

2021 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	HMO Plan
Deductibles, Out-of-Pocket Maximums, Participating Hospitals			
Plan Year Deductible	\$375 individual \$750 family	\$2,600 individual \$2,950 family	N/A
Health Savings Account - Washoe County Contribution	Not Applicable	\$2,000 if enrolled on 1/1/2021, prorated thereafter based on coverage effective date	Not Applicable
Plan Year Out of Pocket Maximum	\$3,450 individual \$6,900 family	\$5,250 individual \$6,350 family	\$3,500 individual \$7,000 family
Co-insurance	80% (plan pays) 20% (member pays)	80% (plan pays) 20% (member pays)	None
Participating Hospitals:	Renown, Saint Mary's and Carson-Tahoe	Renown, Saint Mary's and Carson-Tahoe	Saint Mary's, Northern Nevada, and Carson- Tahoe
Office Visits and Professional Services			
Primary Care Physician	\$25 co-pay (PPO) 20% (non-PPO)	0% after deductible	\$30 co-pay
Specialist	20% after deductible	0% after deductible	\$50 co-pay
Telemedicine (Teledoc)	0% no deductible	0% after deductible	\$0 co-pay
Preventative Care	0% no deductible	0% no deductible	\$0 co-pay
Diagnostic Outpatient Lab	20% after deductible \$5 co-pay (in office)	20% no deductible	\$0 co-pay
Outpatient X-Ray	20% after deductible \$10 co-pay (in office)	20% after deductible	\$30 co-pay
Complex Imaging (MRI, CT, PET)	20% after deductible	20% after deductible	\$225 co-pay
Physical Therapy	20% after deductible	20% after deductible	\$30 co-pay
Chiropractic	20% after deductible; Limit 25 visits	20% after deductible; Limit 25 visits	\$50 co-pay; Limit 20 visits
Mental Health and Substance Abuse (Outpatient)	\$25 co-pay (PPO); 20% of U&C (non-PPO)	0% after deductible	\$30 co-pay

Self-funded PPO Plan		High Deductible PPO Plan	HMO Plan
Surgical and Hospital Services			
Inpatient Hospital	20% after deductible (PPO); 80% of U&C(non-PPO) + \$500	20% after deductible (PPO); 80% of U&C (non-PPO) + \$500	\$1,000 co-pay
Outpatient Surgery	20% after deductible	20% after deductible	\$500 co-pay
Maternity	20% after deductible	20% after deductible	\$1,000 co-pay
Emergency Room	20% + \$75 co-pay	20% after deductible	\$250 co-pay
Urgent Care	20% after deductible	20% after deductible	\$40 co-pay
Ambulance	20% after deductible	20% after deductible	\$100 co-pay for ground ; \$200 co-pay for air & water
Substance Abuse (In-Patient)	20% after deductible	20% after deductible	\$1,000 co-pay
Skilled Nursing Facility	20% after deductible	20% after deductible	\$1,000 co-pay
Home Health Care	20% after deductible	20% after deductible	\$30 co-pay
Vision Services	See below	See below	See below
Prescription Drugs			
		After deductible:	
Generic	\$7 co-pay	\$7 co-pay	\$7 co-pay
Preferred Brand	\$30 co-pay	\$30 co-pay	\$30 co-pay (When generic available or \$30 + ancillary charge)
Non-preferred Brand	\$50 co-pay	\$50 co-pay	\$50 co-pay (When generic available or \$50 + ancillary charge)
Specialty	20%	20%	20%
Mail Order Benefit (Mandatory for Maintenance Drugs)	3 months for 2 co-pays	3 months for 2 co-pays	3 months for 2 co-pays
Rx Maximum	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 on regular dentistry		
Vision Services	\$1,500 lifetime maximum on Orthodontia Vision Service Plan (VSP) \$10 co-pay for annual exam Basic lenses or contacts every 12 months \$150 allowance for frames every 24 months		
Life Insurance	Enrollee - \$20,000 when under 65; \$13,000 when over. Covered dependents - \$1,000	age 65-69; \$7,000 when age 70 and	