KNOW YOUR BENEFITS.

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Benefits 101 Guide

KNOW YOUR BENEFITS.

Table of Contents

Introduction.....3

Health Insurance Basics 4

Health Care Reform 11

Types of Health Insurance Plans.....13

Tax-advantaged Health Accounts 15

Voluntary Benefits and Other Types of Insurance.....17

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Introduction

Employee benefits are a crucial but often complicated part of an employment package, and it is not always as easy to understand quantifiable perks such as salary and vacation time. However, insurance benefits are much more than just a workplace bonus—they are key safeguards that can enhance your quality of life for decades to come.

When you first receive information about your employee benefits package, you might feel a bit overwhelmed. The complex terminology and mechanics of insurance policies can be daunting, and you might be uneasy about spending a portion of your paycheck in return for something that may not be of use to you for some time. There is also the anxiety that results from wondering how to take full advantage of these benefits as well as knowing that these are big decisions that can have a significant long-term impact.

This guide is intended to provide you with the basics about employee benefits so that you can understand what your employer is offering to you.

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Health Insurance Basics

How Does Health Insurance Work?

Health insurance is an arrangement with an insurance company that can help protect you from the high costs of health care. At its most basic, you pay premiums and the insurance company agrees to pay part of your medical expenses for illnesses or injuries, prescription drugs, and preventive care.

Health insurance works by spreading the cost of care among large groups of people—so insurance paid by one person also helps pay for the care of others. In a large enough group, most people are healthy and use few health services in a given year. A minority of individuals account for the majority of health care spending for the group. Sharing this risk is a critical part of insurance since it is likely that every person will get sick at some point, and many individuals suffer injuries or even become disabled.

In addition to spreading financial risk, health insurance also improves access to health care services. Numerous studies have shown that, compared to those who are insured, people without health insurance receive fewer options in health services, or their care is delayed. Health insurance not only protects individuals from catastrophic expenses, it also improves access to important routine, preventive and primary care services.

There are several different types of health insurance that provide a range of coverage for medical expenses. Expenses vary based on how much coverage someone signs up for and the number of family members he or she decides to cover. Some types of insurance allow individuals to set aside pre-tax income to use at a later date.

Depending on the type of health insurance coverage, either the individual pays costs out of pocket and is then reimbursed, or the insurer makes payments directly to the provider.

After every visit to a health care provider, you will get a document called an explanation of benefits (EOB) that shows how much your insurance will pay and the amount your out-of-pocket expenses will be.

Group Health Insurance

Health insurance can be acquired in several ways. Currently, the most common way to obtain insurance is through packages offered by employers; this method is called group health insurance. Group health insurance often leads to lower rates for the coverage because the financial risk is spread out over many people, most of whom are in good health.

According to Gallup, in the second quarter of 2014, 43.5 percent of Americans between the ages of 18 and 64 were insured in group packages through their employers. Twenty percent of Americans obtained coverage through government-sponsored programs like Medicaid, Medicare, or military and veterans benefits, while another 20 percent were covered through an individual health plan or by a family member's health plan. Over 16 percent of people had no health insurance at all.

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Individual Health Insurance

Individual health insurance is health coverage that is purchased by an individual or a family that is not tied to a job or a group of policyholders.

Health Insurance Terminology

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Participants

There are a number of participants involved in health insurance. The "provider" is a clinic, hospital, doctor, laboratory, health care practitioner or pharmacy. The "insurer" or "carrier" is the insurance company providing coverage. The "policyholder" is the individual or entity that has entered into a contractual relationship with the insurance carrier. The "insured" is the person with the health insurance coverage. For individual health insurance, you may be both the policyholder and the insured. For group health insurance, your employer will typically be the policyholder and you will be the insured.

Premium

A premium is the amount of money charged by an insurance company for coverage. The cost of premiums may be determined by several factors, including age, geographic area, number of dependents and tobacco consumption. Policyholders pay these rates annually or in smaller payments over the course of the year, and the amount may change over time. When insurance premiums are not paid, the policy is typically considered void and companies will not honor claims against it. With employer group insurance, the employer determines how much of the premium employees will be required to pay for coverage. Your share of the premiums is deducted from your paycheck by your employer. Employer-based premiums are usually, but not always, deducted before taxes.

