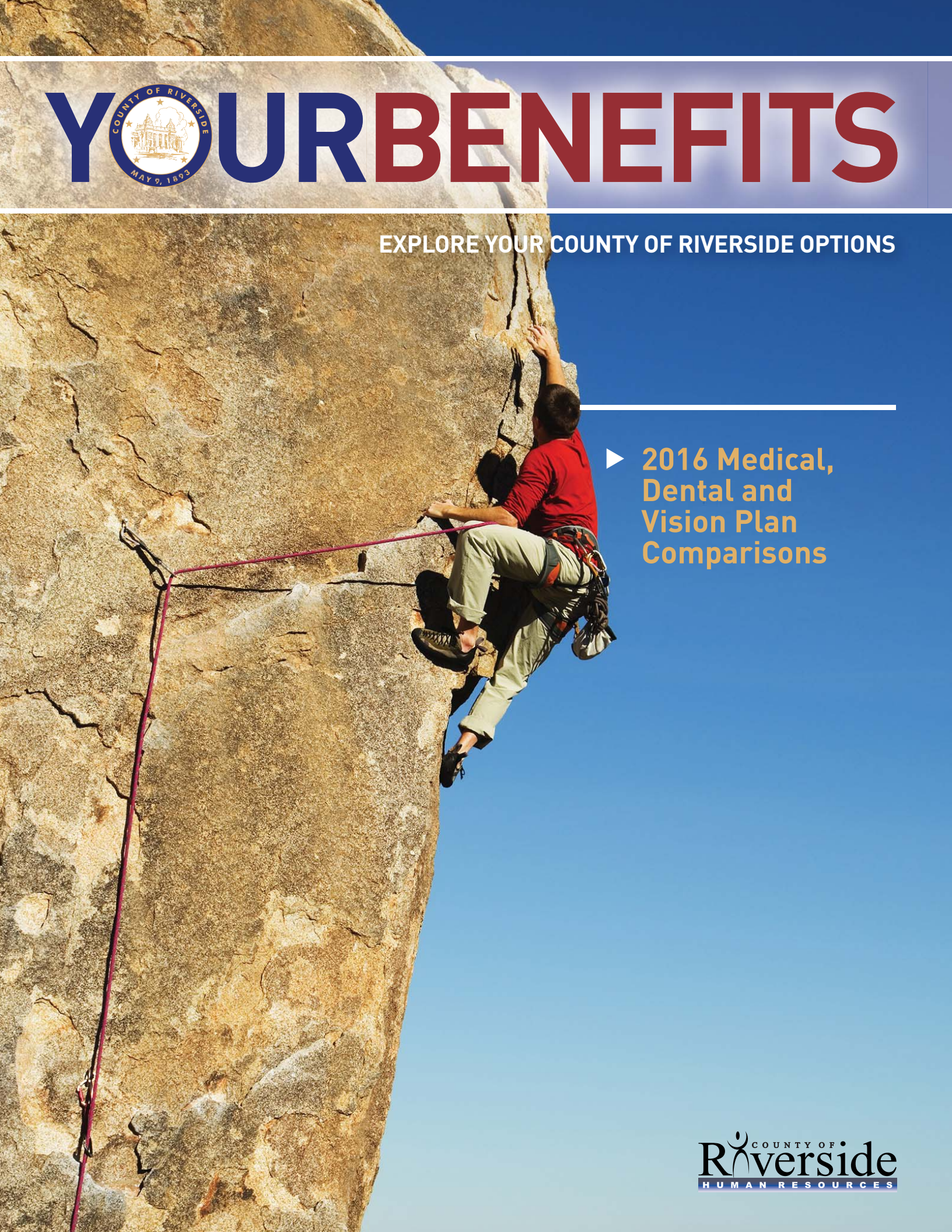
YOUR BENEFITS

EXPLORE YOUR COUNTY OF RIVERSIDE OPTIONS



- 2016 Medical, Dental and Vision Plan Comparisons

COUNTY OF Riverside
HUMAN RESOURCES

COUNTY MEDICAL PLANS COMPARISON CHART

These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.

