ICHRA Overview

Guide to Insurance basics

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What is an ICHRA?

An Individual Coverage Health Reimbursement Arrangement (ICHRA) is an employer-funded, tax-advantaged health benefit used to reimburse employees for individual health insurance premiums.

Employer-funded pre-tax employee contributions

Employee must purchase **qualified** health plan to be eligible for an employer ICHRA contribution

Employer contributes a monthly dollar amount towards the insurance premium chosen by the employee

How Employees Benefit with an ICHRA

Change for the Better

An ICHRA is a benefit where the company gives you a monthly allowance to buy the health plan that works best for you. It's the fastest growing employer-sponsored health insurance program in the US.

Choice

An ICHRA gives you the power to choose the health plan that fits your life; NOT a one-size-fits-all plan chosen for everyone.

Flexibility

Instead of the company picking one plan for the whole team, you get a monthly allowance to pick any individual health plan that works best for you. Your doctors, your budget, your needs.

Personal Control

You're in control. You can choose the coverage level and price point that matches your situation, whether you want the lowest premium, richest plan, or something in between.

Simple Process

You shop for a plan from the company's ezICHRA portal just like you'd shop for a car. Compare options, pick what you like, and the company contributes up to your maximum ICHRA allowance.

Help Along the Way

You're not on your own—the ezICHRA Plan Advisory team can help guide you through choosing the plan that best meets your needs. You get more choice, with support throughout the process.

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How ICHRA Allowances Work

If you select a plan with a **Monthly Premium** that is **MORE than your Monthly Employer Contribution**

Your employer will deduct the difference, your cost, through payroll deduction.

If you select a plan with a **Monthly Premium** that is **LESS THAN OR EQUAL to your Monthly Employer Contribution**

YOU WON'T PAY ANYTHING!

This works differently in the Medicare marketplace. Since the Social Security Administration does not accept a third-party payment, employees pay for their own premiums and are reimbursed, up to their monthly maximum ICHRA allowance through payroll, pre-tax, through a Section 105 medical reimbursement.

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Health Insurance Policy Basics

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Health Insurance Plan Elements Simplified

Term	What it Means	How it Affects Members
Copay	A fixed dollar amount members pay for a service.	Example: $25 for a doctor visit.
Deductible	The amount members pay *first* before insurance starts helping. **Some plans have Copays available prior to having to reach a deductible. In that case, members just pay the Copay for those services.*	Members pay 100% of costs until they hit this number. **Unless the plan has a "pre-deductible" Copay. In that case, members just pay the Copay for those services.*
Coinsurance	A percentage members pay after they meet their deductible.	Example: Members pay 20%, insurance pays 80%.
Maximum Out-of-Pocket (MOOP)	The most members pay in a calendar year for covered care.	After a member hits this limit, insurance pays 100% for the rest of the year for their covered services.

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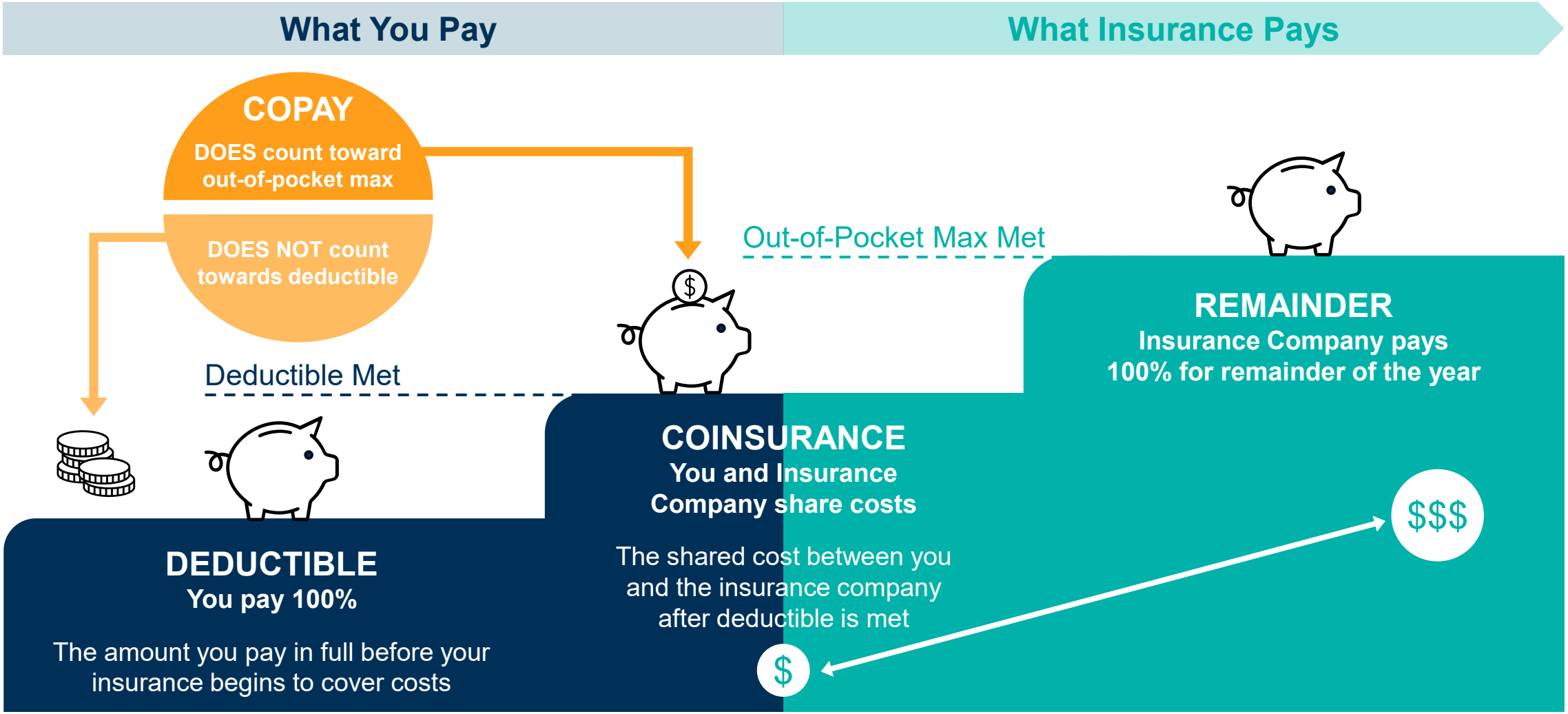
Health Insurance Cost Sharing Illustration



