MEDICAL INSURANCE

Quick Guide

This Quick Guide was prepared by Truebridge

Member FDIC

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Major Types of Medical Insurance Plans

Prior to the Affordable Care Act, an estimated 47 million Americans lived without health coverage. Unpaid medical bills were the number one reason for personal bankruptcy in America.

Why You Can't Be Without It

Because the costs of health care are rising much faster than overall inflation rate, no one is immune from the devastating financial hardship that can arise from a serious medical illness or injury. The cost of insurance premiums, deductibles, and out of pocket expenses could not only drain your personal finances but potentially cripple you financially. That is why it pays to do your homework, know your options and utilize what's out there. If you are not covered by an employer-sponsored health plan, you can search for private health insurance on your own or through the Health Insurance Marketplace at www.healthcare.gov.

Fortunately, many people are covered by employer health plans. Most employers subsidize the actual cost of insurance to you. In years past, many employers used to shoulder the entire burden of your health insurance premiums. Today, an increasing number of employers are asking you to pay a portion of your insurance premiums.

It is important to realize two things:

- Obtaining coverage through an employer has many features and benefits you most likely will not be able to obtain individually
- Employer coverage can reduce your premium payments dramatically.

One provision of the Affordable Care Act is the minimum coverage provision, also called the individual mandate. Under the ACA, just about everyone is required to have health insurance as of January 1, 2014. Otherwise, they are liable for a tax penalty. Coverage does not have to be supplied through the exchange. People can also get healthcare coverage through an employer, COBRA, Medicare, veterans' benefits, etc. The penalty for not having health insurance, as of 2015, is $325 per adult and $162.50 per child. The maximum penalty per family is $975 or 2% of yearly household income that exceeds the tax filing threshold, whichever is higher. In 2016, the penalty is $695 per adult and $347.50 per child. The maximum penalty per family is $2,085 or 2.5% of yearly household income that exceeds the tax filing threshold, whichever is greater. The maximum penalty is the national average premium for a bronze plan. If you owe a penalty, it will be assessed on your income tax return.

IMPORTANT NOTE: If you are over 65, see the section on Medicare.

Employer Plans

Employers typically offer a choice of one or more plans, so deciding which one is best for you may be difficult. There are many decisions that go into selecting the right plan—not just the cost of the premium. The first step in making the best choice is understanding how the different types of medical plans work.

Key Terms for Understanding Your Medical Plan Options

- **Covered Expenses.** These are the service provider and pharmaceutical charges the insurance company considers eligible for reimbursement.
- **Service Provider.** The doctor, hospital, or eligible health care practitioner that actually delivers the service.
- **Deductible.** This is the amount of money you have to pay out-of-your pocket before the insurance company reimburses you or pays your service provider directly for covered expenses (depending upon the type of plan).
- There is typically a deductible per individual and a deductible per family. If you have more than two family members, the family deductible can help your coinsurance (see below) kick in faster. Here's how:
  - Say your individual deductible is $250 per year and your family deductible is $500. Your covered expenses are $250, your spouse's are $200, and your child's are $150—that's a total cost of $600 in covered expenses. Even though only one of you has met the $250 individual deductible, together you have met the $500 family deductible. So, your coinsurance starts to pay your costs over $500.
- **Coinsurance.** After your deductible is satisfied, the insurance company pays a percentage of covered expenses by either reimbursing you or paying your service provider directly, depending upon the type of plan. The insurance company pays at least 50%, but in most cases the coinsurance

ranges from 70% to 90%, up to a specified limit. The insurance company then pays 100% of covered expenses thereafter. (See *Out-of-Pocket Maximum* below.)

- **Copay.** This is the amount you have to pay for doctor's visits in a Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO). The copayment typically is not applied against your deductible.
- **Out-of-Pocket (OOP) Maximum.** It is the maximum amount of out-of-pocket costs for covered medical expenses you will need to pay in a calendar or plan year. Most plans also have an OOP maximum for the individual and the family. Here are two examples of how your plan may describe the OOP maximum.
  - ***Example 1:*** After the deductible is satisfied, the company will pay 80% (coinsurance) of the next $5,000 of covered medical expenses, and 100% thereafter.
  - ***Example 2:*** The OOP for an individual is $1,000 and $3,000 per family, plus the deductible, or the OOP is $1,500 for an individual and $3,000 per family, including the deductible.
- Reasonable and Customary Charges. This is the average fee charged for a particular service, rendered in a particular geographic area, by service providers with similar training and experience.

Types of Health Insurance Plans

To make the right health insurance decisions, you will need to understand what kinds of insurance plans are available. The principal ones are as follows:

- **Traditional group plans,** which allow you to see any provider and reimburse you for a percentage of what you pay for doctor's bills.
- **Preferred Provider Organization (PPO) plans,** where you typically make only a small copayment if you see a provider in the plan's network.
- **Health Maintenance Organizations (HMOs) plans,** which are similar to PPOs but require you to select providers within the network.
- **Consumer-Driven Health Care (CDHC) plans,** which combine high-deductible insurance with an untaxed employer-funded personal health account with which you pay medical expenses.
- **Under the Affordable Care Act**, exchanges were put in place in October 2013 to provide individuals and small businesses an opportunity to purchase coverage at competitive prices. Twelve states and the District of Columbia operate their own exchanges, while 27 states opted to use the federally-facilitated marketplaces, and 11 are operating it via a state-federal partnership (including 4 federally-supported marketplaces and 7 state partnership marketplaces).

