

2022-2023 Member Benefit Program



Building Industry Association of San Diego



Broker Contact



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American River Benefit Administrators

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



Benefit Plans

12/01/2022-11/30/2023

Kaiser Permanente	Platinum 90 HMO 0/10 + Child Dental Alt	Platinum 90 HMO 0/20 + Child Dental
Benefit	In Network	In Network
Individual / Family Deductible	\$0 / \$0	\$0 / \$0
Individual / Family OOP Max	\$3,000 / \$6,000	\$4,500 / \$9,000
Co-insurance	0%	0%
PC/Specialist	\$10/\$20	\$20/\$30
Inpatient Hospital	\$500/admit	\$250/day up to 5 days
Lab/X-Ray	\$20/\$40	\$20/\$30
Emergency Room	\$200 (waived if admitted)	\$150 (waived if admitted)
Urgent Care	\$10	\$20
Rx Generic / RX Brand	\$5 / \$15	\$5 / \$20

Kaiser Permanente	Gold 80 HMO 250/35 + Child Dental	Gold 80 HMO 1000/40 + Child Dental Alt
Benefit	In Network	In Network
Individual / Family Deductible	\$250 / \$500	\$1,000 / \$2,000
Individual / Family OOP Max	\$7,800 (incl ded) / \$15,600 (incl ded)	\$7,800 (incl ded) / \$15,600 (incl ded)
Co-insurance	0%	0%
PC/Specialist	\$35/\$55 ded waived	\$40/\$60 ded waived
Inpatient Hospital	\$600/day after ded up to 5 days	\$600/day after ded up to 5 days
Lab/X-Ray	\$35/\$55 ded waived	\$30/\$60 ded waived
Emergency Room	\$250 (waived if admitted) after ded	\$350 (waived if admitted) ded waived
Urgent Care	\$35 ded waived	\$40 ded waived
Rx Generic / RX Brand	\$15 ded waived / \$40 ded waived	\$20 ded waived / \$50 after \$250

Effective Date: 12-01-2022
USI Insurance Services, LLC CA License: 0G11911



Benefit Plans

12/01/2022-11/30/2023

Kaiser Permanente	Silver 70 HMO 1650/55 + Child Dental Alt	Silver 70 HMO 2250/55 + Child Dental	Silver 70 HDHP HMO 2500/20% + Child Dental
Benefit	In Network	In Network	In Network
Individual / Family Deductible	\$1,650 / \$3,300	\$2,250 / \$4,500	\$2,500 ind only; \$2,800 ind w/family / \$5,000 Family
Individual / Family OOP Max	\$8,200 (incl ded) / \$16,400 (incl ded)	\$8,200 (incl ded) / \$16,400 (incl ded)	\$6,850 (incl ded) / \$13,700 (incl ded)
Co-insurance	40%	30%	20%
PC/Specialist	\$55/\$80 ded waived	\$55/\$90 ded waived	20% after ded
Inpatient Hospital	40% after ded	30% after ded	20% after ded
Lab/X-Ray	\$30/\$75 ded waived	\$55/\$90 ded waived	20% after ded
Emergency Room	40% after ded	30% after ded	20% after ded
Urgent Care	\$55 ded waived	\$55 ded waived	20% after ded
Rx Generic / RX Brand	\$20 ded waived / \$75 after \$350	\$17 ded waived / \$80 after \$300	20% after ded; \$250 max/script

Kaiser Permanente	Bronze 60 HMO 6300/65 + Child Dental	Bronze 60 HDHP HMO 7000/0% + Child Dental
Benefit	In Network	In Network
Individual / Family Deductible	\$6,300 / \$12,600	\$7,000 / \$14,000
Individual / Family OOP Max	\$8,200 (incl ded) / \$16,400 (incl ded)	\$7,000 (incl ded) / \$14,000 (incl ded)
Co-insurance	40%	0%
PC/Specialist	\$65/\$95 ded waived 1st 3 visits	0% after ded
Inpatient Hospital	40% after ded	0% after ded
Lab/X-Ray	\$40 ded waived/40% after ded	0% after ded
Emergency Room	40% after ded	0% after ded
Urgent Care	\$65 ded waived 1st 3 visits	0% after ded
Rx Generic / RX Brand	\$18 after \$500 / 40% after \$500; \$500 max/script	0% after ded

