Decoding Benefits & Health Care

A quick reference guide to break down complex terminology

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Health Insurance Basics

Don’t speak health insurance? We’ve got you covered.

Health insurance and benefits can be confusing. Use this quick reference guide to help understand some of the most common terms.

Copayment

A copayment or copay is a fixed monetary amount for a covered medical service, paid by you, the patient, to a health care provider such as a doctor’s office. Your health insurance policy will determine the amount, which you as the insurance policyholder will pay each time a medical service is provided.

Deductible & Coinsurance

A deductible is the amount of money you pay out of pocket each plan year before your insurance company begins to pay. Each plan year, the deductible must be met. Depending on whether you have an individual or family plan, you may have to meet an individual deductible or a family deductible. After the deductible is met, the cost of care is then shared according to your insurance plan. This sharing of cost is referred to as coinsurance. Some plans have a coinsurance policy that will either cover a percentage of the fees charged, while others limit costs to a specific dollar amount.

In/Out of Network

An in-network provider is a doctor, hospital or other health care professional that has an agreement with your insurance company to provide services to you as a plan member for a set rate. This in-network provider, sometimes called a Preferred Care Provider (PCP), accepts your specific insurance carrier and plan type. That usually means your insurance company will pay a larger percentage of health care charges.

An out-of-network provider is any provider that does not have a contract with your insurance carrier. Generally, an insurance company will pay less money or not pay anything at all for services you receive from out-of-network providers.

Out-of-Pocket Maximum

The out-of-pocket maximum is a cap on how much you as an insurance policyholder has to pay for covered medical expenses in a plan year. If you reach that amount within the year, your insurance plan will pay 100 percent of covered services after that point. There is an individual out-of-pocket maximum and a family out-of-pocket maximum.

Premium

A premium is simply the amount you pay for a particular health insurance policy and is typically deducted from your paycheck.

Common Health Insurance Plan Types

Health Maintenance Organization (HMO)

With a Health Maintenance Organization (HMO), costs are fixed to plan members in advance with a set fee, usually monthly or yearly. Preventive care is key in an HMO arrangement. As a plan member, you typically select a primary care physician (PCP) from a list of approved physicians who will then coordinate your care, meaning that you must contact your PCP to be referred to a specialist. In many plans, specialist visits are only covered if referred by the PCP. Depending on the type of plan, you may be able to go out of network to visit another doctor by providing a copayment or you may have to pay the entire cost for out-of-network services.

High Deductible Health Plan (HDHP)

A high deductible health plan (HDHP) is a type of health insurance plan characterized by lower premiums and higher annual deductibles than traditional health plans. With most HDHPs, preventive care is fully covered. The HDHP will pay medical bills from in-network providers after the deductible has been met. As an insurance policyholder of this type of plan, you may be able to select out-of-network providers; however, they cost more and may not be fully covered, depending on your plan. HDHPs are often paired with tax-advantaged programs like a health savings account (HSA) or health reimbursement arrangement (HRA).

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) is a type of health care coverage an employer may offer employees. In a PPO, a group of doctors, hospitals and other health care professionals have contracted with an insurance company or a third-party administrator to provide their services to PPO customers at a discounted rate. Health care professionals within the PPO plan are sometimes called in-network providers, meaning that when services are received from in-network providers, the insurance company will pay a larger percentage of health care charges. Depending on the type of PPO plan, the insurance company may or may not pay a percentage of the cost of services for out-of-network providers. Some plans require insurance policyholders to see a primary care physician in order to be referred to a specialist. Typically, in this type of plan, a premium is paid to maintain coverage.

Health Care Account Plan Comparison Chart

A comparison of HSA, HRA and FSAs

Health care accounts are not all created equal. To help you understand the differences between HSAs, HRAs and FSAs, take a look at the comparison chart below.

	HSA	HRA	FSA
	Health Savings Account	**Health Reimbursement Arrangement**	**Flexible Spending Account**
Definition	An HSA is a tax-advantaged savings account that is used in combination with a high deductible health plan (HDHP). Consumers use the HSA funds to cover qualified medical expenses.	An HRA is an employer-funded plan that may be used to reimburse employees for qualified medical expenses.	An employer-established, tax-advantaged account funded by the employee and/or the employer to pay for qualified medical expenses with pre-tax dollars.
Who "owns" the account?	Individual\Employee	Employer	Employer
Who can contribute to the account?	Individual\Employee, Employer	Employer only	Employee and Employer
Where are funds held?	In HSA Deposit Account – Qualified Financial Institution and Mutual Funds	By employer	By Employer
Pre-tax payroll deductions allowed?	Yes	No	Yes
Annual maximum limit on contributions [www.irs.gov]	Yes[1]	No[2]	Yes[3]
Entire election available for reimbursement at start of plan year	No	Depends on plan design	Yes
What distributions are allowed?	Debit Card[4] Request for distribution or bill-pay Online/Paper	Debit Card "Claim" – Request for reimbursement or bill pay Online/Mobile/Paper	Debit Card "Claim" – Request for reimbursement or bill pay Online/Mobile/Paper