Premium Example

Mary has group insurance through her employer, with pre-tax premiums. Every pay period, her share of the health insurance premium is deducted from her paycheck before taxes are calculated to cover the cost of her health insurance.

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Copayment

A copayment, or copay, is a fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Copayment Example

Sally takes her son to the pediatrician for a bad cough. She has a copay of $15 at the doctor's office.

Cost of Visit:	$200
Sally pays:	$15
Health plan pays:	$185

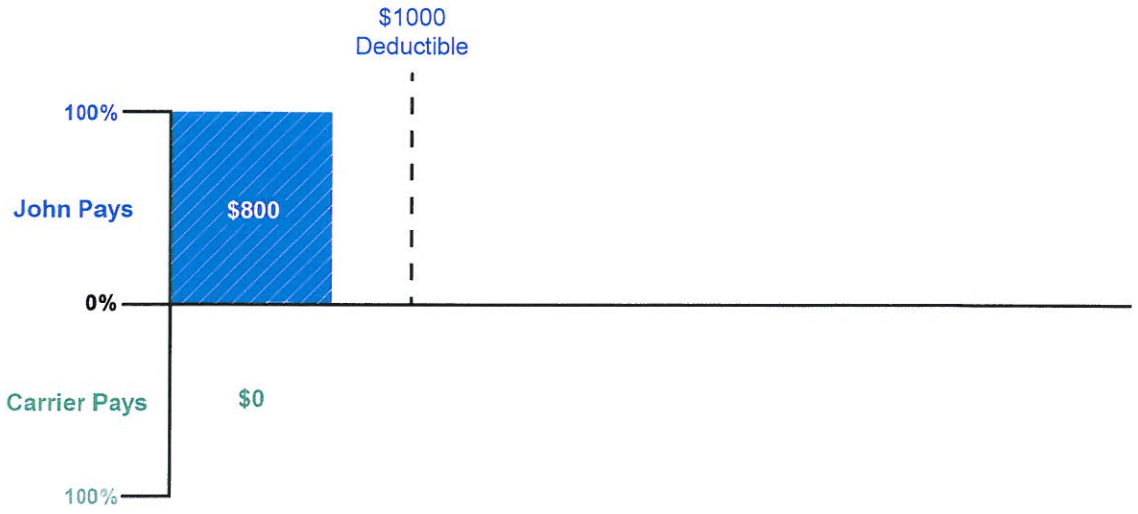
Deductible

A deductible is the amount you owe for health care services each year before the insurance company begins to pay. For example, if your annual deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services that are subject to the deductible. The deductible may not apply to all services, such as preventive care services.

Deductibles are useful for keeping the cost of insurance low. The amount varies by plan, with lower deductibles generally associated with higher premiums. They are fairly standard on most types of health coverage.

Deductible Example

John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.



Coinsurance

Coinsurance is your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service. You pay coinsurance plus any deductibles you still owe for a covered health service.

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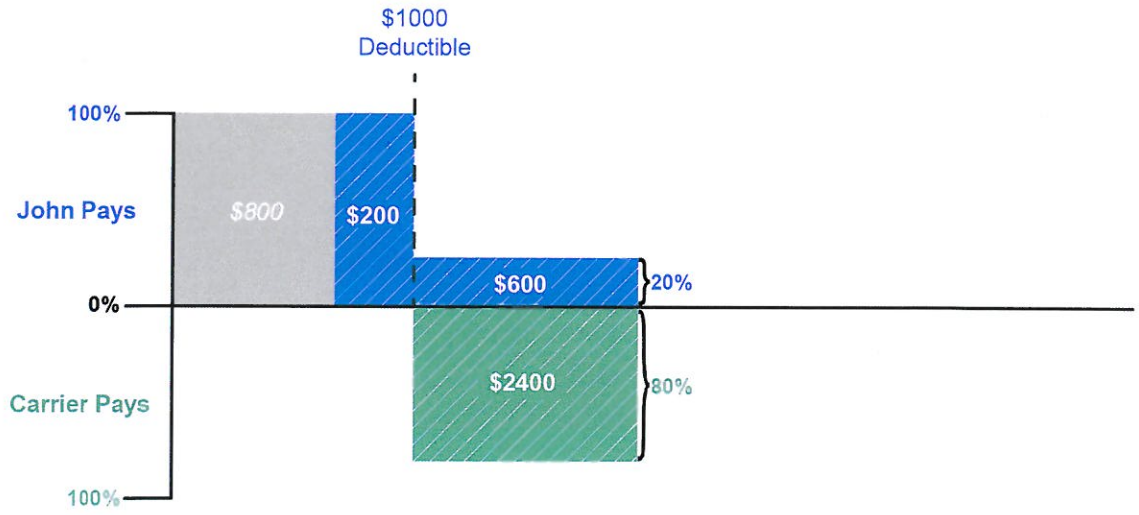
Coinsurance Example

