parrott Benefit Group

Open Enrollment FAQ Guide

During open enrollment, you likely have questions about how to make educated choices on benefits enrollment for the upcoming year. Open enrollment is an annual window that offers the opportunity to enroll in, change or update coverage options such as health insurance, and voluntary benefits like dental, life and disability insurance.

The choices made during this period can have a lasting impact on both your health and overall well-being. However, navigating the array of plans, yearly changes, terminology, and cost structures can be challenging.

This guide outlines questions you might have about open enrollment.

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When Is Open Enrollment?

Open enrollment is the designated period each year when you can enroll in, change or cancel your health insurance coverage. This window typically occurs in the fall, but exact dates can vary depending on your employer or health plan. Outside of open enrollment (which usually lasts two to four weeks), changes to your coverage usually require a qualifying life event, such as marriage, birth or loss of other coverage.

Where Do I Sign Up?

Your employer will guide you through the enrollment process. Typically, you'll receive an email or HR communication with the following information:

- Enrollment dates and deadlines
- Access to your benefits portal or HR system
- Plan comparison tools
- Links to Summary Plan Descriptions
- Contact information for HR or a benefits advisor

Most employers use an online platform that lets you select and confirm your choices digitally. Some may offer in-person or virtual benefits fairs to help you understand your options.

How Will I Know How Much Care I Need?

Understanding your anticipated health care needs is essential to choosing the right plan. Start by reviewing your medical history and considering any expected life changes. Ask yourself questions such as:

- How often did you visit doctors last year?
- Do you or your dependents have any chronic conditions?
- Are you planning for a major procedure, surgery or childbirth in the coming year?
- Do you take regular prescriptions? If so, what types of prescription drugs
  (e.g., generic medications, specialty drugs)?

In addition to considering your health needs, evaluate out-of-pocket costs, verify whether your preferred providers are in network, and

determine if a health savings account (HSA) or flexible spending account (FSA) is a suitable option for your situation. Your medical situation may influence whether you choose to enroll in a high deductible health plan (HDHP) or a plan with a lower deductible.

What Is a 401(k)?

A 401(k) is a retirement savings plan offered by many employers that allows you to set aside a portion of your paycheck before taxes are taken out. This money is invested in options like mutual funds or stocks, and it grows over time without being taxed until you withdraw it in retirement. Many employers also offer a matching contribution, which means they'll add money to your account based on how much you contribute. Participating in a 401(k) is a smart way to build long-term financial security and take advantage of tax benefits and compound growth.

What Is a Premium?

A health insurance premium is the amount you must pay to keep your health insurance policy active. In return for your premium payment, your health plan covers a portion of your health care expenses, as outlined in your health insurance policy. You must pay your premium to keep coverage active, regardless of whether you use it or not.

Most people pay their premiums monthly, but payments may be due biweekly or quarterly. If your employer provides health insurance, your premiums will typically be taken directly out of your paycheck.

You'll still pay the premium even if you don't use your insurance, so it's essential to balance the premium cost with potential medical expenses. A low-premium plan may come with a high deductible, while a high-premium plan may offer more comprehensive coverage and lower out-of-pocket costs.

What Is a Deductible?

Your health insurance deductible is a set amount you must pay before your insurance company starts sharing the cost for covered medical expenses. Essentially, it represents your initial financial responsibility before insurance helps cover the financial burden of medical care. Understanding your out-of-pocket health insurance costs can help you manage your annual medical expenses and improve your health literacy.

Finding the health care plan with the right deductible for you will vary depending on your health and financial circumstances. For example, if you are healthy, don't need much medical care and prefer lower monthly premiums, a higher deductible health plan may be right for you. Alternatively, a health care plan with a lower deductible may be a better choice if you expect high medical costs for the year and prefer more comprehensive coverage. Depending on what health care plan options your employer offers, you may have the option to choose between an HDHP or a plan with a lower deductible but higher premiums.

What Is a Copay?

A copayment, or copay, is a fixed amount of money you may be required to pay when you receive certain covered health care services or purchase prescription medications. It is a cost-sharing arrangement between you and your insurer in which your insurer covers the remaining portion of your medical expenses in exchange for your copayment.

The exact cost of your copayment will vary depending on the health care plan you choose. For example, your copay for an annual checkup with your primary care physician might be $20, $25 or $30. Health insurance plans with higher premiums typically have lower copayments, whereas plans with lower premiums usually have higher copayments.

What Is Coinsurance?

Coinsurance is a cost-sharing arrangement between you and your health insurance provider. It represents the health care costs you pay after meeting your deductible. Unlike a copayment, which is a fixed dollar amount you pay for a specific service or medication, coinsurance is a percentage of the total cost of a covered service.

Common splits are 80/20 or 70/30, where the insurance company pays the larger portion of the claim. For example, suppose your plan has a 20% coinsurance rate and you've already met your deductible. If you have a $2,000 hospital bill, you pay $400 (20%) and insurance pays $1,600 (80%).

Unlike a copay, coinsurance can be unpredictable because it's based on the total cost of care. It's essential to check whether your providers are in network, since out-of-network services often have higher coinsurance rates or aren't covered at all.

What Is an Out-of-Pocket Maximum?

An out-of-pocket maximum (OOPM) is the most you'll pay for covered health care services in a plan year. After reaching it, your plan typically covers 100% of your in-network, covered costs for the rest of the year. The OOPM usually resets at the start of each new policy year. What counts toward your OOPM can vary by plan, but it generally includes deductibles, copayments and coinsurance—not premiums or out-of-network costs. Plans offer different OOPM levels; those with lower limits often come with higher premiums, while higher OOPMs usually mean lower premiums.