IMPORTANT NOTE: The Affordable Care Act of 2010 put in place certain consumer protections regarding health insurance plan practices. For example, health insurers must publicly justify the reasoning in order to raise premiums by 10 percent or more. Insurers can no longer cancel policies except under specific, strict conditions. And, under the 80/20 Rule, a health insurer must spend at least 80 percent of every premium dollar on medical care and quality improvements. If they spend more than 20 percent on advertising, overhead, or executive compensation, they must provide a rebate to members.

Tax, Funding, and Other Considerations

You will also need to understand how you are paying for medical coverage—is it with pre-tax dollars? If you have a choice of insurance plans, making the right choice depends on a number of factors, and you should take them all into account. If you terminate employment, your employer may be required to offer you COBRA coverage.

In addition, you should look into the costs and benefits of dental plans and vision and hearing plans.

Increasingly, the trend in paying for medical care is for individuals to "self-insure" by establishing a savings account dedicated to medical payments. There are two principal types:

- **Health Care Flexible Spending Accounts**, which save you taxes by allowing you to contribute with pre-tax dollars.
- **Health Savings Accounts**, which also require a high-deductible health plan but are independent of employment and can be established by any qualified individual.

Traditional Group (Indemnity) Plans

Traditional health insurance covers the costs of basic medical costs—(hospitalization and medical and surgical care)—and major medical costs—(physician fees and services). You could buy these coverages separately, but they are generally packaged together as a comprehensive plan. Traditional group plans are

typically known as ***indemnity plans*** because they reimburse you for covered medical expenses. While you are responsible for paying physician services, hospitals typically bill the insurance company for inpatient admissions directly and then bill you the unpaid balance. You are responsible for an annual deductible.

Once you satisfy your annual deductible, your coinsurance typically pays 50% to 90% of covered expenses, depending upon the schedule of coinsurance in your plan. The greater the coinsurance (the more you ask the insurance company to pay), the higher your insurance premiums. After you have incurred a certain amount of out-of-pocket costs for covered expenses, the plan pays for 100% of your subsequent covered medical expenses.

The plan typically reimburses you based on "reasonable and customary charges." If your doctor's fee exceeds the usual charge, you will have to pay the additional costs.

The primary advantage of a traditional group indemnity plan is that it allows you the freedom to use any physician and hospital. But you are responsible for paying your doctor's bills; the insurance company is simply reimbursing you.

If you see your doctor several times during the year, these plans can be more costly than others. Your net out-of-pocket expenses (after reimbursement) are typically more than expenses in managed care programs, such as PPOs and HMOs. Managed care programs tend to pay benefits for many preventive care procedures that indemnity plans usually do not consider a covered expense. They also tend to cover a greater percentage of the actual expense, since managed care programs pay benefits based on predetermined fees.

Preferred Provider Organizations (PPOs) / Point-of-Service (POS) Plans

In a Preferred Provider Organization (PPO) or Point-of-Service (POS) plan, rather than reimbursing you like an indemnity plan, the insurance company contracts with various hospitals and private physicians in a particular geographic location. Physicians and hospitals are paid on a fee-for-service basis. In order for a physician or hospital to be eligible to join the provider network, the service provider agrees to undergo a screening process and agrees to a predetermined set of prices.

The extensive screening process looks at things such as education and ethics, career and personal history, and medical facilities used by the provider. PPO hospitals and other care providers, such as labs, must also meet continuing standards to remain a part of the PPO network.

These plans typically have deductibles, coinsurance, and out-of-pocket maximums for medical, hospital, and outpatient services. But the key feature is that you typically are only asked to make a small copayment for doctor's visits, as long as you use a provider who is part of the network. Some plans require no copayment. And, deductibles are usually waived for doctor visits other than for surgery or pregnancy.

Some PPOs act more like Health Maintenance Organizations (HMOs) and restrict the choice of physicians you can select from their network. Known as the "gatekeeper" concept, this requires you to have a primary physician, who is responsible for monitoring your medical care and making referrals to specialists within the network.

PPOs that offer you the option of going outside the network are referred to as ***point-of-service plans***, also called freedom-of-choice plans. They are hybrids between PPOs and traditional group indemnity plans. If you choose to go outside the network for medical care, the plan will typically reimburse you for certain covered expenses. While your out-of-pocket expenses will be higher out-of-network than if you used a network service provider, you maintain control of where you choose to seek health care services.

While so-called freedom of choice sounds attractive, there are many advantages to using the services in the PPO network. Benefits are paid at a higher percentage, certain preventive care procedures may be covered, deductibles are usually waived for admissions for outpatient surgery, and fees are fixed at a pre-negotiated rate, so you won't have to pay any charges that exceed "reasonable and customary."

Health Maintenance Organizations (HMOs)

Health Maintenance Organizations (HMOs) are similar to PPOs, but they limit you to using the doctors and the medical facilities in the HMO. Their objective is to provide comprehensive medical care at a predetermined price. You are typically required to choose a primary care physician from the HMO when you join the plan. That doctor is responsible for managing your care. In other words, you are required to visit that doctor or obtain a referral from him or her before seeing a specialist.

HMOs come in different shapes and forms, too. Sometimes, the HMO doctors are housed under one roof and are employees of the HMO, while other HMOs contract with individual and group practitioners. How the HMO is organized may influence part of your decision in electing this form of coverage.

