2023-2024 Member Benefit Program

Building Industry Association of the Greater Valley

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American River Benefit Administrators

For detailed plan information, forms and directories please visit https://www.arbadmin.com/association-plans.html

USI Insurance Services, Inc. CA License 0G11911

Dental

DELTA DENTAL®

Delta Dental Plan Options through the Associations

Effective Date: December 01, 2023 - November 30, 2024

Insurance Carrier	DeltaCare USA	Delta Dental
Plan Name	Plan 11B	Fee For Service
Plan Type	HMO	DPO
Provider Network	DeltaCare USA Network ONLY	PPO or Premier Network
Calendar Year Maximum	Unlimited	$1,000
Deductible:	None	Single $50/Family $ 150
Waived for Preventive	Not Applicable	Yes
Diagnostic		*"Delta Pays"* (A)
Office Visit	$20 copay	$26.00
Periodic Oral Evaluation	No Charge	$17.00
Comprehensive Oral Evaluation	No Charge	$22.00
Bitewing X-rays	No Charge	$12.00 - $26.00
Other X-rays	No Charge	$5.00 - $50.00
Preventive		*"Delta Pays"* (A)
Cleanings Adult	No Charge	$40.00
	Additional Cleanings: $45.00	Not Applicable
Child through Age 13	No Charge	$32.00
	Additional Cleanings: $35.00	Not Applicable
		"Delta Pays" (A)
Restorative	No Charge - $240 copay	$53.00 - $148.00
Oral Surgery	No Charge - $110 copay	$26.00 - $175.00
Endodontics (Root Canals)	No Charge - $250 copay	$50.00 - $402.00
Periodontics (Deep Cleaning)	$80 copay - $280 copay	$39.00 - $448.00
		"Delta Pays" (A)
Waiting Period	None	None
Crowns	$55 copay - $240 copay	$343.00 - $391.00
Prosthodontics, Removable	$20 copay - $210 copay	$255.00 - $676.00
Prosthodontics, Fixed	$40 copay - $240 copay	$191.00 - $605.00
Orthodontia		
Pretreatment/Post Treatment	$200 copay / $70 copay	NOT COVERED
Limited Treatment Child to 19	$950 copay	
Limited Treatment 19 to Adult	$1,150 copay	
Comprehensive Treatment Child to 19	$1,700 copay	
Comprehensive Treatment 19 to Adult	$1,900 copay	
Monthly Premium Rate		
Subscriber Only	$38.80	$55.84
Subscriber+1	$58.47	$98.45
Subscriber+2 or more	$82.42	$129.24

(A) For each procedure, you are responsible for the portion of the dentist's fee that is more than the amount listed in the "Delta Dental Pays" column.

