transcarent

Adulting 101





what no one told you about benefits

Open enrollment is here, and let's be real—for most of us, it's really confusing. But the truth is, you don't need to be a benefits expert to get this right. We'll break down confusing terms and give you a simple checklist so you can **pick the right health benefits for you with zero guessing.**

VIBE CHECK

Open enrollment is your once-a-year opportunity to **take control of your health** and make the most of the healthcare benefits your employer pays for. Remember, your compensation is more than just a paycheck; it includes your benefits. If you don't use them, you're leaving free money on the table.

We're giving you the TL;DR on how to approach open enrollment this year. We'll break down confusing terms and give you a simple checklist so you can pick the right health benefits for you with zero guessing. Because wouldn't it be nice if it were as easy as ordering food on a delivery app?

*Any term that has an * next to it indicates that it will later be defined in the Benefits Glossary.*

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Open Enrollment, Decoded

Always review your options because they were designed for you!

This is how you can take control of your health on your terms!

Open enrollment is the **once-a-year window when you can choose or change your health, dental, and vision benefits.** During open enrollment, you're in charge. You can put your health needs first, whether it's saving money, caring for your family, or focusing on your mental health.

PSA: This is the only time you can make changes to your benefits selection for the year.

Unless you have a qualifying life event, like getting married, having kids, starting a new job, or turning 26, you will not be able to change your benefits outside of this period.

Even If You Are Happy With Your Benefits, You Should Still Go Through Open Enrollment

Some of you are probably thinking: I'm happy with my benefits selection right now, so why do I need to pay attention to open enrollment?

Here's why doing nothing is not the move:

- If you miss open enrollment, you will **not** be able to enroll in your employer-sponsored health benefits without a qualifying life event (it's the law!).
- Parts of your plan, or even your whole plan, may not auto-renew. Some benefits and accounts require an active "yes" every year to keep them running.
- Your costs can change. What your same plan cost you last year could be more expensive this year. Your premiums*, deductibles*, and copays* could all increase.
- Your company may be offering new benefits that weren't available the year before.



Benefits Glossary (But Make It Plain English)

For a lot of us, benefits terms can be really confusing. To help you quickly understand them, we're breaking down the most common words and phrases you'll come across in open enrollment below, in a way that actually makes sense.

The Big Three: Types of Health Plans

Whether your employer gives you multiple options to compare or just one standard plan, understanding what you're looking at makes all the difference.
Here are the main plan types you'll likely see:

1. **PPO (Preferred Provider Organization):** The all-access pass. You can see almost any doctor you want, inside or outside the network, which is the group of doctors and facilities your insurance company has partnered with, without needing a referral. You generally pay a higher monthly cost for this freedom.

2. **HMO (Health Maintenance Organization):** The guided tour. You have to pick one main doctor, like your personal tour guide, to coordinate your care, and you need their referral to see any specialists. It is usually cheaper, but you have to stick strictly to their approved list of doctors.

3. **HDHP (High Deductible Health Plan):** The high-stakes bet. What is taken out of your paycheck each month is lower, but if you need care, you have to pay a chunk of your own money upfront, which is often a high deductible*, before the insurance actually chips in.

The Financials, Translated

When you go to a doctor, what you really want to know is what you're paying after your benefits apply. Here are all the terms you'll likely see on that final bill:

Premium: The subscription fee. Just like streaming TV, you pay it whether you use it or not. This is the set amount automatically deducted from your paycheck every pay period, biweekly or monthly, in order to have insurance.

Deductible: The entry fee. It is the initial cost you are entirely responsible for before your insurance starts doing its job. Once you pay enough to hit this number, your insurance activates and starts sharing the cost of your care.

Copay: The cover charge. It's a flat fee you pay directly at the doctor's office front desk or at the pharmacy counter when you pick up your medication.

Coinsurance: Splitting the bill. After you hit your deductible, you agree to split the remaining bills with your insurance provider. You pay a specific percentage of the final amount out of your own pocket, and the insurance covers the rest.

Out-of-Pocket Costs: Your personal tab. Your health plan has rules around what services they will pay for and how much you'll be required to pay. This is the amount not covered by insurance that you'll have to pay.

Out-of-Pocket Maximum: The spending ceiling. This is the absolute most you will have to pay out of your own pocket for covered medical care in a year. Once your combined deductibles, copays, and coinsurance hit this number, your plan steps in and covers 100% of the rest of the year.

Waiting Period: The probation phase. For things like major dental work or disability insurance, you often have to wait a certain number of months after enrolling before they actually let you use the benefit.