Covered services vary by HMO, but generally, joining an HMO offers you these advantages:

- For each office visit, you pay a small flat fee with no deductible. Your hospital stays are usually covered at 100%. Deductibles and coinsurance, typically found in traditional group plans and PPOs, do not apply to covered procedures and services.
- Preventive care is not only covered, it is encouraged. Services such as physicals, immunizations, and routine pediatric care are covered at 100% or for a nominal flat fee.
- Your paperwork burden is reduced since there are generally no forms to fill out.

Due to the comprehensive coverage provided, joining an HMO may be right for you. But be careful: your premiums will be higher than your other plan choices. Before you make the decision to join, make sure you have carefully evaluated the trade-off of your increased premium costs against the added coverage you will be receiving. Carefully review the HMO's list of covered services and participating doctors and hospitals.

Other Types of Coverage— Dental, Vision, and Hearing Plans

Dental Plans

Dental plans make sense for almost everyone who goes to the dentist twice a year for regular check-ups. If rates are reasonable, the annual premium should cost you no more than the cost of the basic services without the insurance. Then, if you require some additional x-rays, a couple of fillings, or a capped tooth, having dental insurance can help save you money.

How Does It Work?

You are covered for certain eligible expenses during a plan year, up to an annual maximum (usually limiting your coverage to no more than $2,000 to $3,000 in a plan year, depending upon your particular plan).

You can have a traditional indemnity type plan, which allows you to choose your own dentist. The plan either reimburses you or you can assign your benefits to your dentist, depending upon the payment arrangements you make. Annual deductibles typically apply to all services except preventive and diagnostic care. Coinsurance varies, depending upon the particular service rendered and the plan's schedule of coinsurance. And, like traditional medical insurance, these plans use "reasonable and customary" charges to pay benefits.

There are other dental plans, such as preferred provider organizations (a Dental PPO) that also allow you the freedom to select your own dentist. However, if you use a network dentist, you will receive certain services at a discount, resulting in lower out-of-pocket expenses. They have deductibles, just as indemnity plans do, but they reimburse you based on a schedule of benefits. Annual deductibles typically apply to all services except preventive and diagnostic care. Regardless of where your dentist is located, there is a maximum benefit you can receive per procedure.

IMPORTANT NOTE: If you live in an area where costs exceed the national average, you may have to cover the portion of your dentist's fee that exceeds the plan's schedule of benefits.

Another type of dental plan is a Dental Maintenance Organization (DMO). A DMO operates like a medical HMO. You choose a dentist from the DMO during the annual enrollment period at your company. A typical DMO has no annual deductible, no annual maximum benefit, and no reasonable and customary charges. Many of the procedures are covered at 100%, while some of the major services may be covered at 60–70%. Your DMO dentist is responsible for your dental care and also makes referrals to specialists within the DMO.

What Services Are Typically Covered in a Dental Plan?

Diagnostic and Preventive Services*	Basic Services	Major Services	Orthodontic Services**
▪ Oral examinations ▪ Fluoride applications for children ▪ Dental x-rays ▪ Supplementary bitewing x-rays ▪ Cleanings	▪ Space maintainers ▪ Emergency palliative treatment ▪ Simple extractions ▪ Oral surgery ▪ Fillings ▪ Periodontal scaling ▪ General anesthesia	▪ Crowns ▪ Dentures ▪ Bridgework ▪ Periodontal surgery ▪ Endodontia (root canal therapy)	▪ Diagnosis and treatment

** The deductible is usually waived for these services.*
***Orthodontic services are usually limited to a lifetime maximum, except for DMOs.*

Should You Buy Dental Insurance?

If you go to your dentist regularly, it generally pays to have dental insurance. But the real answer depends on the cost of the monthly premiums and the condition of your teeth. It's usually worth signing up for the coverage, as long as you go for semiannual checkups, even when your teeth are in great condition. This is because the cost of preventive care alone can be almost as much as the cost of the premium.

The table below illustrates an example of the annual cost of preventive care and the annual cost of dental coverage. In this scenario, the cost of the family premium is $14 per bi-weekly paycheck paid on a pre-tax basis.

Without Dental Insurance		With Insurance Coverage	
Cost of preventive care	$120	Cost per pay period	$14
Number of family members	3	Number of periods	26
OOP cost	$360	OOP cost	$364
Tax savings	$0*	Tax savings	$119**
Net cost	$360***	Net cost	$245

**Assumes no tax benefit because of the 10% AGI limitation or 7.5% for age 65 or older.*
***Assumes 25% savings on income tax and 7.65% savings on FICA.*
****This amount could be set aside in a health care reimbursement account to reduce the net cost through tax savings, making both net costs the same.*

Let's review:

There is no deductible for preventive care. The out-of-pocket costs are nearly the same. But, since an employee pays premiums with pre-tax dollars, he or she actually has to earn less to pay the same dental bills; unless, of course, the employee sets aside money in a Health Care Reimbursement Account. In that case, the cost with insurance and without insurance is about the same.

However, there's a significant advantage to having insurance: If you require basic and major services, in addition to preventive care, your out-of-pocket costs without insurance can rise sharply. Assuming you need one or two fillings, and a possible root canal, your out-of-pocket costs for the year can skyrocket without insurance. So even though you have an annual limit on covered dental expenses, insurance provides you some upside protection.

SUGGESTION: If you select a dental plan other than a DMO and the dental work is major (it exceeds the annual limit and is not an emergency), arrange to have the work split over two or more years. You'll generally be able to recoup more of your expenses.

The dental plan you select should not be based on price alone. Consider the condition of your teeth and the amount of dental work you and your family will require in the coming year.

