There are essentially two types of health insurance plans: 

Indemnity plans (fee-for services) or **managed care** plans. The differences include the choice of providers, out-of-pocket costs for covered services and how bills are paid. There is no one "best" plan for everyone. Some plans are better than others for your or your family's health care needs, but no one plan will pay for all the costs associated with your medical care.

Cafeteria/Flexible Spending Plans are employer-sponsored plans that allow the employee to design his or her own employee benefit package, choosing between one or more employee benefits and cash. Several types of Flexible Benefits or Cafeteria Plans are used by employers, including a pre-tax conversion plan, multiple option pre-tax conversion plan, medical plans plus flexible spending accounts, and employer credit cafeteria plans. For more information about these choices, contact your employee benefits department.

A good way to provide health care benefits to your business employees is with the establishment of a Section 125 Plan - also known as a cafeteria plans, flexible spending plans or similar names depending on the specific plan's purpose. The plans are named after Title 26, Section 125 of the United States Code where "cafeteria plans" are specifically excluded from the calculation of gross income for federal income tax purposes. Not only does a Section 125 plan allow an employer to provide health care benefits, a full cafeteria plan can be used to provide dependent care benefits and spending accounts for employees to decide what they want in their benefits plan.

How the Plans Work

125 plans allow employees to contribute *pretax* dollars into the plan. Contributions toward plans are not subject to federal, state, or social security taxes. The contributions are placed into an account the employee can use to pay for allowed expenses (e.g., premiums for health insurance, dependent care costs, medical supplies & Supplements). Supplements are great for companies wanting to offer many kinds of Gap coverage's that can be add to a Major Medical Plan. Savings can be considerable when added to the Health Insurance Policy. Since no federal, state or social security taxes are taken out and the dollars are not included as gross income, the employee saves anywhere from 27 - 50% on these purchases. The employees determine what aspects of benefits are important to them. And, because the employee is paying a portion of the benefits premiums, premiums are lowered for businesses and smaller employers can offer benefits. There are still greater benefits to the employer:

- **FICA Contribution Savings**- Since the employees' contributions are not subject to social security tax (FICA), the employer does not have to pay its matching contribution either. Thus, your business can save 7.65 cents for every dollar contributed.
- **Workers' Compensation Premium Savings** - Since, depending on your state, workers' compensation premiums are set by size of payroll, the employer's payroll is reduced by every contribution resulting in lower workers' compensation premiums.

The cost to the employer is set up, administration and compliance. There are many health insurance companies and administrators out there so you will be able to choose one that fits your company. Even in Massachusetts certain plans have partnered with the state and count toward compliance with state mandates upon the employer. These administrative costs are quickly offset by the savings in FICA and workers' compensation premiums and the employer typically saves money by implementing a 125 Plan. Check with you business health insurer and insurance professional and see if making a 125 Plan part of your business insurance plan will work for your company.

Below is a brief description of the types of available health insurance plans: Indemnity Plans; Managed Care Options; and Government-sponsored Health Insurance
Department of Insurance (Colorado link)

A. Indemnity Plans

Indemnity Health Plans allow you to choose your health care providers. You can go to any doctor, hospital or other provider for a set monthly premium. The plan reimburses you or your health care provider on the basis of services rendered. You may be required to meet a deductible and pay a percentage of each bill. However, there is also often an annual limit on out-of-pocket expenses, so that once an individual or family reaches the limit, the insurance covers the remaining eligible medical expenses in full. Indemnity plans sometimes impose restrictions on covered services and may require prior authorization for hospital care or other expensive services.

Basic and Essential" Health Plans provide limited health insurance benefits at a considerably lower cost. When buying such a plan, it is extremely important to read the policy description carefully because these plans don't cover some basic treatments, such as chemotherapy, certain prescriptions and maternity care. Furthermore, rates vary considerably because, unlike indemnity plans or a managed care option, premiums are community rated and are based on age, gender, health status, occupation or geographic location.

Health Savings Accounts (HSA) are a recent alternative to traditional health insurance plans. HSAs are basically a savings product designed to offer individuals a different way to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. Instead of paying a premium, you establish a tax-free savings account that covers your out-of-pocket medical expenses. This means that you own and control the money in your HSA. You make all decisions about how to spend the money without relying on a third party or a health insurer. You also decide what types of investments to make with the money in the account in order to make it grow. However, if you sign up for an HSA, you are generally required to buy a High Deductible Health Plan as well.