Effective Date: 12-01-2022
USI Insurance Services, LLC CA

Delta Dental Plan Options through the Associations

Effective Date: December 01, 2022 - November 30, 2023

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		<u>"Delta Pays" (A)</u>
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		<u>"Delta Pays" (A)</u>
Cleanings Adult	No Charge	\$40.00
Child through Age 13	Additional Cleanings: \$45.00	Not Applicable
	No Charge	\$32.00
	Additional Cleanings: \$35.00	Not Applicable
Restorative	No Charge - \$240 copay	<u>"Delta Pays" (A)</u>
Oral Surgery	No Charge - \$110 copay	\$53.00 - \$148.00
Endodontics (Root Canals)	No Charge - \$250 copay	\$26.00 - \$175.00
Periodontics (Deep Cleaning)	\$80 copay - \$280 copay	\$50.00 - \$402.00
		\$39.00 - \$448.00
Waiting Period	None	<u>"Delta Pays" (A)</u>
Crowns	\$55 copay - \$240 copay	None
Prosthodontics, Removable	\$20 copay - \$210 copay	\$343.00 - \$391.00
Prosthodontics, Fixed	\$40 copay - \$240 copay	\$255.00 - \$676.00
		\$191.00 - \$605.00
Orthodontia		
Pretreatment/Post Treatment	\$200 copay / \$70 copay	
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

Association Dental Options

Effective Date: December 01, 2022 - November 30, 2023

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 Deductible:	Unlimited None	\$1,500 / \$1,500 / \$1,500 \$25 / \$50 / \$50 Max 3 per family	\$1,500 / \$1,500 / \$1,500 \$25 / \$50 / \$50 Max 3 per family
Waived for Preventive	Not Applicable	Yes / Yes / Yes	Yes / Yes / Yes
<u>Preventive Services</u>	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		
<u>Basic Services</u>	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		
<u>Major Services</u>	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		
<u>Orthodontia</u>	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

Association Vision Plan

Effective December 1, 2022 to November 30, 2023

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	

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

Small Business medical plan rates

Age on 2022 effective date	Platinum 90 HMO 0/10 + Child Dental Alt	Platinum 90 HMO 0/20 + Child Dental	Gold 80 HMO 250/35 + Child Dental	Gold 80 HMO 1000/40 + Child Dental Alt
0-14 ¹	\$314.12	\$308.67	\$279.34	\$263.83
15 ¹	\$340.79	\$334.87	\$302.93	\$286.04
16 ¹	\$350.99	\$344.88	\$311.95	\$294.53
17 ¹	\$361.19	\$354.90	\$320.96	\$303.02
18 ¹	\$372.18	\$365.68	\$330.68	\$312.17
19	\$369.17	\$362.48	\$326.40	\$307.32
20	\$380.55	\$373.65	\$336.46	\$316.79
21	\$392.32	\$385.21	\$346.86	\$326.59
22	\$392.32	\$385.21	\$346.86	\$326.59
23	\$392.32	\$385.21	\$346.86	\$326.59
24	\$392.32	\$385.21	\$346.86	\$326.59
25	\$393.89	\$386.75	\$348.25	\$327.89
26	\$401.74	\$394.45	\$355.19	\$334.43
27	\$411.15	\$403.70	\$363.51	\$342.26
28	\$426.45	\$418.72	\$377.04	\$355.00
29	\$439.01	\$431.05	\$388.14	\$365.45
30	\$445.28	\$437.21	\$393.69	\$370.68
31	\$454.70	\$446.45	\$402.02	\$378.52
32	\$464.12	\$455.70	\$410.34	\$386.35
33	\$470.00	\$461.48	\$415.54	\$391.25
34	\$476.28	\$467.64	\$421.09	\$396.48
35	\$479.42	\$470.72	\$423.87	\$399.09
36	\$482.55	\$473.80	\$426.64	\$401.70
37	\$485.69	\$476.88	\$429.42	\$404.32
38	\$488.83	\$479.97	\$432.19	\$406.93
39	\$495.11	\$486.13	\$437.74	\$412.15
40	\$501.39	\$492.29	\$443.29	\$417.38
41	\$510.80	\$501.54	\$451.62	\$425.22
42	\$519.83	\$510.40	\$459.59	\$432.73
43	\$532.38	\$522.72	\$470.69	\$443.18
44	\$548.07	\$538.13	\$484.57	\$456.24
45	\$566.51	\$556.24	\$500.87	\$471.59
46	\$588.48	\$577.81	\$520.30	\$489.88
47	\$613.20	\$602.08	\$542.15	\$510.46
48	\$641.44	\$629.81	\$567.12	\$533.97
49	\$669.30	\$657.16	\$591.75	\$557.16
50	\$700.69	\$687.98	\$619.50	\$583.29
51	\$731.68	\$718.41	\$646.90	\$609.09
52	\$765.81	\$751.92	\$677.08	\$637.50
53	\$800.33	\$785.82	\$707.60	\$666.24
54	\$837.61	\$822.41	\$740.55	\$697.27
55	\$874.88	\$859.01	\$773.51	\$728.29
56	\$915.28	\$898.69	\$809.23	\$761.93
57	\$956.09	\$938.75	\$845.31	\$795.90
58	\$999.63	\$981.50	\$883.81	\$832.15
59	\$1,021.21	\$1,002.69	\$902.89	\$850.11
60	\$1,064.76	\$1,045.45	\$941.39	\$886.36
61	\$1,102.42	\$1,082.43	\$974.69	\$917.71
62	\$1,127.14	\$1,106.70	\$996.54	\$938.29
63	\$1,158.13	\$1,137.13	\$1,023.94	\$964.09
64+	\$1,176.96	\$1,155.63	\$1,040.58	\$979.77