Buying an Individual Dental Plan

Buying a dental policy on your own can be costly. The premiums are typically higher than those offered under a large group plan and the annual benefit limits may be lower. There is typically a waiting period before you are eligible for basic and major services. This is the insurance company's way of discouraging people from signing up only when they require expensive dental care and dropping coverage immediately thereafter.

Orthodontia services may not be covered or may have a waiting period of several years before you are eligible for benefits. If orthodontia is covered, there may be a lifetime maximum amount payable under the plan.

If you're self-employed, be careful when purchasing your own policy. Make sure you understand the policy's limitations before you decide if it is worth the premium.

SUGGESTION: If your spouse is self-employed, put him or her on your dental plan as a dependant before looking at a separate individual policy. On average, the benefits will be better and the premiums will be lower. If your spouse works for a company with a dental plan and you're considering self-employment, go on your spouse's plan as a dependant.

Vision and Hearing Plans

Do you go for an eye exam annually? Do you like to get new frames every year? Vision plans can be a toss up, simply because your benefits are limited. For example, most plans won't pay a benefit towards a new pair of frames unless the prescription for your lenses has changed. They typically don't cover replacement of broken, lost, or stolen lenses or frames. And they typically will only pay a benefit in a plan year for either frames and lenses or contacts, but not both. You need to estimate the cost/benefit of enrolling in an employer plan, on a year-to-year basis.

Let's look at a sample benefits illustration:

Say you're planning to get an annual eye exam, a new pair of frames, and new lenses in the coming year.

Service	Cost	Benefit	Net Expense
Eye exam	$ 75	$ 55	$ 20
Single vision lenses	$ 45	$ 36	$ 9
Frames	$100	$ 50	$ 50
Total	$220	$141	$ 79
Annual premium	N/A	N/A	$ 34
Your Total Cost	**$220**	**$141**	**$113**

In this example, the total charge for the eye exam, lenses and frames is $220. If you subtract the benefits paid from the charges ($220 minus $141), your net expense is $79. Add the cost of the annual premium and your total cost is $113. You save $107 ($220 minus $113). Enrolling in the vision plan for the coming year is worth the cost.

Paying for Medical Coverage

Many employer-sponsored medical plans are offered as part of an employer's flexible benefits program. This type of plan offers you a choice of benefits and coverage options. Qualified benefits include group-term life insurance, accident and health insurance, group legal services, dependant care assistance, and cash-or-deferred arrangements [commonly known as 401(k) plans].

If your medical plan is part of a flexible benefits program, your medical premiums are deducted on a pre-tax basis. This means your premiums will be deducted before taxes are taken out of your paycheck. The end result is that you'll take home more money.

Let's look at the following example:

	Pre-tax	After-tax
Bi-weekly paycheck	$1,000	$1,000
Taxes (25% bracket)	$0	$250
Medical Premium	$50	$50
Taxes (25% bracket)	$238	$0
Net Take-Home Pay	$712	$700

As you can see, there is $12 more per paycheck for the person who pays with pre-tax dollars.

Health care reimbursement accounts can also help you reduce your costs for non-covered medical expenses that you're likely to incur from year to year.

Making the Right Choice

How do you know which plan is best for you? There is no best plan for everyone. If there were, there would probably be just one plan. Determining which plan is the better choice for you involves evaluating the costs and features of each plan.

Cost	Features
▪ Given your age, family status, dependant responsibility, and you and your family's medical history, which plan is better suited to keep your total out-of-pocket costs lower? ▪ Total out-of-pocket costs include the annual premium, the deductible, and coinsurance up to the OOP limit plus medical expenses not covered or reimbursed under your plan.	▪ How do the features and benefits of the plans compare? ▪ Who are the doctors in the plan? ▪ Are the doctors qualified? ▪ Are the services convenient to me? ▪ Do I have a choice of doctors? ▪ Do I have to be bothered submitting claim forms?

There are some things you should look at closely:

- **Premium.** How do the annual premiums compare among your plan options? Don't necessarily choose the plan with the lowest premium. If you anticipate that your medical expenses for the year will be very high, choosing a plan with a higher premium will

typically keep your plan out-of-pocket expenses lower. If you or your family members make visits to doctor's offices frequently, a PPO or HMO can be advantageous over a traditional indemnity plan. If you rarely see your doctor, keep your monthly premiums low.

- **Deductible.** The higher the deductible, the lower the premium. Your employer may offer you the same plan with different deductibles. If you're young and in good health, it generally pays to take a higher deductible. As you get older, your odds of illness and using medical care increase. Your annual income may increase too. Consider lowering your deductible if it makes economic sense. Keep in mind that some point-of-service plans offer lower deductibles when you use in-network providers.
- **Coinsurance.** The higher the coinsurance (the more the insurance company pays), the higher your premium. As with deductibles, some point-of-service plans have higher coinsurance when you use an in-network provider.
- **Out-of-Pocket (OOP) Limit (maximum).** This is the maximum amount of money that comes out of your pocket for covered expenses in a plan year. If you have a large family with a poor medical history, look for plans that have low OOP limits.
- **Lifetime Maximum.** The new health care law prohibits insurance companies from imposing a lifetime maximum on the amount they will pay per individual. This prohibition is designed to protect those with catastrophic or life-long illnesses who risk going deep into debt after their insurance providers stopped paying.

