

## What's Inside

This benefits comparison chart provides you with an overview of your *Choices* benefits medical and dental plans. Use these charts to compare the features and services offered by the different plans. You can also use it for quick reference now and in the future about the benefits of the plans you select.

Take some time to also review the Enrollment Highlights Guide and Personalized Enrollment Worksheet you received with this comparison chart for descriptions of your benefits plan options, information about premium rates and the *Choices* monthly benefit allowance.

Once you've chosen your plans for 2017, you should save this comparison chart so you can refer to it throughout the year.

Remember, information about your *Choices* benefits plans is also available online 24 hours a day, seven days a week using [mylacountybenefits.com](http://mylacountybenefits.com).

This comparison chart provides a general overview of the *Choices* benefits medical and dental plans. It is provided for your convenience and is not intended to be detailed or comprehensive. Additional details about your benefits are available in other official plan documents, including official summary plan descriptions. To request a copy of an official plan document, contact the plan's customer service department directly.

Dental Plans Comparison Chart							
	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PPO PLAN			ALADS/BLUE CROSS PREMIER PPO PLANS <sup>1</sup>	
			PREFERRED PROVIDER OPTION (PPO)	DELTA PARTICIPATING DENTIST IN-NETWORK	OUT-OF-NETWORK <sup>2</sup>	IN-NETWORK	OUT-OF-NETWORK <sup>2</sup>
<b>Type of Plan</b>	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers two provider networks and out-of-network benefits			An indemnity plan with PPO incentive, offering in- and out-of-network benefits	
<b>Annual Deductible</b>	None	None	None	\$50/person; \$150/family	\$50/person; \$150/family	\$50/person; \$150/family	
<b>Annual Maximum Benefit</b>	None	None	\$1,500/person (all care must be from PPO network)	\$1,200/person	\$1,200/person	\$1,750/person	
<b>PREVENTIVE CARE</b>							
<b>Cleaning</b>	100% (two every 12 months)	100% (two every 12 months)	100% (two per calendar year)	80% (no deductible for first two per calendar year)	80% of R&C (no deductible for first two per calendar year)	100%; no deductible (two in 12 months)	100% of R&C; no deductible (two in 12 months)
<b>Exam</b>	100%	100%	100% (two per calendar year)	80% (two per calendar year)	80% of R&C (two per calendar year)	100%; no deductible	100% of R&C; no deductible
<b>Full Mouth X-Rays</b>	100% (one every 24 months)	100% (one every 24 months)	100% (one every five years)	80% (one every five years)	80% of R&C (one every five years)	100%; no deductible (one every 36 months)	100% of R&C; no deductible (one every 36 months)
<b>BASIC SERVICES</b>							
<b>Emergency Treatment</b>	\$5 copay	\$5 copay	100%	80%	80% of R&C	Covered as regular treatment	Covered as regular treatment
<b>Extractions</b>	100% (except \$50 copay for bony extractions)	100%	85%	80%	80% of R&C	90%	85% of R&C
<b>Fillings</b>	100%	100%	85%	80%	80% of R&C	90%	85% of R&C
<b>General Anesthesia</b>	\$30 copay for medically necessary extractions only (first 30 minutes)	\$30 copay for medically necessary extractions only	85% for oral surgery only	80% for oral surgery only	80% of R&C for oral surgery only	90%	85% of R&C
<b>Gingivectomy</b>	\$55 copay/quadrant	\$55 copay/quadrant	85%	80%	80% of R&C	60%	50% of R&C
<b>Root Canals</b>	\$45 copay/canal	\$45 copay/canal	85%	80%	80% of R&C	90%	85% of R&C
<b>MAJOR SERVICES</b>							
<b>Bridges</b>	\$60 copay/unit	\$60 copay/unit	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
<b>Crowns</b>	\$60 copay/crown	\$60 copay/crown	85% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
<b>Dentures</b>	\$70 copay/complete upper or lower denture	\$70 copay/denture	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
<b>Orthodontia<sup>3</sup></b>	\$1,000 copay + \$150 start-up fees	\$1,150 copay + \$350 start-up fees	Not covered	Not covered	Not covered	50% of R&C up to \$1,750 lifetime max.	
<b>TMJ</b>	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

<sup>1</sup> The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans provide the dental coverage listed on this chart.

<sup>2</sup> Out-of-network benefits are based on "reasonable and customary" (R&C) amount. You pay your share of R&C if any, plus any amount the provider charges above R&C.