	Exclusive Care EPO	Kaiser Permanente HMO	UHC Signature Value HMO
	Network Only	**Network Only**	**Network Only**
Choice of physician	Any Exclusive Care network physician	Any Kaiser Permanente physician and/or facility	All care must be coordinated by your PCP
Deductible	None	None	None
Calendar year out-of-pocket maximum	$1,500/person $3,000/family	$1,500/person $3,000/family	$1,500/person $3,000/family
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited
Pre-existing condition limitation	Fully covered	Fully covered	Fully covered
Office Visit Benefits			
Diagnostic X-ray and lab	100%	100%	100%
Immunizations	100%	100%	100%
Maternity care	100%	100%	100%
Periodic health evaluations/physicals	100%	100%	100%
Physician office visits	100% after $15 copayment	100% after $15 copayment	100% after $15 copayment
Vision exams	100% for screening and refraction	100% after $15 copayment	100% for screening; $15 copayment for refraction
Well-baby care	100%	100%	100%
Well-woman care	100%	100%	100%
Prescription Drugs			
Network retail pharmacies (30- to 34-day supply)	Generic: $10 copayment Preferred brand: $25 copayment Nonpreferred brand: $50 copayment	Generic: $10 copayment (up to 30-day supply) Brand formulary: $25 copayment (up to 30-day supply)	Generic: $10 copayment Preferred brand: $25 copayment Nonpreferred brand: $50 copayment
Network mail order (90-day supply)	Generic: $20 copayment Preferred brand: $50 copayment Nonpreferred brand: $100 copayment **Mail order is MANDATORY for maintenance medications after a 30-day trial.**	Generic: $20 copayment (up to 100-day supply) Brand formulary: $50 copayment (up to 100-day supply)	Generic: $20 copayment Preferred brand: $50 copayment Nonpreferred brand: $100 copayment
Hospital and Emergency Room Benefits			
Ambulance (medically necessary)	100%	100%	100%
Ambulatory surgical center	100%	100% after $15 copayment	100%
Physician hospital visits	100% after $15 copayment	100% after $100 copayment per admission	100%
Inpatient hospital	$100 copayment per admission	$100 copayment per admission	$100 copayment per admission
Outpatient hospital	100%	100%; $15 copayment / procedure for outpatient surgery	100%
Emergency room services	100% after $100 copayment at a network facility	100% after $50 copayment; waived if admitted	100% after $100 copayment; waived if admitted
Urgent care	100% after $20 copayment at network facility; 100% after $50 copayment at non-network facility	100% after $15 copayment	100% after $35 copayment; waived if admitted

COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)

These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.

	Exclusive Care EPO	Kaiser Permanente HMO	UHC Signature Value HMO
	Network Only	Network Only	Network Only
Mental Health Treatment			
Inpatient Benefit	$100 copayment per admission	100%; unlimited admissions	$100 copayment per admission (unlimited admissions)
Outpatient Benefit	$15 copayment/visit (unlimited visits)	$15 copayment/private visit; $7 copayment/group visit (unlimited visits)	$15 copayment/visit (unlimited visits)
Substance Abuse Treatment			
Inpatient Detoxification	$100 copayment per admission	$100 copayment per day, as medically necessary (detox only)	$100 copayment per admission (unlimited admissions)
Outpatient Detoxification	$15 copayment/visit (unlimited visits)	$15 copayment/private visit; $5 copayment/group visit (unlimited visits)	$15 copayment/private visit; (unlimited visits)
Other Benefits			
Allergy testing and treatment	100% after $15 copayment	100% after $15 copayment; $3/injection	100% after $15 copayment
Chiropractic	100% after $15 copayment; up to 12 visits/calendar year	100% after $15 copayment/visit; up to 20 visits/calendar year	100% after $15 copayment for chiropractic and acupuncture; up to 20 visits combined annual maximum
Durable medical equipment	50%	100%	100%
Family planning			
- Elective pregnancy termination	100% after $50 copayment for 1st trimester; $100 for 2nd trimester; 3rd trimester not covered unless life-threatening	100% after $15 copayment	100% after $125 copayment for 1st trimester; $200 for 2nd trimester; 3rd trimester (after 20 wks) not covered unless life threatening
- Infertility services	50% of costs, up to a lifetime maximum benefit of $10,000	50% of costs	50% of cost copayment
- Tubal ligation	100%	100%	100%
- Vasectomy	100%	100% after $15 copayment	$50 copayment
Home health care	100%	100%, up to 100 visits/calendar year	100% after $15 copayment; up to 100 visits/calendar year
Hospice – routine home and inpatient respite care	100%	100%	100%
Hospice – 24-hour continuous home care and general inpatient care	100%	100%	100% (prognosis of life expectancy of one year or less)
Physical therapy	$15 copayment/visit; up to 30 visits/disability (within 90-day period)	100% after $15 copayment	100% after $15 copayment
Skilled nursing facility	100%; up to 100 days/disability	100% up to 100 days/calendar year	$100 copayment; up to 100 days/benefit period

COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)

These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.

