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	$5,000 deductible	Not Covered
Health Savings Account (**Washoe County Contribution)**	Not Applicable	$2,250 **If enrolled after 1/1/2023, amount will be prorated based on coverage effective date.*	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
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

Surgical and Hospital Services				
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
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%
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			