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Marketplace Plan Metal Levels

	Bronze	Silver	Gold	Platinum
Plan Pays (Average)	60%	70%	80%	90%
Monthly Cost of Plan	$	$$	$$$	$$$$
Cost When You Get Care	$$$$	$$$	$$	$
Good Option if You	Don't plan to use a lot of health care services	Need to balance your monthly withholding with your out-of-pocket costs	Expect to use plan often – may cost more out of your paycheck but will keep your out-of-pocket costs low when using the plan	Plan to use a lot of health care services and don't mind paying more through your payroll (not available in all market areas)

Occasionally, an individual who is guaranteed to meet their Max Out-of-Pocket (MOOP) cost during the year may benefit from a Bronze-Level plan (when considering monthly cost + MOOP)

Health Insurance Networks & Exchanges Simplified

Term	What it Means
Network	A health insurance **network** consists of doctors, hospitals, clinics and other medical providers that work with and insurance company to deliver care at agreed-upon costs. Using in-network providers results in lower out-of-pocket costs, while care from out-of-network providers may not be covered at all. Types of networks include HMO (most common), EPO, POS & PPO. Networks are a key factor in determining affordability and accessibility of healthcare under a given plan.
ACA On-Exchange Marketplace Plan	An **on-exchange plan** is a health insurance plan you buy through the government Marketplace (like HealthCare.gov). An on-exchange plan is qualified to be reimbursed through an ICHRA as long as there is no Premium Tax Credit (PTC) included (all plans in the ezICHRA portal are qualified because no plan selected through the portal will include a PTC. ACA marketplace plans are available to individuals under the age of 65 and are not otherwise Medicare eligible because of a disability or other medical condition.
ACA Off-Exchange Marketplace Plan	An **off-exchange plan** is a health insurance plan you buy directly from an insurance company or through a broker, not through the Marketplace. An off-exchange plan is qualified to be reimbursed through an ICHRA. ACA marketplace plans are available to individuals under the age of 65 and are not otherwise Medicare eligible because of a disability or other medical condition.
Medicare Marketplace Plans	Medicare marketplace plans are available primarily to individuals 65 or older, but younger individuals my qualify under certain conditions such as disabilities or specific medical conditions. Parts of Medicare include **Part A** (Hospital), **Part B** (Medical), **Part C** (Advantage/Supplement) and **Part D** (Drug).

Medicare Open Enrollment Preparation

Medicare Marketplace (65 & Older)

1

If already enrolled in Medicare and receiving a Social Security check skip to #3

2

Apply for Medicare Parts A & B by either:

- going online at **SSA.gov** or
- calling **1-800-722-1213** or
- visiting local Social Security office

Documents needed: Social Security #, proof of age & citizenship, if already over the age of 65 and covered under a group health plan – employer coverage documents

