

**City of Riverside
2019 Renewal Medical Illustration**

	KAISER HMO	KAISER HMO
Benefits	\$15, 100% HMO PROVIDER	\$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 / Specialty/Injectables	\$10 / \$20 (30 Days) / 20% Specialty Rx	\$10 / \$20 (30 Days) / 20% Specialty Rx
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)

**City of Riverside
2019 Renewal Medical Illustration**

Benefits	BLUE SHIELD <i>Custom Access + HMO 15</i> <i>Zero Admit</i> HMO PROVIDER	BLUE SHIELD <i>Custom Access + HMO 20</i> <i>Per Day</i> HMO PROVIDER	BLUE SHIELD <i>Custom Full PPO Split Deductible</i> <i>20 - 500 - 80/60</i> Network Provider Out of Network Provider	
	Full	Full		
Network	Full	Full		
Annual Deductible (Individual / Family) * Deductible Applies	None	None	\$500 / \$1,500	\$500 / \$1,500
Out-of-Pocket Maximum Individual / Family	\$1,500 / \$3,000	\$2,500 / \$5,000	\$3,500 / \$7,000	\$7,000 / \$14,000
Physician Services				
Office Visits	\$15 / \$35 Spc (self-referred)	\$20 PCP / \$40 Spc (self-referred)	\$20	40% *
Preventative Services (schedule applies)	No Charge	No Charge	No Charge	40% *
Outpatient Services				
General Lab, X-Ray	No Charge	No Charge	\$20 *	40% * (limited to \$350 max/visit)
Complex Radiology & Imaging	No Charge	No Charge	\$20 *	40% * (limited to \$350 max/visit)
Emergency Services				
Urgent Care	Inside your PCP service area: \$15	Inside your PCP service area: \$20	\$20	40% *
Emergency Room (True Emergency)	\$100 (waived if admitted)	\$150 (waived if admitted)	\$150 + 20%	\$150 + 20%
Ambulance (True Emergency)	No Charge	\$100/Trip	20% *	20% *
Hospital Services (Prior Authorization)			<i>Blue Shield requires prior authorization for all inpatient stays, both in-network and out-of-network.</i>	
Inpatient, Semi-Private Room	No Charge	\$250/Day - 3 Day Copay Max/Adm	20% *	40% * up to \$600 max/day
Outpatient-Surgery	No Charge	\$125 per surgery	20% *	40% * (limited to \$350 max/visit)
Prescription Drugs	Participating Pharmacies	Participating Pharmacies	Participating Pharmacies	
Generic / Brand / Non-Formulary / Specialty/Injectables or Tier 1 / Tier 2 / Tier 3 / Tier 4-Tier 5	\$15 / \$30 / \$50 / 30% up to \$250 Max/Rx \$150/Member -\$450/Family Rx Brand-NF Ded. Per CY	\$15 / \$30 / \$50 / 30% up to \$250 Max/Rx \$150/Member -\$450/Family Rx Brand-NF Ded. Per CY	\$15 / \$40 / \$60 / 30% up to \$200 Max/Rx \$150/Member-\$450/Family Max Rx Brand-NF Ded. Per CY	
Miscellaneous				
Chiropractic	Chiro: \$10 / Acupuncture: \$10 (60 Combined visits per member per CY)	Chiro: \$10 / Acupuncture: \$10 (60 Combined visits per member per CY)	Chiro: \$20 *, 30 Cmb visits/CY Acupuncture: \$20 *, 30 Cmb visits/CY	Chiro: 40% *, 30 Cmb visits/CY Acupuncture: 40% *, 30 Cmb visits/CY
Hearing Aid Allowance	\$4,000 allowance every 36 months	\$4,000 allowance every 36 months	20%, \$5,000 allowance every 24 months	
Durable Medical Equipment	No Charge	50%	20% *	40% *

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**City of Riverside
DeltaCare DHMO Dental**

		DELTA CARE <i>Plan CAA22</i> 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
CROWNS		
D2750	Porcelain fused to High noble	\$90
D2751	Porcelain fused to predominately Base metal	\$90
D2752	Porcelain fused to Nobel metal	\$90
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
ORAL SURGERY		
D7240	Impacted Tooth - Completely Bony	\$80
D9223/D9243	IV Sedation - 15 minute increments	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
Delta Dental PPO**

		DELTA DENTAL Program A	
		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%
CROWNS			
D2750	Porcelain fused to Nigh noble	60%	50%
D2751	Porcelain fused to predominately Base metal	60%	50%
D2752	Porcelain fused to Nobel metal	60%	50%
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	Gingevectomy per Quadrant	90%	80%
PROSTHODONTICS			
D5130	Immediate Denture	60%	50%
D5110	Complete Denture	60%	50%
ORAL SURGERY			
D7240	Impacted Tooth - Completely Bony	90%	80%
D9223/D9243	IV Sedation - 15 minute increments	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

	CAPITOL ADMINISTRATORS <i>DHMO Clone</i> Panel Dentist
DEDUCTIBLE Individual / Family	None
ANNUAL DENTAL BENEFIT MAXIMUM PER PERSON	\$2,000
PREVENTIVE D0150 Office Examination D1110 Prophylaxis (Schedule Limits May Apply) D0210 Complete Series X-Rays (Schedule Limits May Apply)	No Charge No Charge No Charge
FILLINGS D2140 Amalgam One Surface D2150 Amalgam Two Surfaces D2160 Amalgam Three Surfaces D2330 Resin One Surface - Anterior D2331 Resin Two Surfaces - Anterior D2335 Resin Three Surfaces - Anterior	90% 90% 90% 90% 90% 90%
CROWNS D2750 Porcelain fused to Nigh noble D2751 Porcelain fused to predominately Base metal D2752 Porcelain fused to Nobel metal	65% 65% 65%
ROOT CANAL THERAPY D3310 Anterior (Excluding Final Restoration) D3320 Bicuspid (Excluding Final Restoration) D3330 Molar (Excluding Final Restoration)	90% 90% 90%
PERIODONTICS D4341 Perio Scaling & Root Planing Per Quadrant D4210 Gingevectomy per Quadrant	90% 90%
PROSTHODONTICS D5130 Immediate Denture (Scheduled Limits & Allowances Apply) D5110 Complete Denture (Scheduled Limits & Allowances Apply)	65% 65%
ORAL SURGERY D7240 Impacted Tooth - Completely Bony D9241 IV Sedation - 1st 30 minutes	90% Not Covered
ORTHODONTIA Start-Up Fee D8680 Orthodontic Retention D8080 Children - 2 Year Full Banding D8090 Adults - 2 Year Full Banding	\$220 \$1,250 Discount of UCR off total Ortho fee \$1,250 Discount of UCR off total Ortho fee \$1,250 Discount of UCR off total Ortho fee

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**City of Riverside
VSP Vision**

BENEFITS	VISION SERVICE PLAN	
	Plan B 12 / 12 / 24	
	Self-Funded Plan	
	Participating Provider	Non-Participating Provider
DEDUCTIBLE Individual/Family	None	None
EXAM Frequency	\$10 Copayment 12 Months	Up to \$50 Reimbursement 12 Months
LENSES Frequency	Single, Bi-Focal, Tri-Focal, Standard Progressive: \$25 12 Months	Single: \$50, Bi-Focal: \$75, Tri-Focal: \$100, Standard Progressive: \$75 12 Months
FRAMES Frequency	\$120 Allowance, 20% off amount over your allowance 24 Months	\$70 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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