

2024 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	Surest Plan	Medicare Advantage Plan
Deductibles, Out-of-Pocket Maximums, Participating Hospitals				
Plan Year Deductible (In-Network)	Individual: \$375 Family: \$750	Individual: \$2,600 Family: \$3,200	Not Applicable	Not Applicable
Plan Year Deductible (Out-of-Network)	Individual: \$1,000 Family: \$2,000	Individual: \$4,500 Family: \$5,500	None None	Not Covered
Health Reimbursement Account (Washoe County Contribution)	Not Applicable	Retiree Only: \$2,250 <i>*If enrolled after 1/1/2024, 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: \$4,000 Family: \$8,000	\$2,500 per year
Plan Year Out of Pocket Max (Out-of-Network) *Provider may balance bill above out of pocket maximum	Individual: \$6,675* Family: \$13,350*	Individual: \$10,500* Family: \$10,750*	Individual: \$8,000 Family: \$16,000	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	Not Applicable	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	Renown, Saint Mary's, Northern Nevada, Sierra Medical Center 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	\$10 - \$65 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	\$10 - \$65 co-pay	\$25 co-pay
Telemedicine (Teladoc*)	*\$0 - no deductible	* \$49 before meeting 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	\$0 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	\$75 - \$500 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	\$10 - \$50 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 Limit 25 visits Member pays: 20% after deductible Limit 25 visits	\$15 co-pay Limit 60 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	\$10 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	\$150-\$2,500 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	\$20 - \$2,500 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	\$625 - \$1,375 co-pay	Not Covered
Emergency Room (In-Network)	Plan pays: 80% after deductible Member pays: \$75 co-pay + 20% after deductible	Plan pays: 80% after deductible Member Pays: 20% after deductible	\$325 co-pay	\$125 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	\$30 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	\$160 co-pay	\$225 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	\$1,600 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	\$1,200 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				
	Deductible Does Not Apply	After Deductible	Deductible Not Applicable	
	Generic: \$7 co-pay	Generic: \$7 co-pay	Tier 1: \$15 co-pay	Preferred generic: \$2 co-pay Non-preferred generic: \$8 co-pay Mail Order: \$0
	Preferred brand: \$30 co-pay	Preferred brand: \$30 co-pay	Tier 2: \$40 co-pay	Preferred brand: \$41 co-pay
	Non-preferred brand: \$50 co-pay	Non-preferred brand: \$50 co-pay 3 months for 2 co-pays	Tier 3: \$60 co-pay	Non-preferred brand: \$94 co-pay
Specialty	ShaRx Advocacy Program	ShaRx Advocacy Program	\$170 - \$230	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 2.5 co-pays	2.5 x 30-day supply at retail x 30-day supply at mail order) (2)
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%, Orthodontic - 50% \$3,000 maximum benefit per calendar year \$1,500 lifetime maximum on Orthodontic			
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			