3

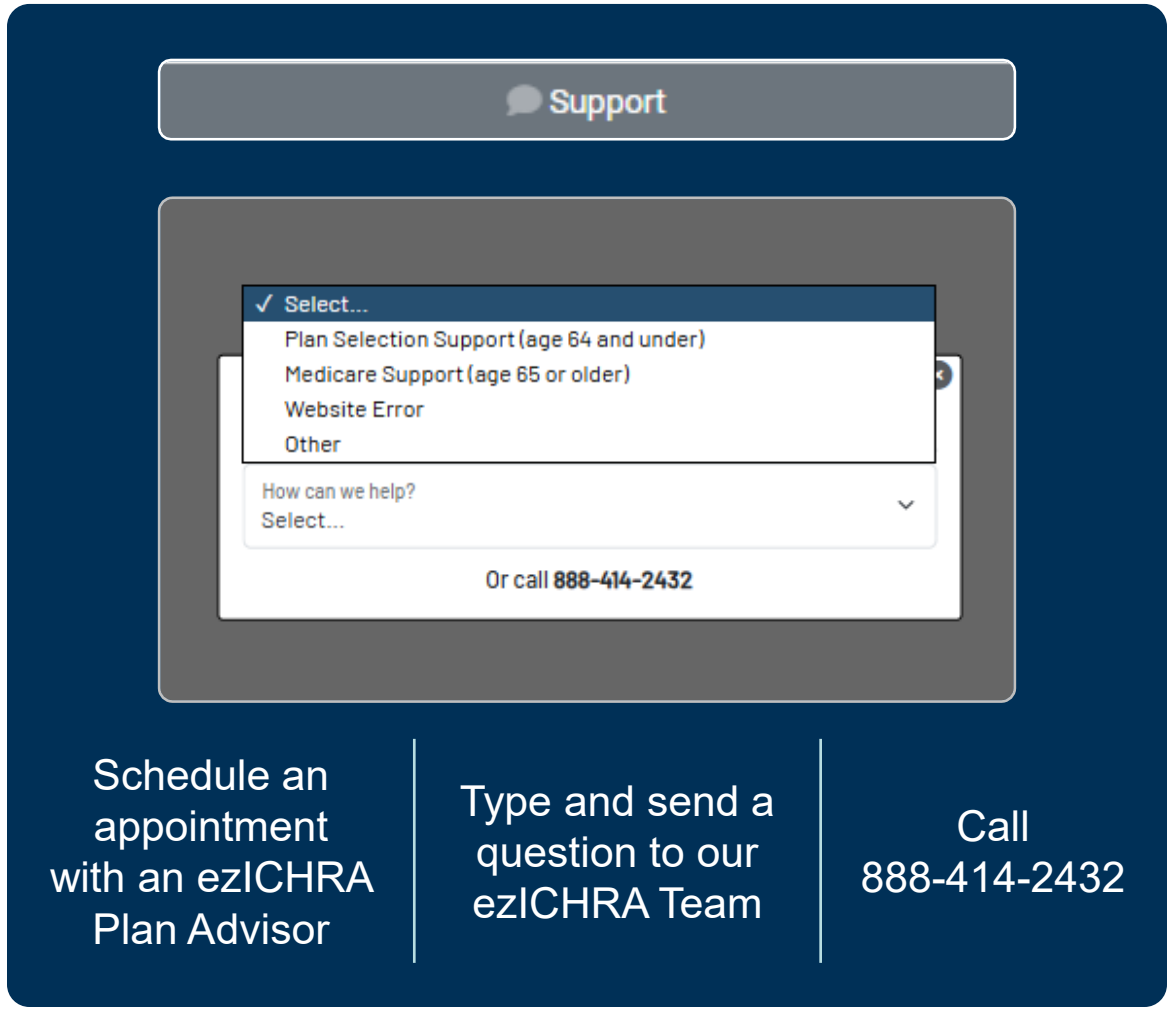
Once enrolled in Medicare Parts A & B choose a:

- Medicare Advantage Plan (Part C) or
- A Prescription Drug Plan (Part D) + a Medicare Supplement Plan or
- No additional plan

An employee or spouse aged 65 or older will access the Medicare Marketplace to purchase their insurance. Moving from a group health plan to an ICHRA creates a Special Enrollment Period to allow the individual to enroll outside of the Annual Enrollment Period. Missing a Special Enrollment Period or an Initial Enrollment Period when turning 65, can lead to permanent late-enrollment penalties, increasing the cost of Medicare premiums indefinitely.

Need help of a licensed Agent

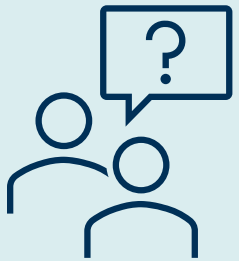
At any time during your shopping experience, you may click on the Support icon which will open a support window allowing you to request help



Schedule an appointment with an ezICHRA Plan Advisor

Type and send a question to our ezICHRA Team

Call 888-414-2432



At ezICHRA, we know health insurance can be confusing for individuals that don't deal with it often. That's why our team is here for you!

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Things to remember

Your new individual policy goes into effect January 1st.

When the ezICHRA team enrolls you into your new plan, the insurance carrier enrollment system will auto-generate an invoice that will be sent to your home address. **DO NOT PAY** the invoice because your Employer will make your payment for you

Unless you are an employee with a Medicare plan, then you will make your own payment and be reimbursed through payroll

Your selected insurance carrier will send you a Welcome Kit and an Insurance ID Card directly to your home address.

We are your advocate.

If you have any questions throughout the year, please do not hesitate to call ezICHRA:

888-414-2432

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