How It All Comes Together: Doing the Insurance Math

Whenever you get care, you'll eventually receive an Explanation of Benefits, or EOB, in the mail or online. This is the paper you may have gotten in the past that says "this is not a bill" but looks a lot like a bill. Even though it isn't a bill, it breaks down exactly who is paying for what. To better explain more what an EOB looks like in action, we've broken down the bill you might receive below.

The Scenario:

You twisted your ankle and went to an in-network urgent care for x-rays. The total bill is $2,000. Assuming you haven't used your insurance at all yet this year, here is how the math actually breaks down on your EOB.

Line Item	Amount	What it Means For Your Wallet
Premium	N/A	You already paid this out of your paycheck this month. It's the subscription fee you pay just to have the plan. It doesn't show up on the paper you get in the mail.
Copay	$50	You pay this. This is the cover charge you paid at the front desk before the doctor even looked at your ankle.
Deductible	$950	You pay. Because it's the beginning of the year, you haven't hit your yearly deductible, so you'll cover a lot of the costs here.
Insurance Pays	$1,000	Your insurance pays this part of the bill directly to the urgent care.
Your Total Out-of-Pocket Cost	$1,000	This is the final amount that came out of your own wallet for this visit.

Benefits Glossary: Continued

When you select your health plan, you will also have the opportunity to add on accounts and tools that help you stretch your dollars and maximize your care.

Spending Accounts $$$

Healthcare FSA (Flexible Spending Account): The prepaid debit card for your health. You set aside pre-tax money automatically from your paychecks to use alongside your health plan for everyday medical expenses—from copays and prescriptions to new glasses and first-aid kits. Just remember: if you don't use the money by the annual deadline or you quit your job, you lose whatever is left.

FYI: The full amount you choose to contribute for the year is front-loaded on January 1! That means your entire balance is available to spend on day one, even if you haven't contributed the full amount through your paychecks yet.

Flexible Spending Account (FSA): A prepaid debit card with an expiration date. You add pre-tax money automatically from your paychecks to use alongside almost any health plan for a huge variety of specific everyday expenses, from standard healthcare costs like copays and prescriptions to family expenses like daycare and camps. But if you don't use the money in time or you quit your job, you lose it.





In addition to general-purpose FSAs, there are other types of FSAs:

Dependent Care FSA: This account covers pre-tax expenses for child care or adult day care. Unlike a Healthcare FSA, this usually doesn't come with a debit card—instead, you pay upfront and submit receipts for reimbursement as funds accumulate in your account from paychecks.

Limited-Purpose FSA: This account pairs specifically with an HSA, which is defined below, and can only be used for dental and vision expenses.

Health Savings Account (HSA): The piggy bank in your bedroom. Still taken out of your paycheck, but the money belongs to you, never expires, stays with you between jobs, and is tax-free! The only catch? You are only allowed to use funds on qualified healthcare expenses, like regular doctor visits, medications, and lab tests.

Pro tip: You can use your HSA even when you're retired, and you're never taxed on the dollars used for qualified healthcare expenses.

Health Reimbursement Arrangement (HRA): The corporate card for your health. Your employer funds the entire balance and reimburses you tax-free for qualified medical expenses. The catch? Because it's technically their money, it stays with the company. If you quit or switch jobs, you have to leave the remaining balance behind.

Benefits Glossary: Continued

Formulary: The pre-approved medication shopping list. It's the official catalog of medications your health plan agrees to cover, usually ranked in tiers that determine how much you'll pay at the pharmacy counter. For example, the brand name of an antidepressant might be categorized as tier 2 or 3, while a generic form of the same drug might be tier 1.

Prior Authorization: The insurance permission slip. Your doctor has to get your insurance company's approval before certain medications or treatments are covered. This is usually needed for brand-name medications or treatments that have a cheaper alternative. For example, if your doctor prescribes an expensive brand-name prescription to treat migraines, your insurance may require your doctor to provide proof that the generic options didn't work first.

In-Network vs. Out-of-Network: The VIP list. In-network doctors are on the guest list (meaning cheaper prices). Out-of-network doctors are general admission, meaning you will pay way more at the door.

Annual Maximum (Dental): The cutoff limit. Unlike medical insurance, where a maximum protects you, a dental annual maximum is the absolute most the insurance company will pay for your teeth before they cut you off for the year.

In Case of an Emergency

When life throws a major curveball, these benefits step in to protect your paycheck and support your loved ones if you're unable to work.

Short-Term Disability: Paycheck protection. If you are temporarily benched from work, like recovering from surgery or having a baby, this ensures you still get a portion of your income as long as your disability meets the definition of an approved one.