¹HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

Counties (Partial):Imperial, Kern,Riverside, San Bernardino, San Diego

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

Small Business medical plan rates

Age on 2022 effective date	Silver 70 HMO 1650/55 + Child Dental Alt	Silver 70 HMO 2250/55 + Child Dental	Silver 70 HDHP HMO 2500/20% + Child Dental	Bronze 60 HMO 6300/65 + Child Dental	Bronze 60 HDHP HMO 7000/0 + Child Dental
0-14 ¹	\$238.33	\$236.57	\$221.56	\$205.10	\$193.78
15 ¹	\$258.27	\$256.36	\$240.01	\$222.08	\$209.76
16 ¹	\$265.90	\$263.92	\$247.06	\$228.58	\$215.87
17 ¹	\$273.52	\$271.49	\$254.11	\$235.07	\$221.98
18 ¹	\$281.73	\$279.63	\$261.71	\$242.07	\$228.56
19	\$275.95	\$273.79	\$255.32	\$235.07	\$221.15
20	\$284.46	\$282.23	\$263.19	\$242.32	\$227.97
21	\$293.25	\$290.96	\$271.33	\$249.81	\$235.02
22	\$293.25	\$290.96	\$271.33	\$249.81	\$235.02
23	\$293.25	\$290.96	\$271.33	\$249.81	\$235.02
24	\$293.25	\$290.96	\$271.33	\$249.81	\$235.02
25	\$294.43	\$292.12	\$272.41	\$250.81	\$235.96
26	\$300.29	\$297.94	\$277.84	\$255.81	\$240.66
27	\$307.33	\$304.92	\$284.35	\$261.80	\$246.30
28	\$318.77	\$316.27	\$294.93	\$271.54	\$255.47
29	\$328.15	\$325.58	\$303.62	\$279.54	\$262.99
30	\$332.84	\$330.24	\$307.96	\$283.54	\$266.75
31	\$339.88	\$337.22	\$314.47	\$289.53	\$272.39
32	\$346.92	\$344.20	\$320.98	\$295.53	\$278.03
33	\$351.32	\$348.57	\$325.05	\$299.27	\$281.55
34	\$356.01	\$353.22	\$329.39	\$303.27	\$285.31
35	\$358.36	\$355.55	\$331.56	\$305.27	\$287.19
36	\$360.70	\$357.88	\$333.73	\$307.27	\$289.07
37	\$363.05	\$360.21	\$335.90	\$309.27	\$290.95
38	\$365.40	\$362.53	\$338.07	\$311.26	\$292.83
39	\$370.09	\$367.19	\$342.42	\$315.26	\$296.60
40	\$374.78	\$371.84	\$346.76	\$319.26	\$300.36
41	\$381.82	\$378.83	\$353.27	\$325.25	\$306.00
42	\$388.56	\$385.52	\$359.51	\$331.00	\$311.40
43	\$397.95	\$394.83	\$368.19	\$338.99	\$318.92
44	\$409.68	\$406.47	\$379.04	\$348.99	\$328.32
45	\$423.46	\$420.14	\$391.80	\$360.73	\$339.37
46	\$439.88	\$436.44	\$406.99	\$374.72	\$352.53
47	\$458.36	\$454.77	\$424.08	\$390.45	\$367.34
48	\$479.47	\$475.72	\$443.62	\$408.44	\$384.26
49	\$500.29	\$496.37	\$462.88	\$426.18	\$400.94
50	\$523.75	\$519.65	\$484.59	\$446.16	\$419.75
51	\$546.92	\$542.64	\$506.03	\$465.90	\$438.31
52	\$572.43	\$567.95	\$529.63	\$487.63	\$458.76
53	\$598.24	\$593.55	\$553.51	\$509.61	\$479.44
54	\$626.10	\$621.19	\$579.28	\$533.35	\$501.77
55	\$653.96	\$648.83	\$605.06	\$557.08	\$524.09
56	\$684.16	\$678.80	\$633.01	\$582.81	\$548.30
57	\$714.66	\$709.06	\$661.22	\$608.79	\$572.74
58	\$747.21	\$741.36	\$691.34	\$636.52	\$598.83
59	\$763.34	\$757.36	\$706.27	\$650.26	\$611.76
60	\$795.89	\$789.66	\$736.38	\$677.99	\$637.84
61	\$824.05	\$817.59	\$762.43	\$701.97	\$660.41
62	\$842.52	\$835.92	\$779.52	\$717.71	\$675.21
63	\$865.69	\$858.91	\$800.96	\$737.44	\$693.78
64+	\$879.75	\$872.88	\$813.99	\$749.43	\$705.06

¹HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

Counties (Partial):Imperial, Kern,Riverside, San Bernardino, San Diego



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Please Visit:
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for detailed plan information and enrollment forms.