High-Deductible Health Plans (HDHP) are sometimes referred to as catastrophic health insurance coverage. An HDHP is an inexpensive health insurance plan that kicks in only after a high deductible is met of at least $1,000 for an individual or $2,000 for a family. *Contact Us*

B. Managed Care Options

Health Maintenance Organizations (HMOs) offer access to an extensive network of participating physicians, hospitals and other health care professionals and facilities. You choose a primary care doctor from a list provided by the HMO and this doctor coordinates your health care. You must contact your primary care doctor to be referred to a specialist. Generally, you pay fewer out-of-pocket expenses with an HMO, but you are often charged a fee or co-payment for services such as doctor visits or prescriptions.

Point-of-Service (POS) plans are an indemnity-type option in which the primary care doctors in the POS plan usually make referrals to other providers within the plan. If a doctor makes a referral out of the plan, the plan pays all or most of the bill. However, if you refer yourself to an

outside provider, the service is covered by the plan, but you will be required to pay co-insurance.

Preferred Provider Organizations (PPO) charge on a fee-for-service basis. The participating doctors, hospitals and health care providers are paid by the insurer on a negotiated, discounted fee schedule. Costs are lower if you use in-network healthcare services, but you have the option of going out-of-network. If you choose an out-of-network provider, you are generally required to pay the difference between what the provider charges and what the plan pays. *Contact Us*

C. Government-sponsored Health Insurance

Medicaid is a federal/state public assistance program created in 1965. It is administered by the states for people whose income and resources are insufficient to pay for health care or private insurance. All states have Medicaid programs, though eligibility levels and coverage benefits vary.

Medicare is a federal government program for people 65 and older, or those with certain disabilities, that pays part of the costs associated with hospitalization, surgery, doctors' bills, home health care and skilled-nursing care.

State Children's Health Insurance Program (SCHIP) is administered at the state level and provides health care to low-income children whose parents do not qualify for Medicaid. SCHIP may be known by different names in different states.

Military Health Care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) as well as care provided by the Department of Veterans Affairs (VA).

State-specific Plans are available for low-income uninsured individuals. These plans are known by different names in different states.

Indian Health Service (IHS) is a Department of Health and Human Services program offering medical assistance to eligible American Indians at HIS facilities. In addition, the HIS helps pay the cost of selected health care services provided at non-HIS facilities.

Contact Us

Supplemental Insurance

- Accident
- Dental
- Hospital Confinement Indemnity
- Hospital Intensive Care
- Life
- Long-Term Care
- Personal Sickness Indemnity
- Lump Sum Critical Illness
- Short-Term Disability
- Vision

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Single-Point Billing Services

Contact Us

What is it?

Single-Point Billing is a service that allows the payroll deduction process to be simplified by creating a single billing transaction for multiple products and/or carriers. Through this simplification, employers spend less time reconciling payroll withholdings while continuing to offer attractive benefit packages.

The Single-Point Billing service provider reconciles the different carrier invoices and distributes the funds accordingly. All that is left for the employer to do is to issue one check for all premiums deducted. A single deduction can be made for any number of benefits. This will free up "deduction slots" in a payroll system in order for a benefits package to be expanded.

What makes this service even better is that it is completely Web-enabled, providing users with quick information access and less paperwork processing. Point-and-click control of participants via the Web or by a secure "upload" and "download" facility will eliminate duplication of reporting and the attendant issues of reconciliation of payroll withholding to insurance company invoices.

Service Fees

Service Fees for Single-Point Billing

The service provider will charge a processing fee based on the number of Participants for each Special Account. The service provider will recalculate rates on the anniversary date for the Special Account listed in the pre-certification form based on the number of Participants at that time. These rates assume that no more than 5 premium payments will be made per payroll cycle. An additional $4.00 per month per premium payment over 5 will be added.

Participants per month	Rate
Less than 100 Participants	$1.25
100 to 499 Participants	$1.11
500 to 1,000 Participants	$1.01
1,000 to 5,000 Participants	$0.90
5,000 to 10,000 Participants	$0.85
10,000 to 15,000 Participants	$0.80
15,000 to 20,000 Participants	$0.75
More than 20,000 Participants	Individually quoted

Forms

WHAT OTHER INSURANCE SHOULD MY BUSINESS HAVE?

- ☐ Property Insurance
- ☐ Liability Insurance
- ☐ Business Vehicle Insurance
- ☐ Workers Compensation Insurance

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