

## Healthcare benefits

Healthcare benefits provide preventive and protective medical, dental, vision, or prescription drug coverage to employees and their families. Most employer-provided plans cover the employee and the employee's dependents, including spouse and children.

*High deductible health plan (HDHP).* This type of plan typically features a higher deductible and lower insurance premiums than those of traditional health plans. Normally the plan includes catastrophic coverage to protect against large medical expenses, but the insured is responsible for routine out-of-pocket expenses up until they meet the plan deductible.

Internal Revenue Service (IRS) minimum deductible amount allowed for single coverage HDHP plans

Year	Amount
2015 – 2017	\$1,300.00
2018 – 2019	\$1,350.00
2020	\$1,400.00

Source: Internal Revenue Service (IRS): [www.irs.gov](http://www.irs.gov)

## Medical care

Medical care plans provide services or payments for services rendered in the hospital, by a qualified medical care provider, or specialist.

### Limitations on coverage

*Overall limits.* The NCS uses this term to refer to restrictions that apply to all or most benefits under the plan, as opposed to selected individual benefits. An example of an overall limit is a \$300-per-year deductible that must be paid before medical expenses become eligible for reimbursement. Another example is an 80-percent coinsurance that applies to all categories of care except outpatient surgery.

*Coverage limits.* Limits may be set in terms of dollar or day ceiling on benefits, a requirement that the participant pay a percentage of costs (coinsurance), or a requirement that the participant pay a specific amount (deductible or copayment) before reimbursement begins or services are rendered. For example, a \$250 copayment for hospital room and board.

*Maximum out-of-pocket expense.* The annual dollar amount limit a participant or family is required to pay out-of-pocket during, in addition to the plan deductible. Until it is met, the plan and the member share in the cost of covered expenses. Once reached, covered expenses are fully reimbursed for the rest of the year.

*Deductible.* The deductible is a dollar amount that an insured person pays during the benefit period—usually a year—before the insurer starts to make payments for covered medical services. Plans may have both individual and family deductibles. Some plans have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may vary between services received from an approved provider (that is, a provider with whom the insurer has a contract or an agreement specifying payment levels and other requirements) and those received from providers not

on the approved list or as part of a different tier of benefits. Some deductibles vary based on other factors (aside from plan network), such as employee length of service, salary range, or enrollee age.

*Coinsurance.* This form of medical cost sharing requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, is paid. After any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits, up to the maximum allowed charges. The individual is responsible for any charges in excess of what the insurer determines to be “usual, customary, and reasonable.” Coinsurance rates may differ between services received from an approved provider and those received from providers not on the approved list.

*Copayments.* The fixed dollar amount that an insured person must pay when a service is received before any remaining charges are paid by the insurer.

## Plan networks

*In-network.* Healthcare providers (e.g., specialists, hospitals, laboratories) that have accepted contracted rates with the insurer are considered in-network. The insured person typically pays a lower price for using services within the network.

*Out-of-network.* Services received outside the network, healthcare providers with contracted rates, typically carry a higher cost to the insured person.

*Most-generous coverage.* Insurers may offer more than two tiers of benefits and provide the insured person with the most-generous coverage, lowest costs (deductible, copayment, or coinsurance amounts), for using the preferred provider(s). The insured person may also receive services from the other in-network providers.

## Outpatient prescription drugs

Prescription drug plans include both stand-alone drug plans and prescription drug benefits included as part of a medical care plan. Outpatient prescription drugs dispensed during a hospital stay are covered as hospital miscellaneous charges.

*Formulary drugs.* These are both generic and brand-name drugs approved by the healthcare provider. Drugs not approved by the healthcare provider are nonformulary drugs, for which enrollees receive less generous benefits, such as a higher copayment per prescription.

*Brand-name drugs.* These are drugs that once were, or still are, under patents.

*Generic drugs.* These are drugs that are not under any patents. Once a drug’s patent has expired, some plans provide more generous coverage for same-formula generic drugs than for name-brand drugs; the practice is adopted as a cost containment measure.

*Mail-order drugs.* These are drugs that can be ordered through the mail. As a cost containment measure, some plans use mail-order pharmacies that typically provide a 3-month supply of maintenance drugs.