical plan should use, this list is unique to the carriers that negotiate the costs with different providers. In-Network providers are required with some medical plans, while other plans will give lower cost to those using them.

Out-Of-Network- This is any doctor or medical provider not on the participants list of in-*network doctors*. Many plans do allow for some coverage out-of network, but they could have significantly increased costs by using these providers. The deductibles and co-insurance costs are often higher, and their may be no negotiated rates reductions.

Annual deductible-Your annual deductible is the amount you must pay for many covered medical services each year before the plan begins to pay its portion. Most services that are offered with a co-payment are not subject to the deductible, nor do co-payments apply towards the deductible.

Aggregate Deductible- Used when the participant is insuring family members. This is when a family deductible must be met, before any services are covered by the insurance plan. The medical cost of all insured family members apply to one larger deductible. Once the deductible is met the plans co-insurance will begin.

Embedded Deductible – Used when the participant is insuring family members. Each insured family member only has to meet their own deductible before the plans *co-insurance* starts coverage.

Coinsurance-Once your annual *deductible* is met, the plan shares in the cost of your covered medical services through co-insurance.

Out-of-pocket maximum-The out-of-pocket maximum is the most you will pay for covered medical services in a calendar year.

Co-Pay- Certain service can be covered for a fixed payment, once the participant pays their Co-payment the rest of the bill is covered by the insurance. Co-pay's are very common with HMO's and very rare with HDHP's.

Preventive Coverage- All ACA plans pay for "preventive" services at 100%. Immunizations, annual physicals, wellness exams are often covered. Be careful with how you word that coverage to employees though, if the doctor diagnosis or corrects anything during the "preventive" appointment, the normal deductibles, co-pays, or Co-insurance will apply.

Medical and Core Accounts

HC FSA-Health Care Flexible Spending Accounts- This is an account available to help participants cover the cost of qualified health care expenses (medical, dental and vision). They can elect to have up to $2,600 to be put in the FSA by their Employer. They will then pay back the elected amount through pre-tax payroll deductions. FSA's have a use it or lose it feature, if you don't have eligible expenses in the plan year, you may forfeit your remaining balance. Two variations to that are available, the FSA may allow for a $500 roll over to the following year, or they may allow for a 2.5 month extension to accrue expenses.

Limited FSA- This FSA is sometimes available when *HSA's* are offered. They follow most of *Health Care FSA* rules, except the funds can NOT be used for medical, only qualified dental and vision expenses.

HSA-Heath Savings Accounts- This is a bank account available to participants of HDHP's. They can elect up to $3,450 to go in for an Individual or $6,900 to go in for family level coverage; the contributions are pre-tax through pay roll. Those over 55 can "Catch up" $1,000 extra a year. Many employers will provide some funding for the HSA. The Employee is the owner of the account, it will roll over each year and it still belongs to the employee if they leave the company. If they use the funds in the account for qualified Health care expenses they come out tax free, funds used for non-eligible expenses will have extra tax penalties.

HRA-Health Reimbursement Accounts- This account is paired with a *CDHP;* the employer funds the account with a pre-determined annual amount. Those funds can then be used to reimburse the employee for medical expenses the company considers eligible. Often times the reimbursement is automatic. Unused funds can sometimes accumulate to a predetermined maximum.

Dep FSA-Dependent Care Flexible Spending Accounts- This is an account available to help participants cover the cost of qualified Dependent care. Babysitters and daycare for children, or elder care for adult dependents. They can elect to contribute up to $5,000 into the account to get reimbursed for those qualified expenses. The money is available for reimbursement only after it has been deposited through payroll deductions, it is not pre funded.

General Information

HIPAA- Health Insurance Portability and Accounting Act, HIPAA covers many things related to health insurance, your primary concern here, will be to protect the privacy of any heath information you may have access to.

Dependent- Eligible family member of the plan participant. A spouse, child, Step-child, child whom the participant has legal guardianship over. In many cases Domestic partners and their Children can be Eligible as well.

Dependent Verification- Many companies require Dependent to be verified when first put on a plan. Requirement vary by company, but birth certificates, marriage License, 1040's or court papers are commonly excepted.

Domestic Partner- The exact definition of a domestic partner varies a lot from company to company. They are generally partners in a mutually caring relationship for some length of time, most commonly a year. If a participant adds a domestic partner, they should be aware that premiums and benefits received for the DP will be post-tax, not pre-tax.

Beneficiary- The person, trust or organization the participant sets to receive any insurance proceeds in the event of death.

Wellness Program- Many companies have a program that allows participants to spend less on their insurance if they meet the Wellness Programs guide lines. The penalties/rewards for the program vary for each company, as well as the guide lines. Be sure to give employees accurate description of any programs that apply to them.

Dental

Dental PPO- Similar to medical this dental coverage will have a preferred providers list of In-Network dentists, but will allow for lower out of network coverage. Be sure to let Employees know the *deductibles, co-insurances*, and limits of the policy.

Dental HMO- This dental plan requires all care to go through one *PCP*, with referrals needed for any services that office cannot complete. Participants will be given a list of covered services; they will be responsible for the *co-payment* on that list for any covered services received.

