



City of Riverside 2016 Kaiser Options Kaiser HMO 15 and HMO 30 Options

Benefits	KAISER HMO \$15, 100% HMO PROVIDER	KAISER HMO \$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 per procedure
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 2016 Anthem Blue Cross HMO Options Anthem BC HMO 15 and HMO 20/40 Options

Benefits	ANTHEM BLUE CROSS HMO 15 (Custom Premier) 15/100% w/Chiro 10/30 HMO Provider	ANTHEM BLUE CROSS HMO 20 (Value Copay) 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	\$15	\$20 PCP / \$40 Spc
Preventative Services (schedule applies)	No Charge	No Charge
Outpatient Services		
General Lab, X-Ray	No Charge	No Charge
Complex Radiology & Imaging	\$100/Test	\$100/Test
Emergency Services		
Urgent Care	Contracted PMG UC Facility: \$15	Contracted PMG UC Facility: \$20
Emergency Room (True Emergency)	\$100 (Waived If Admitted)	\$150 (Waived If Admitted)
Ambulance (True Emergency)	No Charge	\$100/Trip
Hospital Services (Prior Authorization)		
Inpatient, Semi-Private Room	No Charge	\$250/Day - 3 Day Copay Max/Adm
Outpatient-Surgery	No Charge	\$125/Adm
Prescription Drugs		
Generic / Brand / Non-Formulary / Injectables or Tier 1 / Tier 2 / Tier 3 / Tier 4	Participating Pharmacies \$15 / \$30 / \$50 / 30% \$150/Member (3 max) Rx Brand-NF Ded.	Participating Pharmacies \$15 / \$30 / \$50 / 30% \$150/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%



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City of Riverside 2016 Anthem Blue Cross PPO Option

Benefits	ANTHEM BLUE CROSS Premier PPO 500/20/20	
	Network Provider	Out of Network Provider
Annual Deductible (Individual / Family) * Deductible Applies	\$500 / \$1,500	\$1,500 / \$3,000
Out-of-Pocket Maximum		
Individual / Family	\$3,500 / \$7,000	\$10,500 / \$21,000
Physician Services		
Office Visits	\$20	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	\$20	40% *
Emergency Room (True Emergency)	\$100 (wvd if admitted) +20%	\$100 (wvd if admitted) +20%
Ambulance (True Emergency)	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	Participating Pharmacies	
Generic / Brand / Non-Formulary / Injectables or Tier 1 / Tier 2 / Tier 3 / Tier 4	\$15 / \$30 / \$50 / 30%	
Miscellaneous		
Chiropractic	\$20, 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 2016 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



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City of Riverside 2016 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%



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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 (Schedule Limits May Apply)	No Charge
D0210 Complete Series X-Rays (Schedule Limits May Apply)	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 (Scheduled Limits & Allowances Ap	65%
D5110 Complete Denture (Scheduled Limits & Allowances Ap	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