Your A-Z Open Enrollment Cheat Sheet

Provided by The Drury Group

Common Open Enrollment Terms

Open enrollment is the yearly period when you can enroll in, change or renew your benefits for the upcoming plan year. Understanding the vocabulary can help you feel more confident when choosing or reviewing your coverage.

Use these definitions of common open enrollment terms to help you navigate your options.

A

Affordable Care Act (ACA) is federal legislation that sets coverage requirements affecting many employer plans.

Allowed amount is the maximum amount your plan will pay for a covered service.

B

Balance billing is when an out-of-network provider bills you for the difference between their charge and what your plan paid.

Beneficiary is the person designated to receive benefits, such as life insurance proceeds, under your plan.

C

COBRA (Consolidated Omnibus Budget Reconciliation Act) allows employees and their dependents to continue employer-sponsored health coverage for a limited time after a qualifying event, such as job loss or a reduction in hours, typically at the employee's own expense.

Coinsurance is the percentage of a covered service's cost that you pay after you meet your deductible. For example, if your plan pays 80%, your coinsurance is 20%.

Consumer driven healthcare (CDHC) plans give you more control over your healthcare spending. They typically pair lower premiums with higher deductibles and are often combined with an account, such as a health reimbursement arrangement (HRA) or health savings account (HSA), to help pay for care.

Copayment (copay) is a flat fee that you pay toward the cost of covered medical services, usually at the time of service.

Covered charges are eligible expenses for which your plan pays benefits, subject to your deductible, copay or coinsurance.

D

Deductible is the amount you pay out of pocket each plan year before your plan begins to pay for covered services. Some plans waive the deductible for certain services, such as preventive care.

Dental insurance is a plan that helps cover the cost of preventive, basic and major dental care, such as cleanings, fillings and other procedures.

Dependent care flexible spending account (FSA) allows you to set aside pre-tax dollars to pay for eligible dependent care expenses, such as childcare or eldercare, so that you can work or look for work.

Dependent is a family member, such as a spouse or child, who is eligible for and enrolled in your plan. Under the ACA, children can stay on a parent's plan until age 26.

E

Effective date is the date your coverage begins.

Essential health benefits are service categories certain plans must cover under the ACA.

Explanation of benefits (EOB) is a statement showing what your plan paid on a claim and what you may still owe.

F

Flexible spending account (FSA) lets you set aside pre-tax dollars for eligible medical or dependent care expenses that insurance doesn't reimburse. You choose your contribution at the start of the plan year. Funds generally must be used by the end of the year, though your employer may allow a limited carryover or grace period.

Formulary is the list of prescription drugs a health plan covers, often organized into cost tiers.

G

Grace period is a short window after a missed premium payment during which coverage continues.

Group health plan is health coverage an employer offers to a defined group of employees, rather than coverage purchased individually.

H

Health maintenance organization (HMO) is a plan that limits coverage to care from doctors and facilities in its network, except in emergencies. You choose a primary care physician (PCP) to manage your care and provide referrals to specialists. HMOs often have lower out-of-pocket costs but less flexibility.

Health reimbursement arrangement (HRA) is an employer-owned medical savings accounts in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account to reimburse qualified healthcare expenses.

Health savings account (HSA) is an employee-owned medical savings accounts used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high deductible health plans (HDHPs).

High deductible health plan (HDHP) is a qualified health plan that combines low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

I

Individual coverage health reimbursement arrangement (ICHRA), also known as a CHOICE Arrangement, is an employer-funded account that reimburses employees for individual health insurance premiums and other qualified medical expenses, rather than providing coverage through a traditional group health plan.

In-network care is care from doctors, hospitals and other providers that contract with your plan. It typically costs you less than out-of-network care.

Inpatient care is care you receive after being formally admitted to a hospital or other facility, typically with an overnight stay.

J

K

L

Life insurance is a policy that pays a designated beneficiary a sum of money upon your death, often used to provide financial protection for your dependents.

Lifetime maximum is the total amount a plan will pay for covered services over the life of the plan.

Long-term disability (LTD) insurance replaces part of your income during an extended qualifying disability.

M

Medically necessary (or medical necessity) describes services and supplies a provider orders to diagnose or treat an illness, injury or condition and that meet accepted standards of good medical practice. They must be the most appropriate care available and not primarily for convenience.

Medicare is an insurance program administered by the federal government to provide health coverage to individuals aged 65 and older or who have specific disabilities or illnesses.

Members are those enrolled in a health plan. This includes eligible employees, their dependents, Consolidated Omnibus Budget Reconciliation Act (COBRA) beneficiaries and surviving spouses.

N

Network is the group of providers a plan has contracted with at negotiated rates.

O

Open enrollment period is the specific window of time each year during which you can enroll in, change or renew your employer-sponsored benefits.

Out-of-network care is care from providers that don't contract with your plan. It usually costs more, may not be covered at all under some plans, and can lead to balance billing.

Out-of-pocket expense is the amount that you must pay toward the cost of healthcare services. This includes deductibles, copayments and coinsurance.

Out-of-pocket maximum (OOPM) is the highest out-of-pocket amount paid for covered services during a benefit period.

P

Point-of-service (POS) plan is a type of health plan that combines features of HMOs and PPOs, requiring you to select a primary care physician for referrals while still allowing some out-of-network coverage at a higher cost.

Preferred provider organization (PPO) is a health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Premium is the amount you pay for a health plan in exchange for coverage. Health plans with higher deductibles typically have lower premiums.

Preventive care refers to routine services, such as annual checkups, immunizations and certain screenings, aimed at catching health issues before they become serious. Many plans, including all ACA-compliant plans, cover a defined list of preventive services at no cost to you, meaning no copay, coinsurance or deductible, as long as they're received in-network.

Primary care physician (PCP) is the doctor you select to coordinate your care under your health plan. PCPs generally include family practice physicians, general practitioners, internists and pediatricians.

Q

Qualifying life event (QLE) is a change, like marriage or a new dependent, that allows benefit changes outside open enrollment.

R

Referral is written approval from your primary care physician to see a specialist.

Renewal date is the date your plan's coverage terms are reviewed and a new plan year begins.

Retirement benefits, such as a 401(k) plan, allow you to set aside a portion of your paycheck, often with an employer match, into a tax-advantaged account to save for retirement.

Rider is an amendment to a policy that adds, excludes or modifies specific coverage.

S

Short-term disability (STD) insurance replaces part of your income during a limited-term disability.

Special enrollment period (SEP) is a window outside open enrollment to enroll or change coverage after a qualifying life event.

Summary of benefits and coverage (SBC) is a standardized document for comparing what plans cover and cost.

T

Telehealth is healthcare delivered remotely by phone, video or other technology.

Third-party administrator (TPA) is a company that processes claims and handles administrative tasks on behalf of a self-funded plan.

U

Usual, customary and reasonable (UCR) allowance is the fee paid for covered services that is (1) a similar amount to the fee charged from a healthcare provider to the majority of patients for the same procedure, (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances.

V

Vision insurance is a plan that helps cover the cost of routine eye exams, glasses and contact lenses.

Voluntary benefits are optional, employee-paid benefits like accident insurance or critical illness insurance.

W

Waiting period is the time between becoming eligible and when coverage begins.

Wellness program is an employer initiative encouraging healthy behaviors, often tied to incentives.

X

Y

Z

This cheat sheet does not account for every term or definition you may see during open enrollment, but it provides an overview of some of the most common ones.

If you have questions, check with your employer for further resources.

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