John's second surgery occurs in the same plan year as his first surgery and costs a total of $3,200. Because he has only paid $800 toward his $1,000 annual deductible, John will be responsible for the first $200 of the second surgery. After that, he has met his deductible and his carrier will cover 80 percent of the remaining cost, for a total of $2,400. John will still be responsible for 20 percent, or $600, of the remaining cost. The total John must pay for his second surgery is $800.



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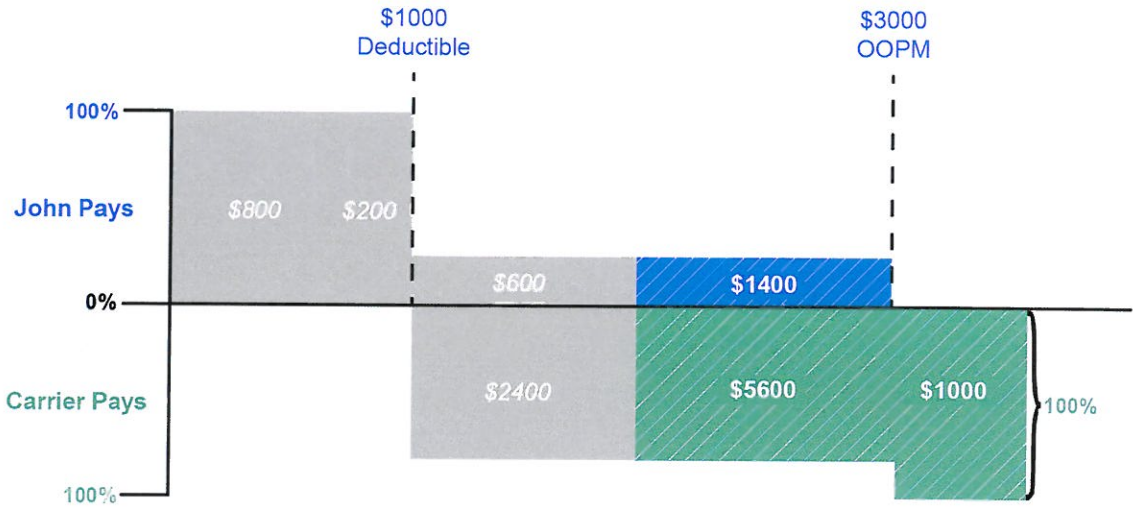
Out-of-pocket Maximum (OOPM)

An OOPM is the most you should have to pay for your health care during a year, excluding the monthly premium. It protects you from very high medical expenses. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.

Some health plans do not count all of your out-of-pocket expenses when determining the OOPM. For example, some plans do not count your annual deductible, copayments, coinsurance payments, out-of-network payments or other expenses toward this limit.

Out-of-pocket Maximum Example

John's third surgery occurs in the same plan year as his first two surgeries and costs a total of $8,000. John has already met his deductible, so he only needs to pay the coinsurance on this surgery, up to the plan's OOPM of $3,000. Without an OOPM, John's coinsurance total for this surgery would have been $1,600 (20 percent of the $8,000 total), but because John's plan allows his deductible to be counted toward his OOPM, John has already spent $1,600 towards his OOPM on previous health care costs this year. Because of this, he only needs to spend $1,400 before he hits his $3,000 OOPM. Once he hits the OOPM, his plan covers the remaining costs. Therefore, John's coinsurance total for the third surgery is $1,400—the 20 percent coinsurance cost, up to the $3,000 maximum—and his plan's total is the remaining $6,600 (on the chart, this is shown as $5,600 before the OOPM, plus $1,000 after John hits his OOPM).