	UHC Select Plus PPO	
	PPO Network	**Out-of-Network**
Choice of physician	Any network provider	Any licensed provider
Annual Deductible	$500/person $1,000/family	
Calendar year out-of-pocket maximum	$3,000/person $6,000/family	
Lifetime maximum benefit	Unlimited	
Office Visit Benefits		
Physician office visits	100% after $20 copayment	40% after deductible has been met
Diagnostic X-ray and lab	100%; deductible does not apply	40% after deductible has been met
Adult preventive care (includes mammography, Pap smear, sigmoidoscopy, and prostate exam)	100%	100%; copayments and deductibles do not apply
Well-baby care	100%	40% after deductible
Well-woman care	100%	40% after deductible
Vision exams	100% after $20 copayment	40% after deductible
Prescription Drugs		
Network retail pharmacies (up to a 31-day supply)	Generic: $5 copayment Preferred brand: $15 copayment Nonpreferred brand: $45 copayment	Generic: $5 copayment Preferred brand: $15 copayment Nonpreferred brand: $45 copayment
Network mail order (up to a 90-day supply)	Generic: $10 copayment Preferred brand: $30 copayment Nonpreferred brand: $90 copayment	Not covered
Hospital and Emergency Room Services		
Inpatient hospital services	20% after deductible	40% after deductible
Physician hospital visits	20% after deductible	40% after deductible
Ambulatory surgical center	20% after deductible	40% after deductible
Ambulance (medically necessary)	20% after deductible	20% after deductible
Hospital emergency room	$50 copayment waived if admitted	$50 copayment waived if admitted
Urgent care facility	100% after $20 copayment/visit	40% after deductible
Mental Health Treatment		
Inpatient services	20% after deductible	40% after deductible
Outpatient services	100% after $20 copayment	40% after deductible
Substance Abuse Treatment		
Inpatient program	20% after deductible	40% after deductible
Outpatient office visits	100% after $20 copayment	40% after deductible
Other Benefits		
Chiropractic	100% after $20 copayment/visit; benefits limited to 24 visits per calendar year	40% after deductible
Durable medical equipment	20% after deductible	40% after deductible
Family planning	20% after deductible	40% after deductible
Home health care	20% after deductible	40% after deductible
	Benefits limited to 100 visits per year	
Hospice services	20% after deductible	40% after deductible
Infertility services	20% after deductible	40% after deductible
	Benefits subject to a separate $500 lifetime deductible and a lifetime maximum benefit of $2,000; GIFT, ZIFT, in vitro fertilization, intrafallopian transfers, and artificial insemination not covered	
Rehabilitation therapy (includes outpatient physical, speech, occupational, respiratory, and cardiac therapy)	100% after you pay $20 copayment per visit	40% after deductible
Skilled nursing facility	20% after deductible	40% after deductible
	Benefits limited to 60 days per year	

COUNTY DENTAL PLANS COMPARISON CHART

These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.

	DeltaCare USA DHMO	Local Advantage EPO Plus	Delta Dental PPO	
	High-Option Plan (10A)	In-Network	Delta Dental PPO Dentists	Premier Dentists Out-of-Network Dentists
Annual deductible	None	None	None	$50 individual | $150 family
Calendar year maximum benefit	None	$1,500/person	$1,500/person	$1,200/person
Diagnostic and Preventive				
Exams	No charge	No charge	No charge	No charge
Cleaning	No charge	No charge	No charge	No charge
Full mouth X-rays	No charge	No charge	No charge	No charge
Topical fluoride – child	No charge	No charge	No charge	No charge
Sealants (per tooth)	$5	No charge (under age 14)	No charge	No charge
Restorative				
Fillings – amalgam (silver)	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Fillings – composite resin (tooth-colored) for anterior (front) teeth	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Fillings – composite resin (tooth-colored) for posterior (back) teeth	$45–$75	When decay is present, you pay the cost difference between amalgam and resin For cosmetic purposes to replace an alloy/ amalgam filling, you pay 50%	Not covered[4]	Not covered
Endodontics				
Single root canal	$45	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Bicuspid root canal	$90	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Molar root canal	$205	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Periodontics				
Periodontal scaling and root planing 4 or more teeth/ quadrant	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Crowns and Bridges				
Crowns	$35–$195	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Bridges	$55–$195	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Prosthodontics				
Complete upper denture	$100	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Complete lower denture	$100	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Oral Surgery				
Simple extraction	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Impaction	$25–$90	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Cosmetic				
Veneers	No benefit	You pay 50%	Not covered	Not covered
Teeth whitening	$125	You pay 50%	Not covered	Not covered
Replacement of existing amalgam filling with composite	Not covered	You pay 50%	Not covered	Not covered
Orthodontics				
Child	$1,700	You pay $120 down, $120 per month for 24 months[2]	You pay 50% of the PPO fee	You pay 50% of the PPO fee after the deductible
Adult (19 and up)	$1,900		You pay 50% of the PPO fee	You pay 50% of the PPO fee after the deductible
Lifetime maximum benefit	None	None	$1,500/person	$1,200/person

