URS
Utah Retirement Systems

Choosing a Healthcare Plan

Understanding the key differences

Many employers offer two main types of health insurance plans: a traditional plan and a high-deductible plan. Each type has advantages and disadvantages, so the best way to make a decision is by examining your unique situation. Depending on circumstances, the plan you choose one year may not make sense for the following year. Check with your employer to determine the specific plans it offers, and when you can make changes to your choice (typically during open enrollment periods).

High-Deductible Plan

- Your employer puts money into an HSA (health savings account) for health-related expenses to offset a higher deductible. An HSA is similar to a flexible spending account (FSA); you contribute pre-tax dollars to pay for eligible health expenses.
- HSA funds carry over from year-to-year and grow tax-free. You never forfeit what you don't spend. You can save for healthcare and retirement expenses.
- This plan often covers the most preventive care services, paid at 100% compared to other plans.
- Certain preventive medications may be covered before you meet your deductible.

Traditional Plan

- You pay a portion of the plan from your paycheck but don't receive HSA contributions from your employer.
- This plan has a lower deductible and gives you predictable costs through fixed co-pays.
- Each family member has their own deductible and out-of-pocket maximum.
- The deductibles do not apply to out-of-pocket maximums.

Key Terminology

Medical deductible » The set dollar amount that you must pay for yourself and/or your family members before insurance begins to pay for covered medical benefits. Some plans might also have a separate pharmacy deductible.

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Plan-year out-of-pocket maximum » The maximum dollar amount that you and/or your family pays each year for covered medical services in the form of copayments and coinsurance and deductibles. Some plans might also have separate out-of-pocket maximums for mental health & substance abuse and for specialty drug charges.

Co-pay » A specific amount you pay directly to a provider when you receive covered services. This can be either a fixed dollar amount or a percentage of the in- or out-of-network rate.

In-network » In-network benefits apply when you receive covered services from in-network providers. You are responsible to pay the applicable copayment.

Out-of-network » If your plan allows the use of out-of-network providers, out-of-network benefits apply when you receive covered services. You are responsible to pay the applicable co-pay, plus the difference between the billed amount and the insurer's in-network rate.

In-network rate » The amount in-network providers have agreed to accept as payment in full. If you use an out-of-network provider, you will be responsible to pay your portion of the costs as well as the difference between what the provider bills and the in-network rate (aka balance billing).