PHYSICIANS & HEALTHCARE PROFESSIONALS

The Physician's Retirement Stack: How to Shelter Far More Than the 401(k) Limit

Most physicians contribute to one retirement account and assume they have "maxed out." The $24,500 elective limit is only the first floor of a structure that, correctly layered, can shelter several times that amount.

Ask a physician how much they can put away for retirement and the answer is almost always the same number — the elective deferral limit, $24,500 for 2026. It is the figure everyone quotes, and it dramatically understates what is actually available to a high earner who knows how the layers fit together.

The retirement rules are not one limit but several, sitting on top of one another. Each has its own ceiling, its own eligibility, and its own deadline — and for a physician earning attending-level income, the difference between using one layer and using all of them can be a five- or six-figure swing in tax-advantaged savings every year. Below is how the stack is built, from the base everyone knows to the layers most physicians never reach.

Layer 1 — The elective deferral (the part everyone knows)

Your personal contribution to a workplace 401(k) or 403(b) is capped at **$24,500** for 2026 — or **$32,500** if you are 50 or older (an $8,000 catch-up), rising to $35,750 for those aged 60 to 63 under the SECURE 2.0 "super catch-up." This is the number most physicians stop at. It is the floor of the stack, not the ceiling.

> THE LIMIT THAT ACTUALLY MATTERS
>
> The elective deferral is only one of two federal limits. The larger one — the §415(c) total additions limit — caps *all* contributions to a plan (your deferral plus employer contributions

plus after-tax dollars) at **$72,000** for 2026. The gap between $24,500 and $72,000 is where most of the unused opportunity lives.

Layer 2 — Employer contributions

On top of your deferral, employer contributions — a match, a profit-sharing contribution, or your own corporation's contribution if you are self-employed — fill the space up toward the $72,000 total. An employed physician's plan terms govern this; a self-employed physician with a solo 401(k) controls it directly, and can often drive total additions well beyond the elective limit on 1099 income alone.

Layer 3 — The mega backdoor Roth

If your plan allows after-tax (non-Roth) contributions *and* in-plan Roth conversions or in-service withdrawals, you can contribute additional after-tax dollars up to the $72,000 total and convert them to Roth — the "mega backdoor." For a physician whose plan permits it, this can move tens of thousands of additional dollars into tax-free growth each year. Not every plan supports it, so the first step is always confirming the plan's features, not assuming.

Layer 4 — The 457(b), stacked on top

Many hospital-employed and academic physicians have access to a **457(b)** plan alongside their 403(b). Because the 457(b) has its own separate $24,500 limit, a physician with both can defer up to that amount *twice* — the 403(b) and the 457(b) do not share a ceiling. This is one of the most powerful and least-used features available to employed physicians.

> GOVERNMENTAL VS. NON-GOVERNMENTAL 457(B)
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> The distinction matters. A **governmental** 457(b) is well-protected and portable. A **non-governmental** 457(b) — common at non-profit hospital systems — remains a general asset of the employer, meaning it carries creditor risk if the institution fails, and its distribution options are more rigid. It is often still worth using, but it deserves a deliberate decision rather than an automatic yes.

Layer 5 — The backdoor Roth IRA

Attending income almost always exceeds the Roth IRA phase-out, closing the front door. The "backdoor" — a non-deductible traditional IRA contribution followed by a conversion — keeps it open, adding **$7,500** per person for 2026 (and the same for a spouse). The one trap is the **pro-rata rule**: if you hold pre-tax IRA balances, the conversion becomes partly taxable. Clearing those balances first (often by rolling them into a 401(k)) is what makes the backdoor clean.

Layer 6 — The HSA, the quietest winner

If you are enrolled in a high-deductible health plan, a Health Savings Account is the only account that is **triple tax-advantaged**: deductible going in, tax-free growth, and tax-free withdrawals for qualified medical costs. Treated as a long-term investment rather than a spending account — paying current medical costs out of pocket and letting the HSA compound — it becomes one of the most efficient retirement vehicles a physician has. It is also the most frequently underused.

Layer 7 — Defined benefit and cash balance plans

For a physician with substantial, stable self-employment income — an established private practice or significant 1099 earnings — a **defined benefit or cash balance plan** can sit on top of everything above and allow deductible contributions well into six figures, scaled to age and income. These plans carry actuarial cost and a funding commitment, so they suit a specific profile: high income, a desire to shelter aggressively, and the cash flow to fund consistently. For the right physician, they are the single largest lever in the entire stack.

How the layers stack — an illustration

SAME PHYSICIAN, TWO APPROACHES

Consider an employed attending with access to a 403(b), a 457(b), and a plan that permits after-tax contributions, plus some 1099 moonlighting income. The contrast between the default approach and the fully layered one is stark.

THE DEFAULT

"I maxed out my 401(k)"

403(b) elective deferral	$24,500

Total tax-advantaged	**$24,500**

This is where most physicians stop — and where they leave the majority of the available shelter unused.

THE LAYERED STACK

Same physician, every eligible layer

403(b) elective deferral	$24,500
457(b) (separate limit)	$24,500
Backdoor Roth (self + spouse)	$15,000
HSA (family coverage)	~$8,750
Solo 401(k) employer on 1099 income	varies
Tax-advantaged, before DB plan	**$72,750+**

Before even considering a cash balance plan, the same physician has multiplied their sheltered savings several times over — using layers that were available all along.

THE FIGURES ARE ILLUSTRATIVE

The amounts above depend on plan features, coverage type, income, and eligibility, and not every physician can use every layer. The point is not the exact total — it is that "maxing out the 401(k)" and "using the retirement stack" are very different numbers, and the gap is worth mapping deliberately.

How I build a retirement stack with physicians

The layers interact, and the order matters — the pro-rata rule, the §415(c) ceiling, plan-specific features, and the funding commitment of a defined benefit plan all have to be coordinated rather

than stacked blindly. I start by auditing exactly what your plans permit, then build the stack in the right sequence, align it with your withholding and estimated taxes, and revisit it each year as limits and your income change.

The result is a retirement strategy sized to what is actually available to you — not the single number everyone quotes. For a high-earning physician, closing that gap is one of the highest-return decisions in the entire tax plan.

This article is educational and reflects 2026 federal retirement plan limits under IRS Notice 2025-67, including the $24,500 elective deferral limit, $72,000 §415(c) total additions limit, and $7,500 IRA limit. HSA and other figures are general and subject to eligibility. Plan features vary; not every physician qualifies for every layer described. Nothing here is tax or investment advice for your situation. Please consult a qualified CPA and, where relevant, a financial advisor before acting.

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