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Preventive Care

Preventive care is medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring. Rather than waiting for a patient to become sick, preventive care aims to keep people healthy, or at least catch an illness at its earliest and most treatable stages. Preventive care includes preventive and diagnostic services performed by providers, such as annual physicals or bi-annual mammograms. Under the provisions of the Affordable Care Act (ACA), non-grandfathered health insurance policies must cover various preventive services for men, women and children without sharing the cost for these services through coinsurance, deductibles or copayments. Some health plans may have additional no-cost preventive services beyond what the law requires.

Preventive Care Example

Mary schedules an appointment with her in-network health care provider for an annual physical and bi-annual mammogram. Because Mary is eligible for these preventive services under the ACA's preventive care coverage guidelines, the total cost of the visit is covered by her health insurance.

Cost of Physical	$200
Cost of Mammogram	$200
Mary Pays	$0
Health Plan Pays	$400

Other Terminology

Essential Health Benefits

Essential health benefits are a set of health care service categories that the ACA requires certain plans to cover. The plans that must cover essential health benefits include plans offered in the individual and small group markets as well as all Medicaid state plans. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Annual Limit

The annual limit is a cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan. These caps are sometimes placed on particular services, such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year. Annual dollar limits cannot be applied to a plan's essential health benefits.

Lifetime Limit

The lifetime limit is a cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (such as a $1 million lifetime cap) or limits on specific benefits (such as a $200,000 lifetime cap on organ transplants, or one gastric bypass

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per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. Under the ACA, insurance companies cannot set a dollar limit on what they spend on essential health benefits for your care during the entire time you are enrolled in that plan.

Qualified Medical Expense

Qualified medical expenses are defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. To be eligible as qualified medical expenses, these expenses must be used to alleviate or prevent a physical defect or illness. They can include payments to providers, including dentists and optometrists, and payments for prescription and over-the-counter medication. They do not include cosmetic procedures or expenses that are only beneficial to general health, such as vitamins. The IRS publishes a full listing of qualified medical expenses every year.

Pre-existing Condition

A pre-existing condition is any condition, either physical or mental, including a disability, that occurred before a health plan went into effect. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition; pregnancy also cannot be considered a pre-existing condition. Insurers cannot deny coverage or charge extra to people with pre-existing conditions, unless a person is covered by a grandfathered individual health plan.

Grandfathered Plans

A grandfathered plan is a health insurance plan that was in effect before the ACA became law and has basically stayed the same since then. They can continue to enroll people and offer coverage while maintaining their grandfathered status. Grandfathered plans are exempt from some of the ACA's reforms. To find out if your health plan is grandfathered, check your plan's materials describing benefits.

Summary of Benefits and Coverage

Summaries of benefits and coverage (SBC) are easy-to-read outlines that let you compare costs and coverage between health plans. You can compare options based on price, benefits and other features that may be important to you. You'll get an SBC when you shop for coverage on your own or through your job, when you renew or change coverage, or when you request an SBC from the health insurance company.

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Health Care Reform

Congress passed the ACA, a significant health care reform law, in March 2010. The ACA is a far-reaching law that affects all aspects of the health care system, including consumers, health care providers, insurance companies and employers. The parts of the law that most affect you are described below.

Individual Mandate

The ACA requires most individuals to obtain acceptable health insurance coverage for themselves and their family members; if they don't, they will face paying a penalty. If you are covered under a health plan offered by your employer, or if you are currently covered by a government program such as Medicare, you can continue to be covered under those programs.

There is a graduated tax penalty, or fee, for individuals who do not obtain health insurance by the time they file their 2014 tax return. While at first the penalty is fairly modest, it increases substantially over the following two years. In addition to the penalty, people without health insurance will still be responsible for 100 percent of the cost of their medical care. The graduated fee schedule is as follows:

2014	• $95 per adult and $47.50 for each child (up to $285 for families), or 1 percent of income, whichever is greater
2015	• $325 per adult and $162.50 for each child (up to $975 for families), or 2 percent of income, whichever is greater
2016 and Beyond	• $695 per adult and $347.50 for each child (up to $2,085 for families), or 2.5 percent of income, whichever is greater

There is a very limited number of exceptions to the insurance mandate, mainly affecting noncitizens, American Indians, incarcerated individuals, religious objectors and people suffering from poverty or hardship. Exceptions are also available for people with short gaps of less than three months in coverage and for those eligible for an employer-provided plan that operates on a noncalendar year basis.

