

2023 Washoe County Medical Plan Comparison Sheet

Summary of the group health plans offered through the Health Benefits Program

	Self-Funded PPO Plan	High Deductible PPO Plan	Prominence HMO Plan	Medicare Advantage Plan
Deductibles, Out-of-Pocket Maximums, Participating Hospitals				
Plan Year Deductible (In-Network)	Individual: \$375 Family: \$750	Individual: \$2,600 Family: \$3,000	Not Applicable	Not Applicable
Plan Year Deductible (Out-of-Network)	Individual: \$1,000 Family: \$2,000	Individual: \$4,500 Family: \$5,500	Individual: \$5,000 Family: \$10,000	Not Covered
Health Savings Account (Washoe County Contribution)	Not Applicable	\$2,250 <i>*if enrolled after 1/1/2023, amount will be prorated based on coverage effective date.</i>	Not Applicable	Not Applicable
Plan Year Out of Pocket Max (In-Network)	Individual: \$3,450 Family: \$6,900	Individual: \$5,250 Family: \$6,350	Individual: \$3,500 Family: \$7,000	\$2,500 per year
Plan Year Out of Pocket Max (Out-of-Network)	Individual: \$6,675 Family: \$13,350	Individual: \$10,500 Family: \$10,750	Individual: \$7,000 Family: \$14,000	Not Covered
Co-insurance (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	Not Applicable	Not Covered
Co-insurance (Out-of-Network)	Plan pays: 60% of U&C after deductible Member pays: Remaining Balance	Plan pays: 60% of U&C after deductible Member pays: Remaining Balance	50% after deductible	Not Covered
Participating Hospitals	Renown, Saint Mary's, Northern Nevada, Sierra Medical Center and Carson-Tahoe	Renown, Saint Mary's, Northern Nevada, Sierra Medical Center and Carson-Tahoe	Northern Nevada, Sierra Medical Center, Saint Mary's and Carson-Tahoe	Renown and Carson-Tahoe
Office Visits and Professional Services				
Primary Care Physician (In-Network)	Plan pays: 100% after co-pay Member pays: \$25 co-pay; no deductible	Plan pays: 100% after deductible Member pays: 0% after deductible	\$30 co-pay	\$10 co-pay

Office Visits and Professional Services				
Specialist (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 100% after deductible Member pays: 0% after deductible	\$50 co-pay	\$25 co-pay
Telemedicine (Teladoc)	0% - no deductible	0% after deductible	\$0 co-pay	\$0 co-pay
Preventative Care (In-Network)	0% - no deductible	0% - no deductible	\$0 co-pay	\$0 co-pay
Diagnostic Outpatient Lab (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$0 co-pay	\$0 co-pay
X-Ray (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$30 co-pay	\$20 co-pay
Complex Imaging(MRI,CT,PET) (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$225 co-pay	CT: \$40 co-pay MRI & PET: \$60 co-pay
Physical Therapy (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$30 co-pay	\$10 co-pay
Chiropractic (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible; Limit 25 visits	Plan pays: 80% after deductible Member pays: 20% after deductible; Limit 25 visits	\$50 co-pay; Limit 26 visits	\$10 co-pay
Mental Health & Substance Abuse (Outpatient) (In-Network)	Plan pays: 100% after copay Member pays: \$25 co-pay; no deductible	Plan pays: 100% after deductible Member pays: 0% after deductible	\$30 co-pay	\$25 co-pay
Surgical and Hospital Services				
Inpatient Hospital (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$1,000 co-pay	\$175 per day(s) 1-3
Outpatient Surgery (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$500 co-pay	\$175 co-pay

Surgical and Hospital Services				
Maternity (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$1,000 co-pay	Not Covered
Emergency Room (In-Network)	Plan pays: 80% after deductible Member pays: \$75 co-pay + 20%	Plan pays: 80% after deductible Member Pays: 20% after deductible	\$250 co-pay	\$75 co-pay
Urgent Care (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$40 co-pay	\$10 co-pay
Ambulance (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	Ground: \$100 co-pay Air & Water: \$200 co-pay	\$150 per trip
Substance Abuse (In-Patient) (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member pays: 20% after deductible	\$1,000 co-pay	\$175 per day(s) 1-3
Skilled Nursing Facility (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member Pays: 20% after deductible	\$1,000 co-pay	\$20 a day (1-20) / \$100 day (21-34)
Home Health Care (In-Network)	Plan pays: 80% after deductible Member pays: 20% after deductible	Plan pays: 80% after deductible Member Pays: 20% after deductible	\$30 co-pay	\$0 per visit
Vision Services	See below	See below	See below	\$0 exam / \$250 eyeglasses or contact lenses
Prescription Drugs				
		After Deductible:		
Generic	\$7 co-pay	\$7 co-pay	\$7 co-pay	Preferred Generic: \$2 co-pay Non-Preferred Generic: \$8 co-pay Mail Order: \$0
Preferred Brand	\$30 co-pay	\$30 co-pay	\$30 co-pay (When generic available or \$30 + ancillary charge)	Preferred Brand: \$41 co-pay
Non-preferred Brand	\$50 co-pay	\$50 co-pay 3 months for 2 co-pays	\$50 co-pay (When generic available or \$50 + ancillary charge)	Preferred Brand: \$94 co-pay
Specialty	20%	20%	20%	33%

Prescription Drugs				
Mail Order Benefit	3 months for 2 co-pays Mandatory for Maintenance Drugs	3 months for 2 co-pays Mandatory for Maintenance Drugs	3 months for 2 co-pays	2.5 x 30-day supply at retail (2 x 30-day supply at mail order)
Rx Maximum	Combined with Medical	Combined with Medical	Combined with Medical	Combined with Medical
All Enrollees are covered by the following				
Dental Services	Self-funded Dental Plan \$50 Calendar year deductible on Basic, Major and Orthodontic services Preventative - 100%, Basic - 80%, Major - 50%, Orthodontia - 50% \$3,000 maximum benefit per calendar year \$1,500 lifetime maximum on Orthodontia			
Vision Services	Vision Service Plan (VSP); Eye Med for Senior Care Plus Members \$10 co-pay for annual exam Basic lenses or contacts every 12 months \$175 allowance for frames every 24 months			
Life Insurance	Enrollee: \$20,000 when under 65; \$13,000 when age 65-69; \$7,000 when age 70 and over. Covered Dependents: \$1,000			