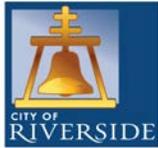


City of Arts & Innovation

**City of Riverside
2015 Kaiser Options
Kaiser HMO 15 and HMO 30 Options**

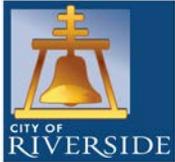
Benefits	KAISER HMO 15 \$15, 100% HMO PROVIDER	KAISER HMO 30 \$30, 250 Adm HMO PROVIDER
Annual Deductible (Individual / Family) * Deductible Applies	None	None
Out-of-Pocket Maximum Individual / Family	\$1,500 / \$3,000	\$1,500 / \$3,000
Physician Services		
Office Visits	\$15	\$30
Preventative Services (schedule applies)	No Charge	No Charge
Outpatient Services		
General Lab, X-Ray	No Charge	No Charge
Complex Radiology & Imaging	No Charge	No Charge
Emergency Services		
Urgent Care	\$15	\$30
Emergency Room (True Emergency)	\$50 (Wvd if admitted)	\$100 (Wvd if admitted)
Ambulance (True Emergency)	\$50	\$50
Hospital Services (Prior Authorization)		
Inpatient, Semi-Private Room	No Charge	\$250 Per Admission
Outpatient Surgery	\$15 per procedure	\$30
Prescription Drugs		
Generic / Brand / Non-Formulary / Injectables	\$10 / \$20 (30 Days)	\$10 / \$20 (30 Days)
Miscellaneous		
Chiropractic	\$5 / Visit (30 Visits Per Year)	Not Covered
Hearing Aid Allowance	\$1,000 Allowance, 1 Device/Ear, 2 Devices per 36 Months	\$1,000 Allowance, 1 Device/Ear, 2 Devices per 36 Months
Durable Medical Equipment	No Charge (formulary guidelines apply)	20% (formulary guidelines apply)



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**City of Riverside
2015 Anthem Blue Cross HMO Options
Anthem BC HMO 15 and HMO 20 Options**

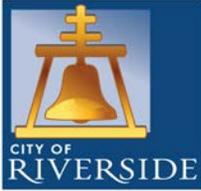
Benefits	ANTHEM BLUE CROSS HMO 15 (Premier) 15/100% w/Chiro 10/30 HMO PROVIDER	ANTHEM BLUE CROSS HMO 20 (Value) 20/40/250/3 Day HMO PROVIDER
Annual Deductible (Individual / Family) * Deductible Applies	None	None
Out-of-Pocket Maximum Individual / Family	\$1,500 / \$3,000	\$3,000 / \$6,000
Physician Services Office Visits Preventative Services (schedule applies)	\$15 No Charge	\$20 PCP / \$40 Specialist No Charge
Outpatient Services General Lab, X-Ray Complex Radiology & Imaging	No Charge No Charge	No Charge \$100/Test
Emergency Services Urgent Care Emergency Room (True Emergency) Ambulance (True Emergency)	Contracted PMG UC Facility: \$15 \$50 (Waived If Admitted) No Charge	Contracted PMG UC Facility: \$20 \$150 (Waived If Admitted) \$100/Trip
Hospital Services (Prior Authorization) Inpatient, Semi-Private Room Outpatient-Surgery	No Charge No Charge	\$250/Day - 3 Day Copay Max/Adm \$125/Adm
Prescription Drugs Generic / Brand / Non-Formulary / Injectables or Tier 1 / Tier 2 / Tier 3 / Tier 4	Participating Pharmacies \$10 / \$25 / \$40 / 20% \$100/Member (3 max) Rx Brand-NF Ded.	Participating Pharmacies \$10 / \$25 / \$40 / 20% \$100/Member (3 max) Rx Brand-NF Ded.
Miscellaneous		
Chiropractic	\$10/Visit (30 Visits Per Year)	Not Covered
Hearing Aid Allowance	No Charge, 1 hearing aid per every three years as part of the DME benefit	50%, 1 hearing aid per every three years as part of the DME benefit
Durable Medical Equipment	No Charge	50%