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Health Insurance Marketplace

Another large component of the ACA is the creation of a health insurance Marketplace, also known as the Affordable Health Insurance Exchange, for individuals and small businesses to purchase private health insurance. The Marketplace allows for direct comparisons of private health insurance options on the basis of price, quality and other factors, while coordinating eligibility for premium tax credits and other affordability programs. The Marketplace first became operational in Oct. 2013, and will be open for enrollment from roughly the start of fall through the end of winter each year.

Uninsured individuals who want to comply with the individual mandate will be able to use the Marketplace to fulfill its requirements. People who are eligible for coverage from their employer may also use the Marketplace to enroll in insurance, but may not be eligible for the health care insurance subsidies and discounts offered to uninsured individuals.

Annual Limits and Pre-existing Conditions

As noted earlier, annual dollar limits cannot be placed on coverage for essential health benefits. Additionally, the ACA compels insurers to cover individuals with pre-existing conditions. Insurance companies cannot turn you down or charge you more because of your condition, nor can they refuse to cover treatment for pre-existing conditions. The only exception is for grandfathered individual health insurance plans—the kind you buy yourself, not through an employer. If you have one of these plans, you can switch to a Marketplace plan during open enrollment and get coverage for your condition.

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Types of Health Insurance Plans

Besides terminology, another factor that makes understanding insurance difficult is the number of different health insurance plans available, each with its own set of rules. There are a number of reasons why there isn't just a one-size-fits-all plan. For example, some people need a certain type of plan that covers more services than another plan. It's important to understand the key differences between plans in order to choose the one that's best for you.

Fee-for-service Plans

Fee-for-service plans are a straightforward type of coverage in which insurers pay for health care services provided to plan participants. With this type of coverage, you can choose any doctor you wish and change doctors any time or go to any hospital in any part of the country.

Health Maintenance Organizations (HMO)

HMOs are a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage.

HMOs also require that you select a primary care physician who is responsible for managing and coordinating all of your health care. Your primary care physician will provide all of your basic health care services, and must give a referral in order for you to see a specialist.

HMOs often provide integrated care and focus on prevention and wellness. HMO plans sometimes include dental and vision coverage.

Preferred Provider Organization (PPO)

PPOs are similar to HMOs in that health care providers enter into an agreement with the insurance companies to offer substantially discounted fees for covered health care services. Your copay and deductibles will also be lower if you choose a provider that is in the PPO network. The payment ratio (what your insurance company pays compared to what you pay) may be high for a PPO plan—for example, it could be in the range of 90/10, with 90 percent of medical costs paid by the insurance company and 10 percent covered by the insured after the copay and deductible.

With a PPO, you do not have to choose a primary care physician—you can choose doctors, hospitals and other providers from the PPO network or from out of network. If you want to stick with a particular doctor or health care provider that is out of network, you are able to do so, but the costs will be higher, generally with a 70/30 ratio.

PPO plans typically include preventive care, wellness programs, immunizations, well-baby care and mammograms, along with regular doctor visits, emergency care, specialist treatments, X-rays, hospital

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stays, surgery and other medical services. PPOs also use a membership card instead of requiring medical insurance claim forms for payment processing.

Exclusive Provider Organization (EPO)

An EPO is similar to a PPO in structure and operation, but the main difference is that services are covered only if you go to doctors, specialists or hospitals in the plan's network. However, there are exceptions for emergencies.

Point of Service Plan (POS)

POS plans combine elements of both HMO and PPO plans. Like an HMO plan, you may be required to designate a primary care physician who will then make referrals to network specialists when needed. Depending on the plan, services rendered by your primary care physician are typically not subject to a deductible, and preventive care benefits are usually included. Like a PPO plan, you may receive care from non-network providers but with greater out-of-pocket costs.