<sup>3</sup> Fire Fighters Local 1014 Medical Plan provides a \$3,000 lifetime orthodontia benefit as well as a \$1,500 "excess dental" benefit for those participants who have out-of-pocket expenses incurred through their LA County dental plan. The plan is only available to members of Local 1014.

Contact Information			
Contact	Phone Number	Fax Number	Website
<b>BENEFIT SYSTEM</b>			
Benefit Enrollment	888-822-0487	310-788-8775	<a href="http://www.mylacountybenefits.com">www.mylacountybenefits.com</a>
<b>COUNTY DEPARTMENT OF HUMAN RESOURCES</b>			
Benefits Hotline	213-388-9982	N/A	<a href="http://employee.hr.lacounty.gov">http://employee.hr.lacounty.gov</a>
<b>MEDICAL</b>			
CIGNA	800-842-6635	N/A	<a href="http://www.cigna.com">www.cigna.com</a>
Kaiser Permanente	800-464-4000	N/A	<a href="http://www.kp.org/countyofla">www.kp.org/countyofla</a>
ALADS/Anthem Blue Cross (HMO)	800-842-6635	N/A	<a href="http://www.anthem.com/ca/alads">www.anthem.com/ca/alads</a>
ALADS/Anthem Blue Cross (PPO)	800-842-6635	N/A	<a href="http://www.anthem.com/ca/alads">www.anthem.com/ca/alads</a>
CAPE/Blue Shield	800-487-3092	N/A	<a href="http://www.blueshieldca.com/cape">www.blueshieldca.com/cape</a>
Fire Fighters Local 1014	800-660-1014	N/A	<a href="http://www.local1014medical.org">www.local1014medical.org</a>
<b>DENTAL</b>			
MetLife (SafeGuard)	800-880-1800	N/A	<a href="http://www.safeguard.net">www.safeguard.net</a>
DeltaCare	800-422-4234	N/A	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
Delta Dental	888-335-8227	N/A	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
ALADS/Blue Cross (dental)	800-842-6635	N/A	<a href="http://www.anthem.com/ca/alads">www.anthem.com/ca/alads</a>
<b>SPENDING ACCOUNTS</b>			
Benefit Concepts, Inc.	866-629-6436	866-629-6390	<a href="http://www.mylacountybenefits.com">www.mylacountybenefits.com</a>
<b>LIFE AND AD&amp;D</b>			
CIGNA Life	800-842-6635	N/A	N/A

## Is This Covered?

To find out if a specific benefit is covered or to learn more about a certain benefit, contact the plan provider or review the Evidence of Coverage document that can be found on each provider's website. You'll find phone numbers and website addresses in the Contact Information section of this chart.

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## 2017 Medical and Dental Plans Comparison Chart