City of Arts & Innovation

City of Riverside 2015 Anthem Blue Cross PPO Option

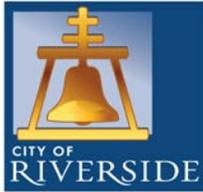
Benefits	ANTHEM BLUE CROSS Premier PPO 250/15/20	
	Network Provider	Out of Network Provider
Annual Deductible (Individual / Family) * Deductible Applies	\$250 / \$750	\$750 / \$2,250
Out-of-Pocket Maximum Individual / Family	\$3,500 / \$7,000	\$7,000 / \$14,000
Physician Services Office Visits	\$15	40% *
Preventative Services (schedule applies)	No Charge	40% *
Outpatient Services General Lab, X-Ray	20% *	40% *
Complex Radiology & Imaging	20% *	40% * (benefit limited to \$800/procedure)
Emergency Services Urgent Care	\$15	40% *
Emergency Room (True Emergency) Ambulance (True Emergency)	\$100 (wvd if admitted) +20% 20% *	\$100 (wvd if admitted) +20% * 20% *
Hospital Services (Prior Authorization) Inpatient, Semi-Private Room	20% *	\$500 Per Adm +40% * (benefit limited to \$1,000/day for non-ER adm)
Outpatient-Surgery	20% *	40% * , (benefit limited to \$350/adm)
Prescription Drugs Generic / Brand / Non-Formulary / Injectables or Tier 1 / Tier 2 / Tier 3 / Tier 4	Participating Pharmacies Rx \$10/\$30/\$45/20% (30 Days)	
Miscellaneous		
Chiropractic	\$15, 30 Cmb visits/year	40% * , 30 Cmb visits/year
Hearing Aid Allowance	Rider: 20% medically necessary as ordered by an otolaryngologist or a state-certified audiologist.	
Durable Medical Equipment	20% *	40% *



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**City of Riverside
VSP Vision
Enrollment with all Medical Plans Only**

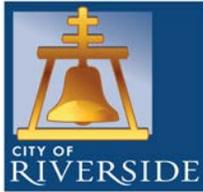
BENEFITS	VISION SERVICE PLAN	
	Self-Funded Plan	
	Participating Provider	Non-Participating Provider
DEDUCTIBLE Individual/Family	None	None
EXAM Frequency	\$10 Copayment 12 Months	Up to \$45 Reimbursement 12 Months
LENSES Frequency	Single, Bi-Focal, Tri-Focal: \$25 12 Months	Single: \$45, Bi-Focal: \$65 Tri-Focal: \$85 12 Months
FRAMES Frequency	\$120 Allowance, 20% off amount over your allowance 24 Months	\$47 Reimbursement 24 Months
CONTACT LENSES (In Lieu of Lenses/Frames)	12 Months	12 Months
Elective Contact Lenses	\$120 Allowance	\$105 Reimbursement
Necessary Contact Lenses	No Charge w/Authorization	\$210 Reimbursement



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City of Riverside Delta Dental DHMO Plan

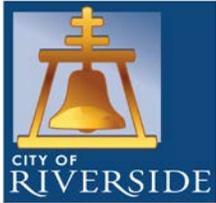
	DELTA CARE
	Panel Dentist
PREVENTIVE	
D0150 Office Examination	No Charge
D0210 Complete Series X-Rays (Schedule Limits May Apply)	No Charge
D1110 Prophylaxis (Schedule Limits May Apply)	No Charge
FILLINGS	
D2140 Amalgam One Surface	No Charge
D2150 Amalgam Two Surfaces	No Charge
D2160 Amalgam Three Surfaces	No Charge
D2330 Resin One Surface - Anterior	No Charge
D2331 Resin Two Surfaces - Anterior	No Charge
D2335 Resin Three Surfaces - Anterior	No Charge
ROOT CANAL THERAPY	
D3310 Anterior (Excluding Final Restoration)	\$45
D3320 Bicuspid (Excluding Final Restoration)	\$90
D3330 Molar (Excluding Final Restoration)	\$135
PERIODONTICS	
D4210 Gingivectomy per Quadrant	\$125
D4341 Perio Scaling & Root Planing Per Quadrant (Schedule Limits May Apply)	\$15
PROSTHODONTICS	
D5110 Complete Denture (Schedule Limits May Apply)	\$110
D5120 Complete Denture (Schedule Limits May Apply)	\$110
D5130 Immediate Denture (Schedule Limits May Apply)	\$125
D5140 Immediate Denture (Schedule Limits May Apply)	\$125
CROWNS	
D6750 Posterior Porcelain fused to Precious Metal Crown	\$90 - \$240
D6790 Posterior Full Cast Precious Metal Crown	\$90 - \$240
ORAL SURGERY	
D7240 Impacted Tooth - Completely Bony	\$80
D9241 IV Sedation - 1st 30 minutes	Not Covered
ORTHODONTIA	
Start-Up Fee	\$350
D8080 Children - 2 Year Full Banding	\$1,600
D8090 Adults - 2 Year Full Banding	\$1,800
D8680 Orthodontic Retention	No Charge