Life and Disability

STD-Short Term Disability- This benefit is designed to replace some of the employee's income if they become too sick or hurt to work, but for a limited time period. Once the participant has doctor's approval, the DI plan will start paying after the elimination period has been met, and continue paying until the doctor approval runs out, or the max benefit period has been met. Work related injuries may not be covered for STD; they would fall under workers comp. Be sure to know the *pre-ex*, *elimination period, Eloy,* payout amount and b*enefit period*s for any STD you are offering.

LTD-Long Term Disability- This benefit is designed to replace some of the employee's income if they become too sick or hurt to work, starting after s set time months, and lasting for years. LTD will protect part of an employee's income if they have a serious illness or injury. LTD will normally stop paying if; they get a different job, income source, if they get better, or if the benefit period runs out. *Pre-ex*, payout amount, *elimination period* and b*enefit periods* may apply.

Supplemental Life- Term insurance the Employee elects during enrollment, as the Employee ages the cost will increase. Amounts available may include *guaranteed issue* and coverage that requires *EOI*.

Whole Life- Permanent Insurance many employers offer this benefit as part of the benefit package. Whole life purchased at work is *portable.* Amounts available may have *Guaranteed Issue*, Simplified Issue, or require some *EOI*. Pointing out this will be available no matter when it is needed can add value to the employee.

Basic Life- Term insurance provided by the Employer, generally a flat amount, or a multiplier of the Employees salary.

Voluntary Benefits

CI-Critical Illness- This benefit is designed to provide a lump sum of money to the participant to use however they see fit. They are common with higher *deductible/out of pocket* plans to offset or pay for the cost of the medical treatment. When a participant is diagnosed with a covered illness, they receive the benefit amount directly. *EOI, Guaranteed Issue, Pre-Ex, Portable* or w*ellness benefits* may apply.

Accident Insurance- This is designed to give the Participant a lump sum of money when they receive medical service for an injury caused by an accident. The Money is paid directly to them and they may use it for whatever they like, offsetting insurance *deductibles* is popular. Pay outs are according to a schedule of benefits and vary a lot based on the plans and the injuries. *Guaranteed Issue, Pre-Ex, Portable* or w*ellness benefits* may apply.

Hospital Indemnity- This is designed to give the participant a lump sum of money when they receive medical service in a hospital. Pay outs are according to a schedule of benefits and vary a lot based on the plan; the payout can be used to offset the un-covered medical expenses. It is common for plans to cover the initial hospitalization, surgeries and each day in the hospital. *EOI, Guaranteed Issue, Pre-Ex, Portable* or w*ellness benefits* may apply.

Pre-paid Legal- This plan is designed to give the participant limited access to a lawyer network to perform many simple duties. The Schedule of benefits varies from carrier to carrier, but often includes document review, document preparation services and consultations.

Identity Theft- This helps participants, review, monitor and correct identity issues that may arise if someone tries to steal and/or use their identity. The programs vary from plan to plan, but often monitor for unauthorized charges or accounts, and helps correct any issues.

EAP-Employee Assistance Program- This programs allow employees to call and speak with counselors regarding a wide range of issues, personal, emotional, legal, financial. EAP's are funded by most employers and when they are the employers want the employees to be made aware of the EAP's availability.

Important Terms

EOI-Evidence of Insurability- This is designed to make sure the participant is healthy enough to insure. It may be needed with Supp Life or any of the VB's. For VB's the questions are often built into the system and asked at the time of enrollment, Normally for Supp Life it is a form they will need to fill out and turn in.

Elimination Period- The amount of time that must past before the disability begins paying. Elimination periods can be from 0 days on up and is an important piece of information for any plan you are working with.

Pre Ex-Pre Existing Conditions- How long it will take before the new policy will cover an existing issue. Many VB's and DI policies have limitations on them, and will not cover you for a certain time frame if a condition is preexisting. For Example a 6/12 Pre Ex, means that for the first 12 months you have the policy, it will not cover you for anything you had treatment for the 6 months preceding owning the policy. Evan Guaranteed issue policies often have a Pre-Ex.

Benefit Period- The maximum length of time a DI policy will pay out. With *STD* this is often in weeks, for *LTD* it is often in years, or to a certain age. If a participant becomes disabled they do not automatically get the benefit period, they will get what the doctors and the carrier approves, up to the benefit period.

Wellness Benefit- A cash payout from a VB for completing qualified health screening. When a participant turns in the wellness form they can receive a set amount, usually between $25 and $100.

Portable- The ability to continue a benefit after the participants is no longer employed at this employer. This is an important feature of most VB plans because they can continue to have the desired coverage after they have moved on.

Convertible- The ability to continue coverage, but under a new plan design. This is often available on Supp life, the participant can convert supp life into a Whole life when they leave, and it is generally at the current age so the insurance becomes much more expensive. This is useful if an employee leaves an employer in poor health.

GI-Guaranteed Issue- Allows a participant to enroll in a benefit without having any *EoI*. This can be a great selling point for any VB's that offer GI, but it is important to note that *DI* and *CI* normally have a Pre-Ex so they can have the policy and can claim for new issues, they may not be able to claim for an existing issue.

SI-Simplified Issue- Allows for a participant to get coverage if they can answer only a few health questions positively. It is the shortest form of *EoI.*

QLE-Qualifying Life Events- They allow Employees to change their pre-tax benefits in the middle of the plan year. Generally employees have 1 chance to change their benefits each year, during open enrollment. However if they have an IRS life event they can make changes relevant to that event within 30 days. The common QLE are changes in marital status, loss of coverage, newly eligible for coverage, births or deaths.

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