1 IRS-imposed HSA limits for 2019: The 2019 annual HSA contribution limit for individuals with self-only HDHP coverage is $3,500 (a $50 increase from 2018), and the limit for individuals with family HDHP coverage is $7,000 (a $100 increase from 2018). Annual catch-up contributions for those 55 and over: $1,000 (unchanged from 2018).
2 IRS does not impose HRA limits; limits are set by employer.
3 Employee contribution limits for 2019 for FSAs is $2,700 (a $50 increase from 2018 (per IRS Rules. Employer contributions may not discriminate in favor of highly compensated individuals. Healthcare reform limits employer contributions to $500 per year or an arrangement in which employer contributions will not exceed the employee's contributions, such as a one-to-one match, up to $2,700.
4 HSA, HRA and FSA debit cards are automatically restricted for use with medical service providers and for items purchased at retail that are identified as qualified medical expenses based on electronic inventory control codes.

	HSA	HRA	FSA
	Health Savings Account	**Health Reimbursement Arrangement**	**Flexible Spending Account**
Substantiation	Not required for payment[5]	Required	Required
Must have Health Plan?	Yes, qualified HDHP whether through employer or not	Beginning in 2014, employees have to be enrolled in employer-sponsored group coverage unless the HRA is limited to vision or dental expenses[6].	No, but employer must offer qualified health coverage.
Can have other (non HDHP) Health Plan?	No, except for certain permissible coverage such as dental or other limited purpose plan(s)[7]	Yes	Yes
Tax Benefit	Contributions, interest and investment gains, and withdrawals are all tax free when used for qualified medical expenses.	Employer deposits and claim payments are tax free.	Employer/payroll deposits and claim payments are tax free.
Interest earning?	Interest can be accrued on a tax-deferred basis in qualified HSAs. And if the account balance reaches the minimum balance requirement, the funds can be invested in mutual funds and those gains are also tax free.	No	No
Access to funds after termination	Individual account not tied to employment status	Employee must be offered COBRA	Employees must be offered COBRA (usually until the end of the year)
Employees carry over unused amounts	No	Depends on plan design	Yes
What distributions are allowed?	Yes. The individual owns the account and any contributions made to it, regardless of the source or timing of the contribution.	Employer discretion	Limited to up to $500 carryover to the immediately following plan year OR a grace period[8]

5 HSA distributions subject to IRS audit to prove they do not exceed out-of-pocket qualified medical expenses since HSA opened.

6 PHS Act sec 2711, per DOL FAQ re: PPACA Part XI Q1, Q3 http://www.dol.gov/ebsa/faqs/faq-aca11.html HRA Enrollees must be enrolled in group health plan.

7 Dental, vision, accident, disability, long-term care, workers' compensation, specified disease or illness and fixed dollar hospitalization, certain deductible plans.

8 Employers may elect to have (i) a "grace" period for employees to use leftover funds from a previous plan year to pay for expenses incurred in the period up to 2 months and 15 days into the new plan year; or (ii) a carryover of up to $500 to the new plan year for payment of medical expenses during the entire year in which it is carried over.