Cypress Ancillary Benefits
Dental Options through the Associations

Effective Date: December 01, 2023 - November 30, 2024

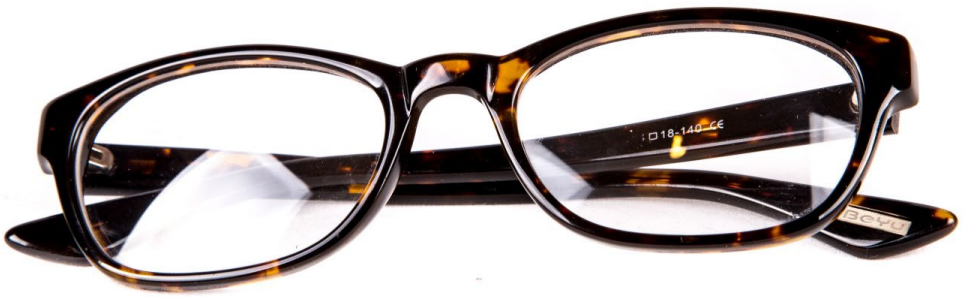
Plan Name	Cypress DHMO CA7740	$1,500 PPO (MAC)	$1,500 PPO (UCR)
Plan Type	DHMO	DPO (MAC)	DPO (UCR)
Provider Network	Administered by MIB	CEN / PPO / Out-of-Network	CEN / PPO / Out-of-Network
Calendar Year Maximum	Unlimited	$1,500 / $1,500 / $1,500	$1,500 / $1,500 / $1,500
Deductible:	None	$25 /$50 / $50 Max 3 per family	$25 /$50 / $50 Max 3 per family
Waived for Preventive	Not Applicable	Yes / Yes / Yes	Yes / Yes / Yes
Preventive Services	No waiting period	No waiting period	No waiting period
Office Visit	$0 copay		
Comprehensive Oral Evaluation	D0150 - $0 copay		
Intraoral, periapical, add'l radiographic image	D0230 - $0 copay	100% / 100% / 100% (MAC)	100% / 100% / 100% (UCR)
Bitewing X-rays	D0274 - $0 copay		
Other X-rays (Panoramic images)	D0330 - $0 copay		
Cleanings	D1110 - $0 copay		
Basic Services	No waiting period	No waiting period	No waiting period
Fillings (Amalgam, 2 surfaces)	D2150 - $10 copay		
Fillings (composite, 2 surfaces, anterior)	D2331 - $10 copay		
Fillings (Composite, 2 surfaces, posterior)	D2392 - $65 copay	90% / 80% / 80% (MAC)	90% / 80% / 80% (UCR)
Root canal, molar (excluding final restoration)	D3330 - $125 copay		
Periodontal scaling/planning	D4341 - $25 copay		
Major Services	No waiting period	No waiting period (1)	No waiting period (1)
Crown, porcelain fused to high noble metal	D2750 - $145 copay		
Crown, resin with high noble metal	D6720 - $145 copay	60% / 50% / 50% (MAC)	60% / 50% / 50% (UCR)
Complete denture, maxillary	D5110 - $200 copay		
Surgical removal of erupted tooth	D7210 - $25 copay		
Orthodontia	No waiting period		
Comprehensive treatment of children	D8080 - $1,600 copay	Not Covered	Not Covered
Comprehensive treatment of adults	D8090 - $2,100 copay		
Monthly Premium Rate	**Cypress DHMO CA7740**	**$1,500 PPO (MAC)**	**$1,500 PPO (UCR)**
Subscriber Only	$28.93	$45.85	$54.90
Subscriber+Spouse	$41.86	$83.64	$98.83
Subscriber+Child(ren)	$39.80	$82.61	$118.17
Subscriber+Family	$56.91	$130.57	$151.32

CEN: Cypress Exclusive Network is not available in all areas. Cypress does not guarantee that all services can be rendered by a CEN provider

MAC: Benefits are paid using fee schedules, less coinsurance and deductibles

UCR: Benefits are paid at the 90th percentile on the Usual, Customary, and Reasonable (UCR), less coinsurance and deductible

Vision



Association Vision Plan

Effective December 1, 2023 to November 30, 2024

Vision Benefit	VSP Vision Care
	In-Network
Co-Pay Exams	$10
Co-Pay Material	$25
Exam	One Every 12 months
Lenses (per pair)	Once every 12 months
Frames	Once every 24 months
Frame Retail Allowance	$150.00
Contact Lenses	Once every 12 months
*Contact lenses are in lieu of frames	Up to $150.00
Rates	**VSP Vision Care**
Employee Only	$8.40
Employee / Spouse	$15.84
Employee / Children	$16.85
Family	$26.33
Administered through Cypress Ancillary Benefits	

Medical

Comparing Medical Plans

Medical Plan Options are commonly referred to as "Metal Plans" representing different tiers of coverage and affordability.

Platinum

- Low deductible
- Low Copays
- Low coinsurance
- Higher premium costs

Gold

- Low/Moderate deductible
- Moderate Copays
- Low/Moderate coinsurance
- High/Moderate premium costs

Silver

- Moderate/High deductible
- Moderate/High Copays & Coinsurance
- Low / Moderate premium costs

Bronze

- High Deductible
- Must meet deductible before plan pays
- Low premium costs

Some high deductible health plans (HDHP) are HSA compatible offering a tax advantage

Choosing a Medical Plan

Deductible

The amount of healthcare cost you will have to pay before the plan starts paying.

Coinsurance

After the deductible is met, you and the plan share in the cost of services. (Example: if the plan pays 80% you will pay 20%)

Copay

A set amount defined by the plan that you will pay when you receive care. (Example: You pay a set dollar amount when you visit your doctor)

Out of Pocket Maximum

Protects you from large medical bills once your out of pocket reaches this amount. The plan will pay 100% once eligible expenses exceed that amount.

In and Out of Network

In Network services will always be the lowest cost option. Check your plan for non network coverage. It may be less coverage or no coverage except in an emergency.