High Deductible Health Plan (HDHP)

HDHPs are health plans with high deductibles and low premiums; the insurer will not cover most medical expenses until the deductible is met. As an exception, preventive care services are typically covered before the deductible is met. The high deductible provides financial security for more severe illnesses. HDHPs are often designed to be compatible with heath savings accounts (HSAs). HSAs are tax-advantaged accounts that can be used to pay for qualified out-of-pocket medical expenses before the HDHP's deductible is met. These expenses can include copayments and coinsurance.

In 2014, for HSA-compatible HDHPs, the minimum deductible amounts are $1,250 for an individual and $2,500 for a family, while the maximum out-of-pocket expenses are $6,350 for an individual and $12,700 for a family.

In 2014, for HSA-compatible HDHPs, the minimum deductible amounts increased to $1,300 for an individual and $2,600 for a family, while the maximum out-of-pocket expenses increased to $6,450 for an individual and $12,900 for a family.

Cafeteria Plans

Cafeteria plans are benefit programs that help employees pay with pre-tax dollars for certain expenses, such as life insurance, disability benefits, medical expenses and child care. Employers select the benefits that will be offered (only certain benefits can be provided), and employees use pre-tax dollars to buy the benefits they want. Employers can also make contributions to subsidize benefits. Cafeteria plans are also known as flexible benefit plans or IRS 125 Plans.

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Tax-advantaged Health Accounts

There are a few different types of tax-advantaged accounts that help individuals pay for qualified medical expenses. They are often paired with HDHPs. There are specific rules for each type of account, such as how much can be contributed and what the account's funds can be used for.

Health Savings Account (HSA)

HSAs are available to people who are enrolled in an HSA-compliant HDHP. The account is employee-owned, and money may be contributed by both the employer and employee. If the employee leaves the company, he or she remains in control of the account.

The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for paying for non-qualified expenses. Funds roll over year to year if you don't spend them, and can accumulate a significant balance. There is a limit to how much money can be put into an HSA every year, but no cap on how much money can be in the account.

For 2014, the individual contriubution limit for HSAs is $3,300 and the family contribution limit is $6,550. Account holders aged 55 or older can contribute up to another $1,000 to these totals.

For 2015, the individual contribution limit for HSAs is $3,350 and the family contribution limit is $6,650. Account holders aged 55 or older can contribute up to another $1,000 to these totals.

Health Flexible Spending Account (FSA)

Health FSAs are arrangements you set up through your employer to pay for many of your out-of-pocket qualified medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles as well as qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into a health FSA, but keep in mind that the ACA limits your pre-tax contributions to your health FSA to $2,500 per year.

Also, because your employer owns the health FSA account, it may establish a limit lower than the ACA's limit for your annual health FSA contributions. Your employer can also establish the types of expenses the health FSA's funds can be used for.

Unlike an HSA, you do not have to be enrolled in an HDHP to be eligible for a health FSA. You can be enrolled in any health plan (or no health plan) and be eligible for a health FSA. Your employer establishes the health FSA's eligibility criteria.

FSAs employ a "use-it-or-lose-it" model. If you do not use the funds that you contribute to your limited-purpose FSA by the end of the year, you will have to forfeit those funds. However, employers also have the option of allowing employees to carry over up to $500 of unused funds from one year to the next. In addition, any amount that is carried over does not count toward the maximum contribution limit.

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Another exception is also possible if your employer's health FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2 1/2 months after the end of the health FSA plan year.

Employers are not required to offer either exception in their health FSA plans, and the two exceptions cannot be combined.

Health Reimbursement Arrangement (HRA)

HRAs are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses. Like HSAs, unused amounts may be rolled over to be used in subsequent years. Unlike HSAs, the employer funds and owns the account. The employer sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period and establishes the types of expenses the funds can be used for.

Unlike an HSA, you do not have to be enrolled in an HDHP to be eligible for an HRA. You can be enrolled in any health plan (or no health plan) and be eligible for an HRA. Your employer establishes the HRA's eligibility criteria.

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Voluntary Benefits and Other Types of Insurance

Voluntary benefits are benefits that employees may choose to take advantage of through their employers with lower rates than they could get on their own. A few examples of traditional voluntary benefits are dental, vision, life, disability, supplemental health and cancer insurance.

Many employers offer voluntary benefits because they can provide a more robust benefits package at little to no cost.

