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Benefit Open Enrollment

Frequently Asked Questions

In the spirit of making sure that you are as informed and prepared as possible, here's a handy guide to some of the most common open enrollment questions:

What is the difference between the EPO and MCPOS plans?

Both the EPO and MCPOS plans are Preferred Provider Organizations (PPO) plans. The major difference between the two is that an EPO offers in-network only coverage, while a PPO plan offers both in and out of network coverage. Both the EPO and PPO plans offer nationwide provider networks.

- An Exclusive Provider Organization (EPO) is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).
- A PPO is a type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

What is a Health Maintenance Organization (HMO)?

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It 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 often provide integrated care and focus on prevention and wellness. All the Kaiser plans are HMO plans.

What is a High Deductible Health Plan (HDHP)?

A high deductible health plan (HDHP), sometimes referred to as an HSA plan, is a plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs out of pocket before the insurance company starts to pay its share (also called your deductible).

The HSA compatible plans will appear on the benefit listing as MCPOS HSA. These are the only MCPOS plans compatible with an HSA account.

An HSA compliant high deductible plan can be combined with a health savings account (HSA), for you to pay for certain medical expenses with money you set aside in your tax-free HSA. This is why it's more commonly called an HSA-eligible plan.

With an HDHP, you will pay everything out-of-pocket until you reach your deductible. After that, the plan coinsurance and/or co-pays kick in, and the insurer picks up a percentage of the bills until you reach your out-of-pocket maximum.

What is coinsurance?

Coinsurance is the amount of a covered service that you must pay after you've met your deductible; it's your share of the cost of a covered healthcare service (the insurance company pays the rest). So, if a plan has 20% coinsurance, you will be responsible for 20% of the covered amount and the insurance company will pay the rest. Your coinsurance doesn't kick in until the deductible is met. Put simply, coinsurance is a shared payment amount between the insured person and the insurance company.

What is a co-pay?

A co-pay is the fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible.

Let's say your health insurance plan's allowable cost for a doctor's office visit is $100. Your copayment for a doctor's visit is $20.

- If you've paid your deductible, you pay $20, usually at the time of the visit.
- If you haven't met your deductible: You pay $100, the full allowable amount for the visit.

Copayments (sometimes called "copays") can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

What's the Difference Between a Deductible and an Out-of-Pocket Maximum?

- Deductible: the amount you must pay before your health plan starts to pay benefits. The plan may cover some items before the deductible is met such as services covered by a copay, emergency services, prescriptions, or preventive care.
- Out-of-pocket maximum: the total amount you must pay during the plan year for all in-network treatment covered by your plan, including the deductible, copays and coinsurance. Covered out of network services have a separate deductible or may not be covered if the plan does not allow for out of network services (eg EPO plans.)
- Premiums, balance billing charges, healthcare not covered by the plan, failure to obtain preapproval for services (when required) do not count toward your of pocket maximum, even though you are still responsible for payment of these services.

What's the difference between an individual deductible and a family deductible?

Once a person covered under a family plan reaches the individual deductible, all covered expenses for that individual will be paid at the covered benefit amount even when the family deductible has not been satisfied. Once another person or a combination of persons meet the remaining portion, the family deductible would be considered satisfied.

Generally, you must pay all the costs from providers up to the deductible amount before the plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

What's the difference between an individual and a family out-of-pocket maximum?

Once a person covered under a family plan reaches the individual out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum has not been satisfied. Once another person or a combination of persons meet the remaining portion, the family out-of-pocket maximum would be considered satisfied.

What's the difference between my deductible and premium?

Your deductible is the amount you pay for covered health care services before your insurance plan starts to pay. If you have a $1,000 deductible, you pay the first $1,000 of covered services yourself.

Your premium is the amount you pay each month for health insurance coverage.

Usually, if your plan has a higher deductible, your premium is lower. And if your plan has a lower deductible, your premium will probably be higher.

What is a Flexible Spending Account (FSA)?