You should also consider the plan features and benefits:

- **Freedom to Choose your own Doctors.** If a PPO, HMO, or CDHC plan is offered in addition to a traditional group plan, don't feel compelled to choose the traditional group plan just to keep your existing doctors. Check the plan's directory of physicians or call your doctors to see if they belong to the plans you are considering.
- **Preventive Care/Well-Baby Care.** Do you have a physical annually? The cost of an annual physical can be a few hundred dollars. PPOs and CDHC plans typically cover certain preventive care procedures. HMOs typically cover preventive care at 100%. Do you have a newborn? HMOs have no charge for pediatric care; PPOs and CDHC plans also cover well-baby visits.
- **Prescriptions.** What kind of provisions does the plan have to cover prescriptions? Does the prescription plan lower your out-of-pocket cost? Does it include an annual deductible and reimbursement plan? Or does it require only a small copay? Can you order bulk quantities through a mail order service? Are the pharmacies that participate in a network plan convenient to your home or workplace?
- **Other Major Services.** You may also want to compare private duty nursing, skilled nursing benefits, home health care, hospice care, and mental health and substance abuse (including alcohol abuse) services. Most plans limit the number of days for skilled nursing and home health care. Outpatient mental health/substance abuse services generally have lower coinsurance and limit the annual covered expenses; inpatient mental health/substance abuse services usually limit hospital stays to 30 days and have low lifetime maximums. If you or someone in your family has a history of mental illness or alcoholism, review these plan limitations carefully. They can vary significantly among plans.
- **Non-Traditional Services.** If you are inclined to see chiropractors or acupuncturists, or seek other non-traditional treatments, check the plans to see what is covered.

Here are some other general considerations:

- Many PPO and CDHC plans act like point-of-service plans and pay benefits to doctors who are not participating in the plan. So, even if you want to use a doctor who is not a member of the network, you will likely still receive some reimbursement for the charges, although you should check the plan for the specifics.
- See if any company-sponsored plan provides post-retirement medical coverage. Some company plans either provide employees with post-retirement medical coverage or allow employees to purchase this coverage in the group plan. This benefit can be extremely valuable.

Deciding on the type of plan option that is best for you also depends on your marital status, age, dependants, and general health. Let's look at each category separately.

Single

If you're young and in good health, consider the plan with the lower premium. As you get older and visits to doctor's offices become more frequent, consider switching to a plan that lowers your overall out-of-pocket costs.

Single with Dependants

If your dependants are young and in relatively good health, a PPO or CDHC plan with a higher deductible

can be a wise choice. If you have dependants who need medical care regularly, an HMO may be the better choice.

Married

If you're young and married, and in relatively good health, keep your monthly premiums low. If you're a two-earner couple, review the cost of each plan as well as the plan features and benefits to determine which spouse's plan to select. As you get older and you require more frequent medical attention, consider switching to a plan with total lower out-of-pocket costs, since your risk of a major illness increases with age.

Married with Dependants

Lower premiums with higher deductibles and higher out-of-pocket costs are for those younger families with no major medical problems. If you have two or more dependants and use doctors frequently, you might want to consider an HMO because it emphasizes preventive care and typically pays for services at 100%. If you're a two-earner couple, review the financial components of each spouse's plan as well as the plan features and benefits to determine which spouse's plan to select.

No one can predict what medical services will be needed in the future or how much those services will actually cost. You can, however, estimate the cost of basic or routine services, such as an annual physical, allergy shots, or physical therapy. You can also estimate the cost of a planned, major (non-emergency) service such as childbirth or a hip replacement.

Terminating Employment and COBRA Coverage

If you're going directly to another employer, chances are you'll elect to join the new company health insurance plan. However, you may not be eligible for plan benefits on your first day of employment. You might have to wait up to three or six months. In some states, you might be eligible to apply for interim medical coverage.

You can elect COBRA coverage through your existing employer. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires mandatory continuation of health benefits at group rates for employees and their dependants who would otherwise lose their group health coverage. Employers exempt from this requirement are small employer plans (fewer than 20 employees), church plans, and federal government plans. Here are a few details about COBRA coverage:

- Continued coverage is available for a period ranging from 18 to 36 months, depending upon the qualifying event (see below).
- The premium cost charged to the employee cannot exceed 102% of the cost to the plan for coverage.
- The benefit coverage must be the same under COBRA as the employee had prior to the qualifying event.
- There is no evidence of insurability conditions.

Qualifying events include the following:

- Death of the employee
- Termination of employment, other than for gross misconduct
- Reduced work hours
- Divorce or legal separation
- A dependent child no longer meets the dependency requirements, e.g., graduates from college

Qualifying Event	Continuation Period		
	Employee	**Spouse**	**Child**
Termination of employment (not gross misconduct)	18 months	18 months	18 months
Reduced work hours	18 months	18 months	18 months
Death of employee		36 months	36 months
Divorce/legal separation		36 months	36 months
Minor child's change in status			36 months

Employees and their dependants must be notified in writing of their eligibility for COBRA coverage. The employee then has 60 days from the later of the date of the COBRA notice or the date of the qualifying event to elect coverage. If you become divorced, legally separated, or your child no longer qualifies as a dependant, you must notify your human resources department within 60 days if you or your dependants want to continue coverage.