Balance Billing

In-network providers are not allowed to bill more than the plan allows, out of network providers can charge the excess of the plan allowance to "balance" the charges.

TIPS: Check the Network to ensure your doctor or hospital is covered. Consider premium cost, deductibles and copays that may affect your true out of pocket.

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Platinum Plans

Plan Benefit Summary	Platinum 90 HMO 0/10 + Child Dental Alt	Platinum 90 HMO 0/20 + Child Dental
Annual Medical Deductible	$0	$0
Drug Benefits Deductible		
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: $3,000 Family: $6,000	Individual: $4,500 Family: $9,000
Primary Care Visit to Treat an Injury or Illness	$10 copay	$20 copay
Other Practitioner Office Visit (Nurse, Physician Assistant)	$10 copay	$20 copay
Specialist Visit	$20 copay	$30 copay
X-rays and Diagnostic Imaging	$40 copay	$30 copay
Laboratory Outpatient and Professional Services	$20 copay	$20 copay
Preventive Care/Screening/Immunization	No Charge	No Charge
Urgent Care Centers or Facilities	$10 copay	$20 copay
Emergency Room Services	$200 copay	$150 copay
Inpatient Hospital Services (e.g., Hospital Stay)	$500 copay per admission	$250 copay per day
Generic Drugs	$5 copay	$5 copay
Preferred Brand Drugs	$15 copay	$20 copay
Non-Preferred Brand Drugs	$15 copay	$20 copay
Specialty Drugs	10% coinsurance	10% coinsurance

Gold Plans

Plan Benefit Summary	Gold 80 HMO 0/30 + Child Dental Alt	Gold 80 HMO 250/35 + Child Dental	Gold 80 HMO 1000/40 + Child Dental Alt
Annual Medical Deductible	$0	Individual: $250 Family: $500	Individual: $1,000 Family: $2,000
Drug Benefits Deductible			Individual: $250 Family: $500
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: $7,500 Family: $15,000	Individual: $7,800 Family: $15,600	Individual: $7,800 Family: $15,600
Primary Care Visit to Treat an Injury or Illness	$30 copay	$35 copay	$40 copay
Other Practitioner Office Visit (Nurse, Physician Assistant)	$30 copay	$35 copay	$40 copay
Specialist Visit	$50 copay	$55 copay	$60 copay
X-rays and Diagnostic Imaging	$40 copay	$55 copay	$60 copay
Laboratory Outpatient and Professional Services	$30 copay	$35 copay	$30 copay
Preventive Care/Screening/Immunization	No Charge	No Charge	No Charge
Urgent Care Centers or Facilities	$30 copay	$35 copay	$40 copay
Emergency Room Services	$250 copay	$250 copay after deductible	$350 copay
Inpatient Hospital Services (e.g., Hospital Stay)	$600 copay per day up to 5 days	$600 copay per day	$600 copay per day
Generic Drugs	$15 copay	$15 copay	$20 copay
Preferred Brand Drugs	$50 copay	$40 copay	$50 copay after deductible
Non-Preferred Brand Drugs	$50 copay	$40 copay	$50 copay after deductible
Specialty Drugs	20% coinsurance	20% coinsurance	20% coinsurance after deductible

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Silver Plans

Plan Benefit Summary	Silver 70 HMO 1900/65 + Child Dental Alt	Silver 70 HMO 2500/55 + Child Dental	Silver 70 HDHP HMO 2700/25% + Child Dental
Annual Medical Deductible	Individual: $1,900 Family: $3,800	Individual: $2,500 Family: $5,000	Self Only: $2,700 Individual: $3,000 Family: $5,400
Drug Benefits Deductible		Individual: $370 Family: $740	
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: $8,750 Family: $17,500	Individual: $8,750 Family: $17,500	Individual: $7,200 Family: $14,400
Primary Care Visit to Treat an Injury or Illness	$65 copay	$55 copay	25% coinsurance after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	$65 copay	$55 copay	25% coinsurance after deductible
Specialist Visit	$100 copay	$90 copay	25% coinsurance after deductible
X-rays and Diagnostic Imaging	$75 copay	$90 copay	25% coinsurance after deductible
Laboratory Outpatient and Professional Services	$30 copay	$55 copay	25% coinsurance after deductible
Preventive Care/Screening/Immunization	No Charge	No Charge	No Charge
Urgent Care Centers or Facilities	$65 copay	$55 copay	25% coinsurance after deductible
Emergency Room Services	45% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible
Inpatient Hospital Services (e.g., Hospital Stay)	45% coinsurance after deductible	40% coinsurance after deductible	25% coinsurance after deductible
Generic Drugs	$20 copay	$19 copay	25% coinsurance after deductible
Preferred Brand Drugs	$100 copay	$85 copay after deductible	25% coinsurance after deductible
Non-Preferred Brand Drugs	$100 copay	$85 copay after deductible	25% coinsurance after deductible
Specialty Drugs	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible

Bronze Plans

Plan Benefit Summary	Bronze 60 HMO 6300/65 + Child Dental	Bronze 60 HDHP HMO 7000/0 + Child Dental
Annual Medical Deductible	Individual: $6,300 Family: $12,600	Individual: $7,000 Family: $14,000
Drug Benefits Deductible	Individual: $500 Family: $1,000	
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: $8,600 Family: $17,200	Individual: $7,000 Family: $14,000
Primary Care Visit to Treat an Injury or Illness	$65 copay	No Charge after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	$65 copay	No Charge after deductible
Specialist Visit	$95 copay	No Charge after deductible
X-rays and Diagnostic Imaging	40% coinsurance after deductible	No Charge after deductible
Laboratory Outpatient and Professional Services	$40 copay	No Charge after deductible
Preventive Care/Screening/Immunization	No Charge	No Charge
Urgent Care Centers or Facilities	$65 copay	No Charge after deductible
Emergency Room Services	40% coinsurance after deductible	No Charge after deductible
Inpatient Hospital Services (e.g., Hospital Stay)	40% coinsurance after deductible	No Charge after deductible
Generic Drugs	$18 copay after deductible	No Charge after deductible
Preferred Brand Drugs	40% coinsurance after deductible	No Charge after deductible
Non-Preferred Brand Drugs	40% coinsurance after deductible	No Charge after deductible
Specialty Drugs	40% coinsurance after deductible	No Charge after deductible