Long-Term Disability: The long-term safety net. If a severe illness or major injury keeps you away for months, years, or permanently, this usually starts after short-term disability ends to keep a portion of your income coming.

Voluntary Life Insurance: The just-in-case safety net. It provides a cash payout to your loved ones if the worst-case scenario happens.

Take control of the unexpected.

The Benefits Starter Packs

It's time to explore how different benefits options might fit your life. Since there is no one-size-fits-all in healthcare, we aren't here to tell you exactly which configurations to pick. Instead, we've put together some suggestions to help guide your thinking.

Find the Starter Pack that best matches your current needs for some ideas on what might work best for you this open enrollment.

The "Routine Care & Regular Meds" Pack

For those who rely on daily prescriptions or regular checkups and want predictable, transparent costs.

Consider This Plan: Standard PPO or HMO plan with predictable copays for prescriptions, so you always know exactly what your medication will cost before you get to the register.

Doctor & Network Check: Check both the provider directory and formulary! You want to confirm that your preferred pharmacy and primary care doctor are in-network and that your specific brand name or dosage hasn't been moved to a hyper-expensive pricing tier this year.

Hack: Pair this with a healthcare FSA. Use pre-tax dollars to cover your recurring prescription copays and everyday pharmacy items.

The "Low Maintenance, Max Savings" Pack

For those who rarely need medical care and want to save as much cash as possible out of every paycheck.

Consider This Plan: HDHP paired with an HSA.

Doctor & Network Check: Because HDHPs have higher deductibles, sticking strictly to in-network doctors is essential to avoid paying steep out-of-pocket prices for routine visits.

Hack: Look for employer HSA contributions. Many companies will deposit free money into your HSA just for opening the account or even for following recommended preventive care.



The "Planning for a Mini-Me" Pack

For those who are expanding their family and need frequent care for themselves and their dependents.

Consider This Plan: PPO or HMO plan with a low out-of-pocket maximum. Having a baby or managing a toddler gets expensive quickly, so you want a cap on the total amount you could owe in a year.

Doctor & Network Check: Double-check that any care you may need, including an OB-GYN, preferred delivery hospital, or pediatrician, is in-network. Out-of-network maternity and delivery costs can add up fast.

Hack: Look out for dependent care FSAs, which let you use tax-free money for daycare, paid parental leave policies, and specific fertility or maternity perks hidden in the benefits package.





The "Therapy is My Standing Appt" Pack

For those who prioritize their mental health and need reliable coverage for ongoing therapy.

Consider This Plan: A PPO plan with strong out-of-network coverage. Many therapists do not take insurance directly, so a plan that reimburses you for out-of-network providers is essential.

Doctor & Network Check: If your therapist doesn't accept insurance, a PPO with out-of-network benefits allows you to submit receipts for partial reimbursement so you don't have to switch therapists.

Hack: Look out for Employee Assistance Programs (EAPs) or mental health telehealth perks. Many employers offer a set number of free therapy sessions a year that are on top of your standard health plan.



The "I Travel and Move Too Much to Have a Local Doctor" Pack

For those who are constantly on the go and need flexible healthcare coverage from anywhere.

Consider This Plan: A nationwide PPO plan.

Doctor & Network Check: Nationwide PPOs give you access to broad in-network doctor directories across the country, so you won't get hit with unexpected out-of-network fees while traveling.

Hack: Look out for your telehealth benefits. If you are on the road, being able to text or video chat a doctor for a quick prescription is a lifesaver.

The "I'm Turning 26 and Apparently I'm an Adult Now" Pack

For those who are aging off their parents' insurance and navigating choosing their own benefits for the very first time.

Consider This Plan: Balanced, middle-of-the-road copay plan, like a PPO or HMO. And if you're healthy or don't want to pay the higher premiums of either of these plans, you could consider an HDHP plan as well.

Doctor & Network Check: If you don't have established doctors yet, choosing a PPO or HMO plan and sticking to in-network providers is the easiest way to build a reliable local care team at predictable prices.

Hack: Look out for dental and vision coverage! These are usually entirely separate from your medical insurance. You have to actively check the boxes to keep your teeth clean and your glasses updated.



Red Flags to Avoid:
What We Wish We Knew About Open Enrollment

Whether this is your first time navigating open enrollment or you've just been winging it for years, it's easy to make choices you think make sense today that you'll come to regret when you have to use your benefits later. To save you the headache, here are the hard-learned lessons we wish someone had told us from the start.