	HSA	HRA	FSA
	Health Savings Account	**Health Reimbursement Arrangement**	**Flexible Spending Account**
What is the tax treatment for employer contributions?	Employer contributions may qualify as a deductible business expense and are exempt from FICA and other employment taxes.	Employer contributions may qualify as a deductible business expense and are exempt from FICA and other employment taxes.	Employer contributions may qualify as a deductible business expense and are exempt from FICA and other employment taxes.
What is the tax treatment for employee contributions?	Employee contributions may be made through a cafeteria plan and are tax free. If made outside of a cafeteria plan, they are treated as an "above the line" deduction.	Employees are not permitted to contribute to an HRA.	Employee contributions to an FSA are made on a pre-tax basis, and therefore reduce annual taxable income.
What expenses qualify for distribution?	Medical expenses under § 213 (d) of the Internal Revenue Code (over the counter drugs are not an eligible medical expense unless prescribed by a health care provider). HSAs may not be used to pay insurance premiums except for (1) COBRA, (2) qualified long-term care insurance (3) health care coverage while the individual is receiving unemployment compensation; and (4) premiums for Medicare Part A or B, Medicare HMO, and (5) after age 65, the employee's share of employer-sponsored retiree health care.	Employers configure the account to reimburse all or a subset of any otherwise unreimbursed expenses that are qualified under §213(d) of IRC (over the counter drugs are not an eligible medical expense unless prescribed by a health care provider). This can include health insurance premiums (other than premiums that are paid through an employer's cafeteria plan) and long-term care insurance premiums. However, long-term care services are not reimbursable.	Any otherwise unreimbursed medical expenses that are defined under §213(d) of IRC (over the counter drugs are not an eligible medical expense unless prescribed by a health care provider). Health insurance premiums and long-term care services are not reimbursable.

Additional Health Insurance Offerings

Accident Insurance

Accident insurance pays cash benefits in cases of accidental injuries. These insurance policies help you pay for non-covered medical expenses such as deductibles and copays. These policies can also help you pay for other ongoing expenses, such as mortgage payments and utility bills, while you're out of work recovering from the accident. The benefits are paid directly to you as the policyholder. Accident insurance policies are typically individual policies that are portable, meaning you can carry this policy with you when switching employers or when leaving the workforce, and are a supplement to medical insurance.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment, or AD&D, pays death benefits in case of accidental deaths. The amount paid by AD&D is in addition to life insurance proceeds that may be payable upon the insurance policyholder's death. An AD&D provision is sometimes referred to as double indemnity, meaning that the life insurance will pay double the face value if the death is caused by an accident. AD&D also pays a benefit directly to the insurance policyholder if he or she loses a body part or limb. AD&D may be purchased as part of a life insurance plan or it may be purchased as a standalone policy.

Critical Illness

A critical illness benefit helps pay for the financial strain that often accompanies a critical illness diagnosis listed in the insurance policy. These plans cover a variety of critical illnesses; however, coverage may vary between insurance companies. If you are diagnosed with one of the illnesses covered under your particular insurance policy, the insurance company will pay you a lump sum benefit, which you can then use for a variety of expenses such as the cost of care or treatment and covering lost income due to a decreased ability to work.

Hospital Indemnity

Hospital Indemnity insurance is a plan that pays benefits when you are confined to a hospital, whether for planned or unplanned reasons, or for other medical services, depending on the policy. These plans help fill gaps in medical coverage by providing cash to help cover deductibles, pharmacy prescriptions and other non-covered expenses that may arise from expensive hospital stays and services.

Long-Term Care Insurance

Long-term care (LTC) insurance is health care coverage that helps pay the cost associated with skilled nursing facilities, adult daycare, assisted living and home health aides. It also helps pay the cost for assistance with activities of daily living. The amount of coverage depends on the daily benefit amount (DBA), which is the daily amount the plan pays for health care and assisted living activities. Most LTC plans offer an inflation provision, allowing the policyholder to gradually increase the daily benefit amount to keep up with inflation and the rising cost of health care. LTC plans may include waiting periods and a maximum duration of coverage. Plans generally have a 30, 60 or 90-day waiting period before the plan pays the daily benefit amount. Most LTC plans will have a maximum duration that it will pay the DBA, which is typically only three to five years.

Long-Term Disability (LTD)

Long-term disability (LTD) is an insurance policy that may replace a portion of income in the event that you as the insurance policyholder are unable to work for an extended period of time because of an illness or injury. Employers may offer group long-term disability coverage to employees as part of their benefits plans. If you experience an event that qualifies under your LTD policy, insurance will typically cover a percentage of your monthly salary and begins after sick leave and short-term disability benefits end. Many LTD policies have a waiting period, or elimination period, before benefits kick in, which can range from days to months. The length of coverage and type of covered disability also varies by plan.

Short-Term Disability (STD)

Short-term disability (STD) is an insurance policy that may replace a portion of income in the event that you as the insurance policyholder are unable to work for a set amount of time due to an illness or injury. Some employers may offer group STD coverage for employees as part of their health benefits plan. Some policies require you to use some or all sick days before being eligible to receive benefits. There may be a waiting period from the time of the qualifying event until the first receipt of disability compensation. Compensation is usually a percentage of salary. The length of coverage and type of coverage disability also varies by plan. After the STD benefit period ends, you may be able to receive long-term disability.