

Clark County Board of Commissioners



2008 Healthcare Plans Comparison Chart Medical & Dental Options

This Summary of Benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This plan may not cover all your healthcare expenses. Please refer to your certificate of Coverage or Summary Plan description for a complete listing of services, limitations, and exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the insurance policies (medical/drug) issued to the enrolling group or summary plan description (dental), the policy or summary plan description prevails.

CEBCO/Anthem	High Plan (Option C)		Low Plan (Option A)	
	Network	Non-Network	Network	Non-Network
Covered Benefits				
Deductible (Single/Family)	None	\$300 / \$600	\$250 / \$500	\$500 / \$1,000
Out-of-Pocket Limit (Single/Family) Includes Deductible	\$500 / \$1,000	\$1,300 / \$2,600	\$1,250 / \$2,500	\$2,500 / \$5,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) Including office surgeries and allergy serum:	\$10 / \$10	20%	\$10 / \$10	40%
o Allergy injections (PCP and SCP)	\$5	20%	\$5	40%
o Allergy testing	No Copayment/coinsurance	20%	20%	40%
o Routine and non-routine mammograms (regardless of outpatient setting)	No Copayment/coinsurance	20%	No Copayment/coinsurance	40%
o Diabetic education (regardless of outpatient setting)	No Copayment/coinsurance	20%	No Copayment/coinsurance	40%
o Certain medical nutritional therapy (regardless of outpatient setting)	No Copayment/coinsurance	Not Covered	No Copayment/coinsurance	Not Covered
o MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies and non-maternity related ultrasounds	No Copayment/coinsurance	20%	20%	40%
Preventive Care Services Services include but are not limited to: Routine exams, pelvic exams, pap testing, PSA tests, immunizations, annual diabetic eye exam, routine vision and hearing exams				
o Physician home and office visits (PCP/SCP)	No Copayment/coinsurance	20%	No Copayment/coinsurance	40%
o Other Outpatient Services @ Hospital/Alternative Care Facility	No Copayment/coinsurance	20%	No Copayment/coinsurance	40%
Emergency and Urgent Care				
o Emergency Room Services @ Hospital (facility/other covered services) (copayment waived if admitted)	\$100	\$100	\$100	\$100
o Urgent Care Center Services	\$35	\$35	\$35	\$35
Inpatient and Outpatient Professional Services Include but are not limited to:	No copayment/coinsurance	20%	20%	40%
o Medical care visits (1 per day), intensive medical care, concurrent care, consultations, surgery and administration of general anesthesia and newborn exams				
Inpatient Facility Services Unlimited days except for:	No copayment/coinsurance	20%	20%	40%
o 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis)				
o 90 days Network/Non-Network combined for skilled nursing facility				
Outpatient Surgery Hospital/Alternative Care Facility	No copayment/coinsurance	20%	20%	40%
o Surgery and administration of general anesthesia				
Other Outpatient Services (including but not limited to):				
o Non surgical Outpatient Services for example: MRIs, C-Scans, Chemotherapy, Ultrasounds, and other diagnostic outpatient services.	No copayment/coinsurance	20%	20%	40%
o Home care services (Network/Non-network combined) 90 visits (excludes IV Therapy)	No copayment/coinsurance	20%	20%	40%
o Durable medical equipment and orthotics (Network/Non-network combined) \$10,000 benefit maximum (excluding Prosthetic Devices and Medical Supplies)	No copayment/coinsurance	20%	20%	40%
o Prosthetic devices \$10,000 benefit maximum	No copayment/coinsurance	20%	20%	40%
o Physical medicine therapy day rehabilitation programs	No copayment/coinsurance	20%	20%	40%
o Hospice care	No copayment/coinsurance	20%	20%	40%
o Ambulance services	No copayment/coinsurance	No copayment /coinsurance	20%	20%
Outpatient Therapy Services (Combined Network & Non-Network limits apply)				
o Physician home and office visits (PCP/SCP)	\$10 / \$10	20%	\$10 / \$10	40%
o Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	20%	20%	40%
Limits apply to:				
o Physical therapy: 30 visits				
o Occupational therapy: 30 visits				
o Manipulation therapy: 24 visits				
o Speech therapy: 20 visits				
Behavioral Health Services: Non Biologically Based Mental Illness and Substance Abuse (limits and maximums apply)				
o Inpatient facility services	No copayment/coinsurance	20%	20%	40%
o Physician home and office visits (PCP/SCP)	\$10 / \$10	20%	\$10 / \$10	40%
o Other Outpatient Services @ Hospital/Alternative Care Facility	No copayment/coinsurance	20%	20%	40%
Inpatient: 30 Network days (includes inpatient mental health Non-Network)				
Outpatient: 50 Network visits				
10 Non-Network mental health visits				
Combined Inpatient and Outpatient substance abuse \$550 Non-Network (Substance abuse rehabilitation programs are limited to two per lifetime Network and Non-Network combined.)				
Biologically based mental illnesses are paid the same as any other illness.				
Human Organ and Tissue Transplants				
o Acquisition and transplant procedures, harvest and storage	No copayment/coinsurance	50%	No copayment/coinsurance	50%
Lifetime Maximum	\$5 Million	\$5 Million	\$5 Million	\$5 Million
Employee cost per biweekly pay period (24 pay periods)	EMPLOYEE ONLY \$6.77 EMPLOYEE + 1 \$14.35 FAMILY \$21.33		EMPLOYEE SHARE - \$0	