Healthcare FSA helps pay for eligible out-of-pocket medical, dental, vision, hearing and prescription drug expenses; this includes deductibles, coinsurance, co-pays and over-the-counter (OTC) items. The healthcare FSA is frontloaded at the beginning of the year, so if the member elects to contribute $2,000 for the year, all $2000 is available; meaning if on February 2nd there is a medical deductible that needs to be paid, the member has access to use the full $2,000 if needed.

Participation in the FSA ends if you terminate employment. This means only expenses incurred prior to the date your participation in the plan ends are eligible for reimbursement. Claims for expenses incurred prior to the plan termination date must be submitted within the "run-out" period.

If money is left over at the end of the year, you are allowed 2.5 months to spend any left-over money. FSA's are generally considered "use it or lose it." These funds do not roll over and you must re-enroll in an FSA every year.

What is a Health Savings Account (HSA)?

An HSA is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in an HSA to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your out-of-pocket health care costs. HSA funds generally may not be used to pay premiums.

While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you have an HSA-eligible plan (sometimes called a High Deductible Health Plan (HDHP)) — generally a health plan that only covers preventive services before the deductible. An HSA may earn interest or other earnings, which are not taxable. Banks, credit unions, and other financial institutions offer HSAs.

If money is left over at the end of the year, it rolls over into the next year. Money contributed to an HSA account is yours to keep. You must re-enroll in HSA every year.

How much can I contribute to my HSA?

The IRS set the contribution limit each year. Please refer to your current year's Benefits Guide for the current contribution amounts. These amounts are set and adjusted annually by the IRS. Remember that not all health plans with a high deductible are HSA-qualified, so before you enroll in a plan, make sure this tax benefit is included.

What happens to the money in my HSA after I turn age 65?

You can continue to use your account tax-free for out-of-pocket health expenses. When you enroll in Medicare, you can use your account to pay Medicare premiums, deductibles, copays, and coinsurance under any part of Medicare. If you have retiree health benefits through your former employer, you can also use your account to pay for your share of retiree medical insurance premiums.

The one expense you cannot use your account for is to purchase a Medicare supplemental insurance or "Medigap" policy. Once you turn age 65, you can also use your account to pay for things other than medical expenses. If used for other expenses, the amount withdrawn will be taxable as income but will not be subject to any other penalties. Individuals under age 65 who use their accounts for non-medical expenses must pay income tax and a 20% penalty on the amount withdrawn.

How do I make sure my preventive care visit is 100% covered?

All of the offered plans are compliant with the Affordable Health Care Act (ACA).. All covered preventative care visits are covered by insurance, free of charge, regardless of whether you've met your deductible.

Before you see the doctor, check to make sure the type of visit you're going in for is covered under your plans preventive care coverage.

What is a Qualifying Life Event (QLE)?

Qualifying Life Events allow you to make changes to your insurance plan within a set period of time (usually 30 or 31 days), regardless of if they occur during the open enrollment window or not. Common QLEs include, but are not limited to the following:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of a spouse or child
- Change in spouse's employment or insurance status.
- Other events may qualify (contact your HR or benefits department for questions)

You will be required to provide evidence of a qualifying life event to change your insurance coverage.

What if I miss the open enrollment period for benefits?

If you miss the open enrollment period, you will not be able to enroll or make changes until the next annual open enrollment period — unless you experience a qualifying life event that permits you to make benefits changes under IRS rules.

Who is an eligible dependent?

A child or other individual for whom a parent, relative, documented domestic partner or other person may claim a personal exemption tax deduction. A dependent child(ren) up to age 26 is covered.

Can I have other health coverage?

Yes, you can be covered by another group health plan and still receive benefits under most medical plans. This is called "dual coverage" and coordination of benefits (COB) will apply. If you're enrolled in an employer-sponsored health plan, that coverage is primary for you, and you must file your claims under this plan first. If some of your out-of-pocket costs are not covered, then you can file a claim under your secondary insurance.

How will my health benefits impact me come tax time?

The amount you pay for your medical, dental and vision premiums are subtracted from your gross pay before any State, Federal, and Medicare taxes are deducted. This means your taxes are lower because the amount of income you're taxed on is reduced.