Don't just hit copy-paste on last year's plan. Health plans can update their rules, prices, and covered doctors every single year. And because many employers offer new benefits every year, it's important to check them out so you can make sure you're taking advantage of what's on the table. What was a great deal for you last year might be terrible for you this year.

Don't assume the most expensive plan is the best health insurance plan. It is tempting to look at the most expensive plan and automatically assume it gives you the best care. But this isn't always true. If you only go to the doctor once a year for a basic checkup, paying top dollar every month for a premium plan is like paying for an unlimited gym membership when you only work out once a month. Pick the plan that actually fits your care needs.

The cheapest plan on payday can be the most expensive plan in real life. A plan that only takes $20 out of your paycheck looks amazing, until you sprain your ankle and realize you have to pay $4,000 out of pocket before the insurance even kicks in. Look at the total cost, not just the monthly fee.

The emergency room is not the place to learn how your insurance works. Don't wait until you are sick to realize an ER visit comes with a massive copay. Save the ER for true emergencies, and take 10 minutes now to find your nearest in-network* urgent care. Better yet, check your benefits for virtual urgent care. Many plans let you see a doctor from your couch for urgent care needs with little to no cost.



Red Flags to Avoid: Continued

Don't assume your favorite doctor is still on the VIP list. Insurance companies can change which doctors are in their network. Always use the plan's directory tool to double-check that your specific doctor is still covered before you hit submit.

Pro tip: Don't do the heavy lifting yourself. See if your employer offers an AI-based care experience to make it easy to use your healthcare and benefits. Instead of just handing you a blank directory, apps like Transcarent can do the work for you—matching you with top-rated doctors, booking your appointments, and guiding your entire care journey.

Don't assume your $10 daily medication will stay $10. Just like doctors, the formulary can change every year. Always check your specific prescriptions to make sure they haven't been quietly moved to a more expensive pricing tier.

Pro tip: Treat your prescriptions like that big online splurge you've been eyeing—always compare prices to snag the best deal! Believe it or not, different pharmacies can charge completely different prices for the exact same medication. If you have an AI-based front door to care, it may provide a **prescription price-checking tool** where you can look up, compare, and estimate the out-of-pocket costs before filling a prescription. It's basically like having a deal-finding browser extension, but for your prescription, so be sure to look out for that!

Make sure you know the Life Event rule. If you get married, have a baby, or age out of your parents' plan at 26, you don't have to wait for open enrollment. But you usually only have a strict 30-day window to update your benefits. If you miss it, you are stuck waiting until next year.

Benefits are for more than when you're sick. Take the time to explore your plan before you actually need it. A huge part of your benefits is focused on prevention and keeping you healthy. Plus, you are probably sleeping on specialty care perks your employer likely invests in, like weight health, women's health, or mental health support.

Pro tip: To make sure you're being proactive in utilizing these perks, look out for experiences like Transcarent. These platforms get to know you and your unique needs and can remind you of the preventive screening that is right for you and connect you with appropriate care.



Before you officially hit submit and close the tab, run through this quick checklist to make sure you didn't miss anything crucial!



The "Did I Do This Right?" Checklist

- ✓ **Verified my VIPs:** I used the plan directory to confirm my favorite doctors and specialists are actually in-network.
- ✓ **Checked the price tag on my meds:** I looked up my specific prescriptions to make sure they are covered.
- ✓ **Looked at the total cost:** I didn't just look at the paycheck deduction; I also checked the deductible, expected contribution to HSA/FSA, and out-of-pocket maximum to see the big picture.
- ✓ **Claimed my people:** I double-checked that my dependents (spouse, kids) are officially added to the plan.
- ✓ **Re-upped the accounts that don't roll over:** I remembered to re-elect benefits that require action every year, like an FSA.
- ✓ **Checked the clock:** I confirmed the final deadline to ensure my choices are locked in on time.
- ✓ **Saved my shortcuts:** I bookmarked my HR team's page or benefits portal so I know exactly where to go if I need this information later.
- ✓ **Earned my adulting badge:** I actually hit submit! I took control of my health and benefits for the year, and can officially check this massive to-do off my list.

Your Next Step

Still confused? Don't stress; be sure to check in with your HR team. They work hard all year to curate these benefits to make it easy for you to access the best care. You can always talk to them to better understand your options. If they offer Transcarent, you can open the app and Just Ask Transcarent® your benefits and care questions. Also, keep an eye out for enrollment platforms that your employer might provide. These tools are designed to do the heavy lifting for you, making it incredibly easy to compare plans, choose your benefits, and get back to your life.

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Want to learn even more about taking control of your health?

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