City of Arts & Innovation

City of Riverside Delta Dental DPO

	DELTA DENTAL	
	PPO Provider	Any Provider
DEDUCTIBLE		
Individual / Family	None	\$25 / \$75
ANNUAL DENTAL BENEFIT MAXIMUM PER PERSON	\$2,000	
PREVENTIVE		Deductible Applies
D0150 Office Examination	100%	100%
D1110 Prophylaxis	100%	100%
D0210 Complete Series X-rays	100%	100%
FILLINGS		
D2140 Amalgam One Surface	90%	80%
D2150 Amalgam Two Surfaces	90%	80%
D2160 Amalgam Three Surfaces	90%	80%
D2330 Resin One Surface - Anterior	90%	80%
D2331 Resin Two Surfaces - Anterior	90%	80%
D2335 Resin Three Surfaces - Anterior	90%	80%
ROOT CANAL THERAPY		
D3310 Anterior (Excluding Final Restoration)	90%	80%
D3320 Bicuspid (Excluding Final Restoration)	90%	80%
D3330 Molar (Excluding Final Restoration)	90%	80%
PERIODONTICS		
D4341 Perio Scaling & Root Planing Per Quadrant	90%	80%
D4210 Gingivectomy per Quadrant	90%	80%
PROSTHODONTICS		
D5130 Immediate Denture	60%	50%
D5110 Complete Denture	60%	50%
CROWNS		
D6750 Posterior Porcelain fused to Precious Metal Crown	60%	50%
D6790 Posterior Full Cast Precious Metal Crown	60%	50%
ORAL SURGERY		
D7240 Impacted Tooth - Completely Bony	90%	80%
D9241 IV Sedation - 1st 30 minutes	90%	80%
ORTHODONTIA	\$2,000 Lifetime Maximum	
Start-Up Fee	50%	50%
D8680 Orthodontic Retention	50%	50%
D8080 Children - 2 Year Full Banding	50%	50%
D8090 Adults - 2 Year Full Banding	50%	50%



City of Arts & Innovation

City of Riverside Local Advantage Self Funded Plan

	LOCAL ADVANTAGE
	Panel Dentist
DEDUCTIBLE	
Individual / Family	None
ANNUAL DENTAL BENEFIT MAXIMUM PER PERSON	\$2,000
PREVENTIVE	
D0150 Office Examination	No Charge
D1110 Prophylaxis	No Charge
D0210 Complete Series X-rays	No Charge
FILLINGS	
D2140 Amalgam One Surface	90%
D2150 Amalgam Two Surfaces	90%
D2160 Amalgam Three Surfaces	90%
D2330 Resin One Surface - Anterior	90%
D2331 Resin Two Surfaces - Anterior	90%
D2335 Resin Three Surfaces - Anterior	90%
ROOT CANAL THERAPY	
D3310 Anterior (Excluding Final Restoration)	90%
D3320 Bicuspid (Excluding Final Restoration)	90%
D3330 Molar (Excluding Final Restoration)	90%
PERIODONTICS	
D4341 Perio Scaling & Root Planing Per Quadrant	90%
D4210 Gingivectomy per Quadrant	90%
PROSTHODONTICS	
D5130 Immediate Denture	65%
D5110 Complete Denture	65%
CROWNS	
D6750 Posterior Porcelain fused to Precious Metal Crown	65%
D6790 Posterior Full Cast Precious Metal Crown	65%
ORAL SURGERY	
D7240 Impacted Tooth - Completely Bony	90%
D9241 IV Sedation - 1st 30 minutes	Not Covered
ORTHODONTIA	
Start-Up Fee	\$220
D8680 Orthodontic Retention	\$1,250 Discount of UCR off total Ortho fee
D8080 Children - 2 Year Full Banding	\$1,250 Discount of UCR off total Ortho fee
D8090 Adults - 2 Year Full Banding	\$1,250 Discount of UCR off total Ortho fee