Medical Plans Comparison Chart — County-Sponsored Plans				
	KAISER PERMANENTE HMO	CIGNA NETWORK HMO	CIGNA NETWORK POS	
			IN-NETWORK	OUT-OF-NETWORK
<b>Annual Deductible</b>	None	None	None	\$500/person \$1,000/family
<b>Annual Out-of-Pocket Maximum</b>	\$1,500/person \$3,000/family	1 party-\$1,000 2 party-\$2,000 Family-\$3,000	1 party-\$1,000 2 party-\$2,000 Family-\$3,000	Unlimited
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>PREVENTIVE CARE</b>				
<b>Immunizations</b>	No charge for most common immunizations	No charge	No charge	60% of R&C after deductible
<b>Periodic Health Evaluations</b>	\$10 copay/visit	No charge	No charge	60% of R&C after deductible
<b>MEDICALLY NECESSARY CARE</b>				
<b>Ambulance</b>	No charge if medically necessary	100% when ordered/approved by CIGNA	100% when ordered/approved by CIGNA	Paid as in-network if true emergency, otherwise 60% of R&C after deductible
<b>Doctor Office Visit</b>	\$10 copay/visit; no charge pediatric visit to age 5 except routine physical exam	\$10 copay/visit	\$10 copay/visit	60% of R&C after deductible
<b>Emergency Room</b>	\$50 copay; waived if admitted	\$50 copay (waived if admitted)	\$50 copay/visit (waived if admitted)	\$50 copay/visit (waived if admitted)
<b>Hospital Care</b>	No charge	100%	\$50 copay/day; \$200 copay annual max	60% of R&C after deductible and after \$1,000 fee/admission (precertification required for non-emergency hospitalization or \$500 penalty and 50% reduction in benefits)
<b>Maternity</b>	\$10 copay for visit to office to confirm pregnancy; no charge thereafter	\$10 copay for visit to office to confirm pregnancy; no charge thereafter	Outpatient: \$10 copay for visit to confirm pregnancy; no charge thereafter	60% of R&C after deductible
<b>Prescription Drugs</b>	\$5 copay generic and \$20 copay brand name for up to 100-day supply for each medication prescribed by a Kaiser physician or any dentist and filled at a Kaiser pharmacy Sexual dysfunction drugs: 50% copay (limitations apply)	Network pharmacy (30-day supply): generic \$5 copay; brand \$20 copay Mail order (90-day supply): generic \$10 copay; brand \$40 copay	Network pharmacy (30-day supply): generic \$5 copay; brand \$20 copay Mail order (90-day supply): generic \$10 copay; brand \$40 copay	60% of R&C after deductible; mail order not covered
<b>Surgery</b>	Inpatient: No charge Outpatient: \$10 copay/visit	Inpatient: 100% Outpatient: \$50 copay	Inpatient: 100% after \$50 copay (\$200 out-of-pocket max/year) Outpatient: \$50 copay	60% of R&C after deductible (precertification required for non-emergency hospitalization or \$500 penalty and 50% reduction in benefits)
<b>X-Ray &amp; Lab Tests</b>	No charge	100% at a contracted provider	100% at a contracted provider	60% of R&C after deductible
<b>MENTAL HEALTH CARE</b>				
<b>Mental Health Outpatient</b>	\$10 copay per individual visit/\$5 copay per group visit	\$10 copay/visit	\$10 copay/visit	60% of R&C after deductible
<b>Mental Health Inpatient</b>	No charge	100%	\$50 copay/day (up to \$200/calendar year)	\$1,000 deductible per admission plus 60% of R&C after deductible
<b>OTHER PLAN BENEFITS</b>				
<b>Chiropractic Care</b>	\$10 copay (up to 30 visits/calendar year) \$50 appliance allowance/calendar year when prescribed by chiropractor participating in American Specialty Health Plans	Not covered	Not covered	60% of R&C after deductible if medically necessary (up to 25 days/calendar year)
<b>Home Health Care</b>	No charge if within Kaiser service area (up to 2 hrs/visit; 3 visits/day; 100 visits/calendar year)	100% (approved medical provider only)	100% (up to 100 visits/calendar year, reduced by out-of-network visits)	60% of R&C after deductible (up to 60 days/calendar year, reduced by in-network visits)
<b>Hospice Care</b>	No charge	100%	100%	100% of R&C after deductible
<b>Physical Therapy</b>	\$10 copay/visit	\$10 copay/visit	\$10 copay/visit	60% of R&C after deductible (up to 60 days/condition)
<b>Skilled Nursing Facility</b>	No charge (up to 100 days/benefit period)	100% when authorized by PCP (up to 100 days/calendar year)	\$50 copay/day, \$200 out-of-pocket max/year (up to 100 days/calendar year, reduced by out-of-network days)	60% of R&C after deductible for semiprivate room rate, plus \$1,000 fee/admission (up to 60 days/calendar year reduced by in-network days)
<b>Vision Care</b>	\$10 copay for eye exam at Kaiser facility (glasses not covered)	\$10 copay for eye exam (one non-medical refraction every 12 months) \$10 copay for glasses (one pair every 12 months) \$45 maximum for frames Through a CIGNA Vision Care Provider (877-478-7557)	Not covered	Not covered

The Affordable Care Act requires that a Summary of Benefits and Coverage (SBC) for each medical plan be available to employees. The SBC provides information on the benefits and costs associated with a plan. SBCs for the plans available to employees in *Choices* may be downloaded at [mylacountybenefits.com](http://mylacountybenefits.com). You may request a hard copy by calling the medical plan directly, see contact information on this comparison chart.

**Important Note:** The County believes the Kaiser Permanente HMO, Firefighters Local 1014, CAPE/Blue Shield Lite POS and CAPE/Blue Shield Classic POS health plans are "grandfathered health plans" under the Affordable Care Act (ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that it may not include certain consumer protections of the ACA that apply to other plans, such as the requirement to provide preventive health services without cost sharing. Grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits. If you have questions about which protections apply and do not apply to grandfathered health plans, and what might cause a plan to change from grandfathered status, call the Benefits Hotline at 213-388-9982. You may also contact [www.healthcare.gov](http://www.healthcare.gov).