Prescription Insurance

Prescription insurance, sometimes called prescription drug coverage, helps pay for prescription drugs and medications. Prescription insurance is often offered as part of a larger health insurance plan, though this is not always the case. Stand-alone individual prescription insurance may be available for people who are not offered prescription drug coverage or who have no health insurance. Eligibility for specific medications and the cost of insurance varies among health plans.

Dental Insurance

Dental insurance helps pay for dental care and usually includes regular checkups, cleanings, X-rays and certain services required to promote general dental health. Some plans will provide broader coverage than others, and some will require a greater financial contribution from you when services are rendered. Some plans may also provide coverage for certain types of oral surgery, dental implants or orthodontia.

Vision Insurance

Vision insurance entitles you to specific eye care benefits defined in the policy. Vision insurance policies typically cover routine eye exams and other procedures, and provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. Some vision insurance policies also offer discounts on refractive surgery.

Life Insurance

Life insurance protects against financial hardship after the death of the insured by paying out a lump sum to beneficiaries upon the insured's death. Term life insurance offers policies that cover a set period of time, while permanent life insurance, such as whole and universal life, provides lifetime coverage. Death benefits from all types of life insurance are generally free from income tax.

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Disability Insurance

Disability insurance protects the insured against major costs associated with disability. With disability insurance, you are awarded a disability benefit as a partial replacement of income lost due to illness or injury.

There are two types of disability insurance: short-term and long-term. Short-term disability insurance (STD) helps you remain financially stable if you become injured or ill and cannot work. Usually, STD coverage begins within one to 15 days of the event that caused your disability. The coverage allows you to continue to receive pay at a fixed weekly amount or a set percentage of your income. The benefits can last up to 52 weeks, although the amount of time you receive STD benefits varies between specific plans. When this STD coverage ends, long-term disability (LTD) coverage typically takes effect.

LTD insurance protects workers if they become disabled for a prolonged period prior to retirement. LTD policies are often offered through employers as part of a standard benefits package. The length of LTD plans varies—some may be limited to a period between two and 10 years, while other plans continue paying out until you reach the age of 65.

Retirement Benefits

Retirement benefits are amounts paid by an employer to a former employee or beneficiary after the employment ends as required under a written retirement plan.

There are two major types of retirement plans.

A defined benefit plan, funded by the employer, promises you a specific monthly benefit at retirement. The plan may state this promised benefit as an exact dollar amount, such as $100 per month at retirement. However, it usually calculates your benefit through a formula that includes factors such as your salary, your age and the number of years you worked at the company. For example, your pension benefit might be equal to 1 percent of your average salary for the last five years of employment multiplied by your total years of service.

A defined contribution plan, on the other hand, does not promise you a specific benefit amount at retirement. Instead, you and/or your employer contribute money to your individual account. In many cases, you are responsible for choosing how these contributions are invested and for deciding how much to contribute from your paycheck. Your employer may add to your account, sometimes by matching a certain percentage of your contributions. The value of your account depends on how much is contributed and how well the investments perform. At retirement, you receive the balance in your account, reflecting the contributions, investment gains or losses and any fees charged against your account. Traditional and Roth 401(k) plans are popular types of defined contribution plans.

The main difference between a traditional 401(k) and a Roth 401(k) is how the money is taxed. Under Roth 401(k) plans, you contribute money that has already been taxed. Then, when you are 59 and a half or older, money you take out of the account—and whatever interest the money has earned—is tax-free, regardless of how long ago you invested the money or how large your account grew.

Contributions to traditional 401(k) plans are subtracted from your taxable income, meaning that you don't pay taxes on the money before you put it into your account. This also lowers your yearly tax burden, and allows for large initial investments. However, you will have to pay taxes on money you withdraw from the account.

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There are many additional differences and regulations involving retirement accounts, so take time to familiarize yourself with them before making any decisions about your retirement benefits.

Non-traditional Benefits

Non-traditional benefits are types of bonus compensation offered outside of standard benefit packages. They can vary widely between companies and may include perks like tuition reimbursement, adoption assistance, counseling services, telecommuting, and flexible hours and work weeks, as well as offering on-site facilities such as fitness centers or dry cleaning services.

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