Medical Rates

KAISER PERMANENTE®

Rating Area 10
Small Business Medical Rate Plans

Effective: December 1, 2023 through November 30, 2024

Counties: Mariposa, San Joaquin, Stanislaus, Tulare

Age	Platinum 90 HMO 0/10 + Child Dental Alt	Platinum 90 HMO 0/20 + Child Dental	Gold 80 HMO 0/30 + Child Dental Alt	Gold 80 HMO 250/35 + Child Dental	Gold 80 HMO 1000/40 + Child Dental Alt	Silver 70 HMO 1900/65 + Child Dental Alt	Silver 70 HMO 2500/55 + Child Dental	Silver 70 HDHP HMO 2700/25% + Child Dental	Bronze 60 HMO 6300/65 + Child Dental	Bronze 60 HDHP HMO 7000/0 + Child Dental
0-14	345.49	339.54	322.16	306.86	289.38	259.44	253.79	238.84	225.73	213.10
15	374.96	368.48	349.55	332.89	313.86	281.26	275.10	258.82	244.55	230.79
16	386.23	379.55	360.02	342.84	323.22	289.60	283.25	266.47	251.74	237.56
17	397.50	390.61	370.50	352.80	332.58	297.95	291.40	274.11	258.94	244.33
18	409.63	402.53	381.78	363.52	342.66	306.93	300.18	282.34	266.69	251.62
19	407.77	400.45	379.06	360.25	338.75	301.92	294.97	276.58	260.45	244.91
20	420.34	412.79	390.75	371.35	349.19	311.23	304.06	285.10	268.48	252.46
21	433.34	425.56	402.83	382.83	359.99	320.85	313.46	293.92	276.78	260.27
22	433.34	425.56	402.83	382.83	359.99	320.85	313.46	293.92	276.78	260.27
23	433.34	425.56	402.83	382.83	359.99	320.85	313.46	293.92	276.78	260.27
24	433.34	425.56	402.83	382.83	359.99	320.85	313.46	293.92	276.78	260.27
25	435.07	427.26	404.44	384.37	361.43	322.14	314.72	295.09	277.89	261.31
26	443.74	435.77	412.50	392.02	368.63	328.55	320.98	300.97	283.42	266.52
27	454.14	445.99	422.17	401.21	377.27	336.26	328.51	308.03	290.07	272.76
28	471.04	462.58	437.88	416.14	391.31	348.77	340.73	319.49	300.86	282.91
29	484.91	476.20	450.77	428.39	402.83	359.04	350.76	328.90	309.72	291.24
30	491.84	483.01	457.21	434.52	408.59	364.17	355.78	333.60	314.15	295.40
31	502.24	493.22	466.88	443.71	417.23	371.87	363.30	340.65	320.79	301.65
32	512.64	503.44	476.55	452.89	425.87	379.57	370.83	347.71	327.43	307.90
33	519.14	509.82	482.59	458.64	431.27	384.38	375.53	352.11	331.58	311.80
34	526.07	516.63	489.04	464.76	437.03	389.52	380.54	356.82	336.01	315.97
35	529.54	520.03	492.26	467.82	439.91	392.08	383.05	359.17	338.23	318.05
36	533.01	523.44	495.48	470.89	442.79	394.65	385.56	361.52	340.44	320.13
37	536.47	526.84	498.71	473.95	445.67	397.22	388.07	363.87	342.65	322.21
38	539.94	530.25	501.93	477.01	448.55	399.78	390.57	366.22	344.87	324.29
39	546.87	537.06	508.37	483.14	454.31	404.92	395.59	370.93	349.30	328.46
40	553.81	543.87	514.82	489.26	460.07	410.05	400.60	375.63	353.73	332.62
41	564.21	554.08	524.49	498.45	468.71	417.75	408.13	382.68	360.37	338.87
42	574.17	563.87	533.75	507.26	476.99	425.13	415.34	389.44	366.73	344.86
43	588.04	577.48	546.64	519.51	488.51	435.40	425.37	398.85	375.59	353.18
44	605.38	594.51	562.76	534.82	502.90	448.23	437.91	410.60	386.66	363.60
45	625.74	614.51	581.69	552.81	519.82	463.31	452.64	424.42	399.67	375.83
46	650.01	638.34	604.25	574.25	539.98	481.28	470.19	440.88	415.17	390.40
47	677.31	665.15	629.63	598.37	562.66	501.50	489.94	459.40	432.61	406.80
48	708.51	695.79	658.63	625.93	588.58	524.60	512.51	480.56	452.54	425.54
49	739.28	726.00	687.23	653.12	614.14	547.38	534.77	501.43	472.19	444.02
50	773.94	760.05	719.46	683.74	642.94	573.05	559.84	524.94	494.33	464.84
51	808.18	793.67	751.28	713.99	671.38	598.39	584.61	548.16	516.20	485.40
52	845.88	830.69	786.33	747.29	702.70	626.31	611.88	573.73	540.28	508.04
53	884.01	868.14	821.78	780.98	734.38	654.54	639.46	599.59	564.63	530.95
54	925.18	908.57	860.05	817.35	768.58	685.02	669.24	627.52	590.93	555.67
55	966.35	949.00	898.32	853.72	802.78	715.51	699.02	655.44	617.22	580.40
56	1,010.98	992.83	939.81	893.15	839.85	748.55	731.31	685.71	645.73	607.21
57	1,056.05	1,037.09	981.70	932.97	877.29	781.92	763.91	716.28	674.52	634.27
58	1,104.15	1,084.33	1,026.42	975.46	917.25	817.54	798.70	748.91	705.24	663.16
59	1,127.98	1,107.73	1,048.57	996.52	937.05	835.18	815.94	765.07	720.46	677.48
60	1,176.08	1,154.97	1,093.29	1,039.01	977.01	870.80	850.74	797.70	751.18	706.37
61	1,217.68	1,195.82	1,131.96	1,075.77	1,011.57	901.60	880.83	825.91	777.75	731.36
62	1,244.98	1,222.63	1,157.34	1,099.88	1,034.25	921.81	900.58	844.43	795.19	747.75
63	1,279.22	1,256.25	1,189.16	1,130.13	1,062.69	947.16	925.34	867.65	817.06	768.31
64 and over	1,300.02	1,276.68	1,208.49	1,148.49	1,079.97	962.55	940.38	881.76	830.34	780.81

A SEPARATE $20 ADMINISTRATION FEE WILL BE ADDED TO CALCULATE THE SUBSCRIBER MONTHLY RATE

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(916) 883-0708

Please Visit:
https://www.arbadmin.com/association-plans.html
for detailed plan information and enrollment forms.