Why Are Health Care Costs Rising?

In recent years, health care costs have been rising drastically. This trend is expected to continue due to a range of factors, including the following:

- Increased use of behavioral health services as the population ages
- Rising prices for hospital services and prescription drugs
- Growing demand for specialty drugs such as GLP-1s, cell and gene therapies, and biologics
- Administrative costs associated with billing and insurance
- Chronic illness rates, such as diabetes and heart disease
- Medical technology advancements, which may be life-saving but expensive

These trends affect premiums, deductibles and out-of-pocket costs. When you review rising health care costs for the upcoming year, these factors play a role in why you may see your health care expenses go up.

What Happens If I Miss the Open Enrollment Period?

If you miss the open enrollment window, you could be locked out of making any changes to your benefits until the next open enrollment period, typically a year away. This means you could be stuck with your current plan, or even go without coverage for you and any dependents you were planning on enrolling. However, there are exceptions. If you experience a qualifying life event, such as getting married, having a baby, losing other coverage or moving, you may be eligible for a special enrollment period (SEP). This SEP typically gives you 30 days from the date of the event to make qualifying changes to your coverage. Mark open enrollment dates on your calendar as soon as your employer announces them, and check your HR portal or emails for notifications.

Can I Make Enrollment Changes Midyear?

You may be able to make changes to your benefits midyear, but only under specific circumstances known as qualifying life events. A midyear qualifying event is a significant life change that justifies altering your benefit elections outside of open enrollment. These events ensure your benefits remain aligned with your current needs. Common examples include changes in marital status (such as marriage or divorce), changes in the number of dependents (like birth or adoption), changes in employment status, a dependent aging out of coverage or relocation that affects plan eligibility.

In some cases, your employer may also allow changes to certain benefits midyear, even without a qualifying life event. For example, you might be able to adjust your HSA or 401(k) contributions at any time. Additionally, some voluntary benefits or resources, such as employee assistance programs, commuter benefits or wellness programs, may allow you to enroll or make changes midyear, depending on your employer's policies.

If I Change Plans, Will My Doctor Still Be in Network?

If you change health insurance plans, your doctor may or may not remain in network with your new plan. It depends on the provider network associated with your new plan. Each plan has its own list of in-network providers; even within the same company, different plans can have different networks. So, just because your doctor accepted your previous insurance doesn't guarantee they'll be covered under your new one.

To find out for sure, start by logging into your new insurance provider's online portal. Most insurers offer a searchable directory that allows you to look up doctors by name, specialty or location. This is usually the most accurate method for confirming network status. You can also call the Member Services number on the back of your insurance card and ask directly. Be sure to provide your plan name and any relevant details, as insurers often have multiple networks.

Another good option is to contact your doctor's office. The staff can usually tell you whether they accept your new insurance and whether your doctor is considered in network. Just make sure to provide them with the exact name of your plan, not just the name of the insurance company.

Keep in mind that even if a doctor accepts your insurance, they may still be out of network, which could result in higher out-of-pocket costs. If

your doctor is out of network and you're undergoing ongoing treatment—like pregnancy, surgery or chronic care—you might qualify for a "transition of care" benefit that allows you to continue seeing them temporarily under in-network terms. And in some cases, doctors offer cash discounts if you choose to pay out-of-pocket.

What Is an HSA?

HSAs provide individuals with a tax-friendly way to save for future medical expenses. They are an innovative, flexible way to save money and pay for health care expenses now and in the future. If you have an HDHP, an HSA can be a valuable companion, offering essential tax advantages and long-term savings potential.

These accounts are available to those enrolled in an HDHP, and many HDHPs offer the option to open and contribute to an HSA. Funds in an HSA can be used for various eligible health care expenses, such as copays, prescriptions, dental care and vision-related costs. The accounts are often used to help offset the higher deductibles and out-of-pocket expenses associated with HDHPs. HSA funds typically roll over year to year and can even be invested to grow your savings over time.

What Is an FSA?

An FSA is an account in an employee's name that reimburses the employee for qualified health care or dependent care expenses. It allows employees to fund qualified expenses with pre-tax dollars deducted from their paychecks. The employee can receive cash reimbursement up to the total value of the account for covered expenses incurred during the benefit plan year and any applicable grace period. FSAs typically follow a "use it or lose it" rule, meaning you need to spend the money within the plan year or risk losing it. However, some plans offer a grace period or small rollover.

What Are Voluntary Benefits?

Voluntary benefits are coverage options and products made available to employees for elective purchase. These programs have four key characteristics:

1. Employee-paid (fully or partially)
2. Offered through an employer
3. Solicited and enrolled through a carrier or enrollment firm
4. Paid through automatic payroll deductions

Because of their cost efficiency and portability, as well as their contribution to an employee's work-life balance, voluntary benefits are becoming a central component of many companies' overall benefits strategies. Examples include life insurance, disability coverage, accident and critical illness insurance, legal services, pet insurance and identity theft protection.

Do I Still Have to Enroll in Employee Benefits if I'm Not Making Any Changes?

Even if you're not making any changes to your benefits, some employers may still require you to actively confirm or reenroll during the annual enrollment period. Others may automatically carry over your current elections if you don't take any action. It's essential to check with your employer to determine whether they have automatic renewal.

Conclusion

Open enrollment is your annual opportunity to review your benefits, make changes and ensure your coverage fits your needs for the year ahead. Taking the time to understand your options can make a big difference in your financial and personal well-being. If you have questions that aren't covered here or need help making decisions, check with your employer for answers to specific questions about your open enrollment.