IMPORTANT NOTE: If you're leaving your present job to work for a new employer or to start your own business, you may want to consider electing COBRA coverage. The health plan available from your new employer may have a waiting period for coverage under the plan. Even if you are eligible for the new plan on your first day of employment or shortly thereafter, the new company's plan might not cover you for preexisting conditions for up to 18 months. Preexisting condition policies vary from employer to employer. However, by law, any exclusion period must generally be reduced by the length of time you had prior health plan coverage. In addition, depending on how your plan is funded, state mandated rules may prevail. If you're thinking of purchasing private group or individual medical insurance, check with your local state insurance department to help you determine if you need COBRA coverage.

Obviously, carrying two plans can be quite costly. If you do need COBRA coverage, you should elect it only if your out-of-pocket cost to treat the preexisting condition exceeds the cost of the additional premium.

Coordinating Employee Benefits with Your Spouse

If you are a two-earner couple, each of you probably has a long list of your own company's benefit options to sort out and choose from. And each of you may be covered under your spouse's company plan. To minimize your cost and obtain sufficient coverage from these benefits, it is important that you evaluate the features and the associated costs of both sets of benefits packages. Make a comparison chart for each type of benefit, listing cost (such as deductibles and copayments), features, and other relevant information. Take your time and evaluate each benefit thoroughly. Remember to put together the package that is best for your current situation as well as for your future needs.

Most companies provide employees with a variety of benefits. These generally include medical insurance, dental insurance, and other health and welfare benefits. To obtain these benefits, employees usually have to pay some portion of the cost, typically on a pre-tax basis, which lessens the cost. You probably are able to change your benefit options and the dependants you are covering under the plan only during an annual enrollment or when you have a qualified family status change. Because you and your spouse may have annual enrollments at different times of the year, you should identify the enrollment periods of each company plan to ensure that there is no gap in coverage for you and your family.

If you're married and each of you are covered separately on your own employer's plans, should you be covered as a dependant on your spouse's plan?

It's typically not necessary to pay for additional coverage when you may not get reimbursed under more than one plan, or the reimbursement from the second plan wouldn't be large enough to justify the additional premium costs. Whether or not the second plan pays and how much, depends on the form of Coordination of Benefits (COB) the employer is required or chooses to use.

In most cases, you must submit your bills to your employer's plan first. After the primary plan pays, you can submit your bills to your spouse's plan. But your spouse's plan may pay very little or nothing at all. If your child is covered on both plans and both plans follow the birthday rule, the plan with the spouse whose birthday falls earlier in the year will be considered the primary plan. If both plans do not follow the birthday rule, the father's plan will typically be considered the primary plan.

If you're covered under your employer's plan and your spouse is self-employed or doesn't have coverage, should your spouse consider having his or her own individual medical coverage? The answer is probably no: Pick him or her up on your plan. It is likely the most affordable, and generally, the most comprehensive way to get coverage.

Your first question should be: Is the cost of coverage for your spouse in your company plan a good deal?

Here are some things to think about when making this determination:
In general, the cost of coverage for a spouse in a company plan is usually cheaper than in individual insurance plans. If your employer passes on a very high premium to you for coverage for your spouse and family, it may be worth investigating the cost of an individual plan for them. Contact a few medical insurance companies in your state and get information on their features and pricing. Also contact an HMO that serves your area or an association you or your spouse belongs to. Premiums may be more competitive and the coverage more comprehensive, depending on the state in which you live. This will serve as a valuable comparison to the company-sponsored plan.

- Can you receive a refund for waiver of medical coverage from your employer? If you opt out of your company's medical plan, you might be entitled to a refund of the premiums that the company would have paid for you. Sometimes, a company medical plan may not offer coverage that is cost competitive

with a comparable outside plan, so opting out may be a consideration for you.

Tax Considerations Regarding Your Employee Benefits

Be sure to take these tax-related factors into consideration when deciding on a benefits plan:

- Health insurance premiums that self-employed people pay may be tax-deductible. Check with your tax professional regarding what is deductible.
- Medical expenses attributable to your spouse may be reimbursed through your company-provided health care flexible spending account. Determine the amount you should contribute to the account to take advantage of the tax savings.

Other Factors Affecting Your Decisions on Employee Benefits

Before you come to a final decision on what plans to use, there are some other non-monetary factors that may affect your decision.

- **How long will the company-employed spouse continue to work?** One of you may be considering leaving work for a period of time, for example, to have children. The one leaving could elect to take a Family Leave of Absence for up to 12 weeks, or if actually terminating employment, could take COBRA coverage* for up to 18 months. The terminating spouse might want to consider electing coverage as a dependant under the other spouse's plan since it may be less expensive than COBRA coverage and could continue for a longer period of time.
- **Is the company experiencing financial troubles?** If the company does go out of business, the insurance plan may be in jeopardy.

**COBRA coverage extends existing health coverage for a period of time following the termination of employment.*

Flexible Spending and Health Savings Accounts—Other Ways to Pay for Health Care

Health Care Flexible Spending Accounts

These accounts can be used to make up for the portion of the costs not covered by the medical, prescription drug, dental, and vision/hearing plans. The benefit of these accounts is primarily tax savings.

These accounts are a convenient, pre-tax way to pay for your out-of-pocket health care expenses. Money from each paycheck is deposited into your personal flexible spending account. You then submit claims to reimburse yourself for eligible expenses from the account. The money that goes into your account is not subject to federal income tax or Social Security withholding. The amount you can contribute to your account is generally limited annually.

When Should You Use a Health Care Flexible Spending Account?

If you expect to incur any medical, dental, or vision/hearing expenses during the year that will not be reimbursed by insurance and that will be payable by you personally, you should consider using this benefit.

How Does It Work?

