

City of Riverside
2017 Medical/Vision and Dental Renewal Selections

	KAISER HMO 15	KAISER HMO 30
Benefits	\$15, 100%	\$30, 250 Adm
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) / 20% Specialty Rx	\$10 / \$20 (30 Days) / 20% Specialty Rx
Miscellaneous		
Chiropractic	\$5 / Visit (30 Visits Per Year) \$1,000 Allowance,	Not Covered \$1,000 Allowance,
Hearing Aid Allowance	1 Device/Ear, 2 Devices per 36 Months	1 Device/Ear, 2 Devices per 36 Months
Durable Medical Equipment	No Charge (formulary guidelines apply)	20% (formulary guidelines apply)

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	ANTHEM BLUE CROSS <i>HMO 15</i> <i>15/100% w/Chiro 10/30</i> HMO Provider	ANTHEM BLUE CROSS <i>HMO 20/40</i> <i>20/40/250/3 Day</i> HMO PROVIDER
Benefits		
Annual Deductible (Individual / Family) * Deductible Applies	None	None
Out-of-Pocket Maximum Individual / Family	\$1,500 / \$3,000	\$2,500 / \$5,000
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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Benefits	ANTHEM BLUE CROSS	
	Classic PPO 500/20/20	
	Network Provider	Out of Network Provider
Annual Deductible (Individual / Family) * Deductible Applies	\$500 / \$1,500	\$500 / \$1,500
Out-of-Pocket Maximum Individual / Family	\$3,500 / \$7,000	\$7,000 / \$14,000
Physician Services		
Office Visits	\$20	40% *
Preventative Services (schedule applies)	No Charge	40% *
Outpatient Services		
General Lab, X-Ray	20% *	40% * (limited to \$350 max/visit)
Complex Radiology & Imaging	20% *	40% * (benefit limited to \$800/procedure)
Emergency Services		
Urgent Care	\$20	40% *
Emergency Room (True Emergency)	\$150 (wvd if admitted) +20%	\$150 (wvd if admitted) +20%
Ambulance (True Emergency)	20% *	20% *
Hospital Services (Prior Authorization)		\$500 Per Adm if PAR not obtained
Inpatient, Semi-Private Room	20% *	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 / \$40 / \$60 / 30% \$150/Member-\$450/Family Rx Brand-NF Ded.	
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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BENEFITS	VISION SERVICE PLAN - Included with all Medical Plans	
	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) Elective Contact Lenses Necessary Contact Lenses	12 Months \$120 Allowance No Charge w/Authorization	12 Months \$105 Reimbursement \$210 Reimbursement

**City of Riverside
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		DELTA CARE - HMO
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	Gingevectomy per Quadrant	\$125
D4341	Perio Scaling & Root Planing Per	\$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 Riverside
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		DELTA DENTAL - PPO	
		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 Riverside
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		LOCAL ADVANTAGE DENTAL PLAN
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 Apply)	65%
D5110	Complete Denture (Scheduled Limits & Allowances Apply)	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