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Many Americans get health insurance at work. Once a year -- typically in fall -- employers have an "open enrollment" period when employees can make changes to their health insurance and other benefits for the coming year. Learn about the different options you may have available at your work and how to pick the best one for you and your family.

Note: If you don't have health insurance at work, see our resources on Open Enrollment 2022 to learn about the Health Insurance Marketplace (aka "exchanges").

Determine Which Type of Plan Is Best for You

Many employers offer more than one type of health insurance, which gives their employees flexibility. The one you choose will determine your out-of-pocket costs and which providers you can see.

Health Maintenance Organization (HMO) offers coverage from doctors, hospital, and other providers 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, which is important to keep in mind now that more people work remotely and may not live where their company's HMO operates.

Preferred Provider Organization (PPO) offers the most choice in providers. You can use doctors, hospitals, and providers outside of the plan's network without a referral. This choice typically comes with higher costs. Using in-network providers can help lower the costs.

Exclusive Provider Organization (EPO) is a managed care plan where services are covered *only* if you use doctors, specialists, or hospitals in the plan's network (except in an emergency). There are typically more options for providers with an EPO compared with an HMO.

High-Deductible Health Plan vs. **Traditional Plan** High-deductible health plans require you to pay more health care costs *yourself* before the insurance company starts to pay its share. Traditional plans have lower deductibles, so the insurance company starts to pay its share more quickly in the year. There are often choices for both types with HMOs, PPOs, and EPOs.

To compare these different plan types, consider the factors outlined in the chart below. Ask yourself which of these factors is most important to you, and then use the chart to determine which plan best fits your needs.

	HMO Health Maintenance Organization	PPO Preferred Provider Organization	EPO Exclusive Provider Organization
Does the plan require you to select a designated Primary Care Physician?	Yes	No	Sometimes
Does the plan require you to get a referral if you want/need to see a Specialist?	Yes	No	No
Does the plan cover health expenses from doctors, hospitals or providers within the Provider Directory?	Yes	Yes	Yes
Does the plan cover health expenses from doctors, hospitals or providers outside of the plan's network?	No	Yes	No
How expensive will your monthly payments be?	$	$$$$	$$
Can you use a Health Savings Account to set aside pre-tax money to pay for costs not covered by your plan?	Sometimes	Sometimes	Sometimes
Does the plan have very high out-of-pocket costs for health expenses, but very low regular monthly payments?	Sometimes	No	Sometimes

Understand Cost Components

Premium: The ongoing payment deducted from your paycheck.

Deductible: The amount you pay before your health insurance starts to cover your bills. In general, if you have a $1,400 deductible, you must pay $1,400 out of pocket before your insurer starts covering the costs. Preventative care is typically paid by insurance even before your deductible is met.

Copay and Coinsurance: Plans vary. Some have a **Copay** which is a predetermined rate you pay for health care services at the time of care. For example, you may have a $40 copay every time you see your

primary care physician. Other plans charge **Coinsurance** payments, where you pay a specified percentage of the service and the plan pays the rest, typically only after your deductible has been met. For example, if you have a 20% coinsurance, you pay 20% of each medical bill, and your health insurance pays 80%.

Compare Plan Costs, Benefits, and Provider Networks

Your employer and its health insurance company(s) likely have lots of online or paper resources to learn about the health plan(s) offered. Start there. Determine if the doctors, specialists, or other providers you already use are "in-network" for the plan(s) available to you. You will pay less for in-network providers.

Often, for people who are healthy and don't anticipate major medical events in the coming year, a low premium/high deductible plan may be best. However, for others, a plan with a higher premium that covers a higher portion of medical costs may be appropriate. Such plans may be appropriate, for example, for people who see a primary physician or a specialist frequently, take expensive medications on a regular basis, are expecting a baby or plan to have a baby, anticipate having surgery, need emergency care frequently, etc.

Options for Managing Out-of-Pocket Costs

Health Savings Account (HSA) is a tax-advantaged medical savings account available to those who are enrolled in a High-Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit, the funds grow tax-deferred, and are not taxable when they are withdrawn to pay for qualified medical expenses at any point in your life. They are completely portable, meaning that if you change jobs you keep the HSA account.

Health Care Flexible Spending Account (FSA) is a tax-advantaged medical savings account to pay for qualified health care costs, typically available to those who are *not* enrolled in a High-Deductible Health Plan. Like HSAs, the funds contributed to an FSA aren't subject to federal income tax at the time of deposit, the funds grow tax-deferred, and are not taxable when they are withdrawn to pay for qualified medical expenses. However, you must use most of the funds in the year in which they were contributed (only a small portion can be rolled over to use the following year).

Dependent Care Flexible Spending Account (FSA) is a tax-advantaged savings account to pay for eligible child and dependent elder care expenses you incur so you can work. Examples include preschool, after-school care for children up to age 13, adult day care, and in-home elder care. These funds must be used in the year they were contributed.

Health Reimbursement Arrangement (HRA) is an employer-funded account to pay for qualified health care costs. These are less common.

When to Enroll

When you start a new job

Typically new employees are able to enroll in the health plan when they are hired or after a short waiting period.

Your company's annual open enrollment

Companies also have annual benefits enrollment times when employees can make changes or additions to their plans. These are usually in the fall for plans that operate on a calendar year basis, or in spring for plans that operate from July-June.

A "qualifying" life event

Outside of the above enrollment periods, employees can only make changes to their coverage when they have a qualifying change in life events. Examples include getting married, having a baby, moving, losing health coverage through a spouse, or aging out of a parent's plan.

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