You submit claims to pay for eligible out-of-pocket expenses related to health care. Reimbursement for your expense is paid to you out of your account, which you have contributed to on a pre-tax basis. Bottom line: You save money on taxes.

What's an Eligible Expense?

Every plan has different definitions. You should refer to your Benefits Book for a listing of what qualifies and what doesn't. Generally, qualifying expenses are those health care expenses that would be considered tax-deductible as a medical expense deduction by the IRS. Note that over-the-counter (OTC) drugs unless prescribed are not a qualifying expense.

SUGGESTION: For a current, complete listing of all IRS approved medical expense deductions, contact the IRS to obtain Publication 502. The publication can also be downloaded from the IRS website at www.irs.gov.

Let's look at an example of how a two-earner couple takes advantage of a health care flexible spending account. Here are the facts: Jack and Mary are married and have one child named Jane. They are in the 25% tax bracket, have combined taxable income of $60,000, and both of their salaries are fully subject to FICA tax at 7.65%. Both companies provide Health Care Flexible Spending Accounts. The following is a list of out-of-pocket medical expenses that they incur in a typical year, assuming there are no major medical problems.

Deductibles	$1,000
Copayments for medical bills	600
Contact lenses for both (employer has no vision plan)	600
Prescription costs not covered by insurance	180
Total out-of-pocket medical expenses	**$2,380**

They could save 32.65% (25% on federal income tax and 7.65% on FICA tax) of the total out-of-pocket medical expenses for the year by using a Health Care Flexible Spending Account. If Jack had put away $2,380 in a health care flexible spending account, the tax savings would have been $777 (32.65% of $2,380). The savings can be significant—all you have to do is estimate your expenses for the year and have it deducted from your paycheck over the course of the year.

Your plan will specify a maximum amount that you can contribute to the plan each year. If both you and your spouse wish to contribute to your respective accounts, you can do so up to the maximum amount specified by each of your plans. You are not limited to a certain amount because you both participate, other than what your plans specify.

SUGGESTION: You can choose to contribute to the health care flexible spending account even if you opt out of medical coverage under your plan.

SUGGESTION: If one spouse's wages are greater than the current FICA wage cap and the other spouse's wages are below the wage cap, you should use the health care flexible spending account, if available, at the lower paid spouse's company since you would save more FICA tax.

SUGGESTION: Many plans allow employees to adjust or change the amount contributed when there is a change in family status, for example, the birth of a child. Make sure to review when you may adjust or make changes to the account. If you have a choice of plans, you may want to choose the plan which allows more flexibility.

IMPORTANT NOTE: You should carefully determine how much to contribute to the flexible spending account, because if you don't use all the money that you put in the account by the end of the plan year, you will lose it. That is the only catch, so it pays to estimate carefully. However, if you do forfeit a small amount of money in any given year, the tax advantage to participating in this plan may make up for the amount of money you've lost. If you feel comfortable estimating your additional out-of-pocket medical expenses, you should arrange to begin contributing or increase contributions to a Health Care Flexible Spending Account.

Tax Advantages Associated with Children and Families

There are tax benefits to be gained from your dependents—the dependency exemption, a dependant care flexible spending account, the child tax credit, and the credit for child and dependant care expenses.

Dependency Exemption

You may claim a dependency exemption for persons qualifying as your dependents. However, many high-income families no longer get any benefits from personal exemptions. If your Adjusted Gross Income (AGI) exceeds certain amounts, the deduction for personal exemptions is phased out.

Dependant Care Flexible Spending Accounts

You may contribute to your employer's dependant care flexible spending account if you have eligible dependant care expenses. Eligible expenses include the following:

- Dependant day care provided in your home (including employment taxes paid) by a caregiver who is not your dependant.
- Dependant day care provided outside your home, including day care, day camp, pre-school, and other child care services including before-school and after-school programs.
- Elder care for dependants who live with you.

Eligible expenses are for care provided so you are able to work. This does not include costs of babysitters you pay when you go out in the evening for pleasure.

Contributions to a flexible spending account are free from federal income tax and Social Security taxes. You pay your dependant care expenses, and are reimbursed by the account. For each plan year, you estimate your dependent care expenses, and an equivalent pre-tax amount is deducted from your paycheck and deposited into your account. It is essential to estimate accurately, since any money in the account that isn't spent at the end of the plan year is forfeited. There is sometimes a grace period of 2½ months for submitting the expenses—you will need to check your flexible spending plan.

If you are married, you may contribute to this account as long as both spouses are employed outside the home, or one spouse is a full-time student (for at least five months out of the year) or disabled. Under most circumstances, you can contribute up to $5,000 ($2,500 if married filing separately) in pre-tax dollars to your account. Amounts are limited under certain conditions.

The IRS places limitations on the amount a "highly compensated" employee can contribute to a dependent care flexible spending account each year. The definition of "highly compensated" is adjusted annually by the IRS. If you will be limited during the year, your company benefits department will notify you. Any amounts contributed up to that point are available to you for pre-tax day care reimbursements. If you are highly compensated and your dependant care contributions will be limited, but your spouse is not highly compensated, use your spouse's dependant care flexible spending account (if available). An eligible dependant is defined as one you can claim on your tax return who is:

• under age 13; or
• your disabled spouse who lives with you more than six months of the year; or
• a disabled dependant who lives with you for more than six months of the year.

If you are divorced or separated and have custody of your dependent child, you may contribute to an account even if you have agreed to let your spouse claim a dependency exemption for the child.