[1, 2, 3, 4] *Refer to the box on page 6 for footnote references.*

VSP HIGHLIGHTS

Benefit Duration	Participating Provider	Non-Participating Provider
Exams (every 12 months)	$20 copayment	$20 copayment
Lenses (every 12 months)	$20 copayment	$20 copayment
Frames (every 12 months)	$20 copayment	$20 copayment
Contacts		
- Visually necessary (every 24 months)	No copayment	No copayment
- Elective (every 24 months)	No copayment	No copayment
Benefit Maximum	**Participating Provider**	**Non-Participating Provider**
Eye examinations	100%	100% up to $45
Eyeglass lenses and frames or contact lenses		
- Single vision lenses	100%	100% up to $45
- Bifocal lenses	100%	100% up to $65
- Trifocal lenses	100%	100% up to $85
- Lenticular lenses	100%	100% up to $125
Frames	100% up to $120	100% up to $47
Contacts (in lieu of frames and lenses)		
- Medically necessary	100%	100% up to $210
- Elective	100% up to $120	100% up to $105

MES PLAN HIGHLIGHTS

Benefit Duration	Plan 1 – Eye Exam and Eyewear		Plan 2 – Eyewear Only	
Exams	12 months		Not covered	
Lenses	12 months		12 months	
Frames	12 months		12 months	
Contacts				
- Visually necessary	12 months		12 months	
- Elective	12 months		12 months	
Percentage Payable	**Plan 1 – Eye Exam and Eyewear**		**Plan 2 – Eyewear Only**	
Eye examinations	100%		Not covered	
Eyeglass lenses and frames or contact lenses	100%		100%	
Benefit Maximum	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye examinations	100%	Up to $60 for ophthalmologist; or up to $50 for optometrist	Not covered	Not covered
Eyeglass lenses or contact lenses				
- Single vision lenses	100%	100% up to $43	100%	100% up to $43
- Bifocal lenses	100%	100% up to $60	100%	100% up to $60
- Trifocal lenses	100%	100% up to $75	100%	100% up to $75
- Lenticular lenses	100%	100% up to $120 for monofocal; or 100% up to $200 for multifocal	100%	100% up to $120 for monofocal; or 100% up to $200 for multifocal
Frames	100% up to $75	100% up to $40	100% up to $75	100% up to $40
Contacts (in lieu of frames and lenses)				
- Medically necessary	100%	100% up to $250	100%	100% up to $250
- Elective	$100 allowance if chosen in lieu of all other services	$100 allowance if chosen in lieu of all other services	$100 allowance if chosen in lieu of all other services	$100 allowance if chosen in lieu of all other services

PLEASE USE THE FOLLOWING FOOTNOTE REFERENCES WITH THE DENTAL PLANS COMPARISON CHART ON PAGE 5:

1. *You will pay any amount charged by your provider that is in excess of the Delta Dental PPO fee.*
2. *Under the DeltaCare USA program, there are no additional charges for precious metal costs on molar teeth. However, under the Delta Dental PPO program, there are additional costs for precious metals on molar teeth.*
3. *Applies to standard cases only. Other discounts apply for nonstandard cases.*
4. *The Delta Dental PPO program will pay for an amalgam filling on a molar tooth after you pay the applicable deductible. You will be responsible for the additional costs for precious metals.*