CEBCO/Caremark Prescription Drug Benefits		
Type of Prescription	Days Supply Limit	Copayment
Retail Program:		
Generic Drugs	30-day Supply per Rx	\$10 per Rx
Preferred Brand Drugs	30-day Supply per Rx	\$20 per Rx
Non-Preferred Brand Drugs And Others	30-day Supply per Rx	\$30 per Rx
Mail Order Program:		
Generic Drugs	90-day Supply per Rx	\$20 per Rx
Preferred Brand Drugs	90-day Supply per Rx	\$40 per Rx
Non-Preferred Brand Drugs And Others	90-day Supply per Rx	\$60 per Rx

*Some drug types may have supply limitations that differ from the standard 30 or 90 day supply noted here.
Diabetic supplies provided at \$0 copay.

Clark County Board of Commissioners

Dental Plan Summary 2008

Administered by MCA or Superior Dental Care

Customer Service Inquiries 1-800-229-6786 for MCA or 1-800-762-3159 for Superior

(When choosing Superior your dentist must be a participant in this Plan. No out-of-network option exists)

You may also visit their websites at www.superiordental.com for superior participants or www.dentemax.com for MCA participants

Class I Services 100% of UCR No Deductible Applies	Class II Services 80% of UCR Deductible Applies	Class III Services 50% of UCR Deductible Applies	Class IV Services 50% of UCR No Deductible Applies
Service Includes: 2 Cleanings per Calendar Year 2 Routine Exams per Calendar Year 2 Scalings (prophylaxis) per Calendar Year 2 Applications of fluoride per Calendar Year 1 Full-mouth x-ray every 3 years 2 Bitewing x-rays per Calendar Year Periapical x-rays as needed Emergency treatment for temporary relief of severe pain Tooth sealants for children 15 and under 2 periodontal cleanings and exams per calendar year	Service Includes: Oral Surgery Fillings to restore diseased or accidentally broken teeth Endodontics (root canal treatment, pulp capping) Apicoectomy Oral lesions (wounds or sores in mouth) Repair of crowns, inlays, onlays, bridgework and dentures Denture adjusting (at least 6 months after their installation. Payable once every 36 months) Periodontal treatments (gingivectomy, gingivoplasty, osseous surgery) Anesthesia for any of the above listed Class II Services	Services Include: Initial Installation of Bridges Initial Installation of Dentures (partial or full) Inlays, onlays, crown restorations (if regular fillings would not restore the plan members teeth) Anesthesia for any of the above listed Class III Services	Service Include: Covered dental charges are the charges made by a dentist for services and supplies in connection with orthodontic treatment, other than for extractions and space maintainers, to correct mal-positioned teeth, provided: Existence of extreme bucco-lingual version of the teeth (unilateral or bilateral) Protrusion of the maxillary teeth of 4mm. Protrusion or retrusive relation of the maxillary or mandibular arch of at least one cusp. An arch length discrepancy of 4 mm. The first active appliance was inserted while the plan member was covered under this plan.

Plan costs per bi-weekly pay period (24 pay periods)

MCA Single: \$10.28 Family: \$35.08 Deductible: \$50 for employee and \$50 for 1 other family member, per family, per year.	Superior Single: \$2.62 Family: \$17.81 Deductible: \$50 for any three family members, for a maximum of \$150 per family, per year.	The deductible only applies to Class II and Class III. There is no deductible for Class I and Class IV Lifetime orthodontic maximums per member is \$750.00.
---	---	---