For expenses to qualify, they must have been incurred for the purpose of allowing you or your spouse to work. Generally, if one spouse isn't working, no credit is allowed. Dependant care costs incurred while you are home ill and unable to work do not qualify. Expenses incurred while performing volunteer work are not considered eligible. However, expenses incurred while you are out looking for work do qualify.

Eligible childcare costs include those only for the actual care of your child, not costs for education, supplies, or meals, unless those costs cannot be separately stated.

If one spouse's wages are greater than the Social Security wage base for Medicare and the other spouse's wages are below the wage base, you should use the dependant care flexible spending account (if available) at the lower paid spouse's company, since you will save more Social Security taxes.

When you file your claim for reimbursement, you will be required to supply the name, address, and Social Security (or tax ID number) of the care provider. If you won't be able to provide this information, don't use a dependant care flexible spending account, since the favorable tax treatment afforded these accounts will be denied by the IRS.

Be careful about how much you put into your account. At the end of the plan year, you lose whatever money you have deposited into your account but don't use for dependant care. It should be easy to reasonably predict what your dependant care costs will be for the year. However, it is important to think about your circumstances for the entire year before you decide on an amount to contribute to the childcare flexible spending account. For example, perhaps you have an older child that could assist with child care in the summer. Paying your son or daughter would not qualify as an eligible expense, and you would not be eligible for reimbursement, because your child is your dependant in this example.

IMPORTANT NOTE: Remember, when using the dependant care flexible spending account that you'll contribute to the account with money that is deducted from each paycheck. At the same time, you'll be paying your child care expenses directly to your provider. In other words, you will pay twice for the care (once through the flexible spending account and once to your provider). You are then eligible for reimbursement when you submit your claims for day care expenses. You will need to plan accordingly. For example, if you pay your day care provider for the entire month on January 2, you will not be reimbursed for the total amount until the end of the month. You can, however, get reimbursed for a portion of the expenses as they are incurred.

Credit for Child and Dependant Care Expenses

Current IRS rules allow you to claim a tax credit for your dependant day care expenses of up to $3,000 for one dependant or up to $6,000 for two or more dependants. The criteria for establishing the eligibility of your dependant and the nature of the expense are the same as those for the dependant care flexible spending account.

Generally, the credit is 20% of expenses paid if your tax return adjusted gross income is more than $43,000. The credit increases to 35% when your adjusted gross income is $15,000 or less. The amount of the credit falls somewhere in between 20% and 35% for incomes between $15,000 and $43,000. Your credit may be limited if you're in the alternative minimum tax bracket.

You can save taxes on dependant care expenses either by claiming the tax credit on your federal income tax return or by participating in your employer's dependant care flexible spending account program. Both are intended to offer you tax savings. The best method for you depends on your income, the number of dependants you have and other factors. You can't duplicate expenses: either you take the credit or you are reimbursed from your account with pre-tax dollars.

Which Way Is Best for You?

Let's look at some general guidelines:
If you have only one eligible dependant and you pay more than $3,000 in eligible childcare expenses, the dependant care flexible spending account may offer greater savings. This is because the credit for one child covers only $3,000 of expense while the account allows you to set aside $5,000.

If you are married, live together, but file separate tax returns, you are not eligible for the credit. You may still use the dependant care flexible spending account.

As a rule of thumb, if you are in the 25% tax bracket or above, you will likely receive a greater tax savings by using the dependant care flexible spending account. If you are in the 10% or 15% tax bracket, you are likely to be better off taking the dependant care credit.

The Child Tax Credit

Parents may claim a $1,000 credit against federal income tax for each child under age 17. In 2016 (same in 2015) the credit is phased out starting from $110,000 of adjusted gross income for married joint filers and ($75,000 for single filers).

The child credit is partly refundable; the refundable portion is referred to as the "additional child tax credit." You receive a refundable credit if your Child Tax Credit is greater than the total amount of income taxes you owe, as long as you had an earned income of at least $3,000 in 2016 (same in 2015).

Health Savings Accounts

The Health Savings Account (HSA) permits eligible individuals who are not enrolled in Medicare to save for "qualified" medical health expenses on a tax-free basis. Note that over-the-counter (OTC) drugs unless prescribed are not a qualifying expense. These accounts may be offered through employers. However, any insurance company or bank can offer HSAs to eligible individuals as well.

These plans are only available to individuals with high-deductible health plans, i.e., plans with a deductible in 2016 of at least $1,300 (same in 2015) for individuals and $2,600 (same in 2015) for families. Contributions are limited to $3,350 in 2016 (same in 2015) for individuals and $6,750 in 2016 ($6,650 in 2015) for families, regardless of income, and additional "catch-up" contributions may be available to those age 55 or older. Contributions are tax-deductible, and distributions, when used for a qualified medical expense, are tax-free. If expenses are not qualified, then the distribution may be treated as taxable income, and a penalty may also apply.

However, when used as intended, HSAs can grow tax-free, and unused balances can roll over from year to year. These accounts are also portable, and may be used across different jobs. These are all potential advantages of using the Health Savings Account when compared with the Flexible Spending Account.

If you're covered under your employer's plan and your spouse is self-employed or doesn't have coverage, should your spouse consider having his or her own individual medical coverage? The answer is probably no: Pick him or her up on your plan. It is likely the most affordable and, generally, the most comprehensive way to get coverage.

There are additional details and restrictions that must be considered. Check with your tax professional or account sponsor regarding your eligibility to use the HSA. ♦