Indicates plan change

Medical Plans Comparison Chart — Union-Sponsored Plans

	CAPE/BLUE SHIELD LITE POS PLAN			CAPE/BLUE SHIELD CLASSIC POS PLAN			ALADS/ANTHEM BLUE CROSS PRUDENT BUYER BASIC AND PREMIER PLANS <sup>†</sup>		ALADS/ANTHEM BLUE CROSS CALIFORNIACARE BASIC AND PREMIER PLANS <sup>†</sup>	FIRE FIGHTERS LOCAL 1014 MEDICAL PLAN
	HMO	IN-NETWORK	OUT-OF-NETWORK	HMO	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK		
<b>Annual Deductible</b>	None	\$400/person; \$800/family		None	\$300/person; \$600/family		\$300/person; \$900/family	\$300/person; \$900/family	None	\$200/person; \$600/family
<b>Annual Out-Of-Pocket Maximum</b>	\$1,500/person; \$3,000/family	After deductible, \$4,000/person; \$8,000/family	After deductible, \$6,000/person; \$12,000/family	\$1,500/person; \$3,000/family	After deductible, \$4,000/person; \$8,000/family	After deductible, \$6,000/person; \$12,000/family	\$450/person	\$6,000/person	\$500/person; \$1,500/family (excludes infertility treatment)	After deductible, In-network: \$1,000/person; \$1,000/family; Out-of-network: \$1,500/person; \$1,500/family
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited		Unlimited	Unlimited		Unlimited		Unlimited	Unlimited
<b>PREVENTIVE CARE</b>										
<b>Immunizations</b>	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
<b>Periodic Health Evaluations</b>	100% (including well baby, well woman exam, Pap smear and mammography)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	70% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography)	100%, No deductible, routine exams and screenings, including well-woman, well-man and well-child benefits
<b>MEDICALLY NECESSARY CARE</b>										
<b>Ambulance</b>	100% after \$50 copay	80% after deductible	80% of allowable amount (after deductible)	100% after \$50 copay	90% after deductible	90% of allowable amount (after deductible)	80% after deductible	80% after deductible	100%	90% after deductible <sup>2</sup>
<b>Doctor Office Visit</b>	100% after \$10 copay	100% after \$25 copay (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	100% after \$10 copay	100% after \$20 copay (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	\$10 copay/visit	90% after deductible <sup>2</sup>
<b>Emergency Room</b>	100% after \$50 copay (waived if admitted)	100% after \$50 copay (waived if admitted)	100% after \$50 copay (waived if admitted)	100% after \$50 copay (waived if admitted)	100% after \$50 copay (waived if admitted)	100% after \$50 copay (waived if admitted)	90% after deductible	90% after deductible	No charge if admitted as inpatient; \$25 copay/visit if outpatient	\$50 copay/visit (waived if admitted)
<b>Hospital Care</b>	100%	80% after deductible	70% of allowable amount (after deductible), up to \$360 carrier max/day	100%	90% after deductible	70% of allowable amount (after deductible), up to \$360 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible; preauthorization required <sup>2</sup>
<b>Maternity</b>	100%	100% after \$25 copay/visit (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	100%	100% after \$20 copay/visit (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	\$10 copay/visit	90% after deductible <sup>2</sup>
<b>Prescription Drugs</b>	\$5 generic; \$15 brand; \$30 non-formulary Mail order (90-day supply): \$10 generic; \$30 brand; \$60 non-formulary	\$5 generic; \$15 brand; \$30 non-formulary Mail order (90-day supply): \$10 generic; \$30 brand; \$60 non-formulary	Covered for emergencies only — copay applies	\$5 generic; \$15 brand; \$30 non-formulary Mail order (90-day supply): \$10 generic; \$30 brand; \$60 non-formulary	\$5 generic; \$15 brand; \$30 non-formulary Mail order (90-day supply): \$10 generic; \$30 brand; \$60 non-formulary	Covered for emergencies only — copay applies	\$5 copay for generic \$15 copay for brand Mail order (90-day supply): \$5 copay for generic \$5 copay for brand	\$5 copay for generic \$15 copay for brand (plus 50% of covered expenses)	\$5 copay for generic \$15 copay for brand Mail order (90-day supply): \$5 copay for generic \$5 copay for brand	\$10 copay for generic; \$20 copay for brand (when generic unavailable); \$30 copay for brand plus cost above generic allowance (when generic available)
	(non-formulary must be preapproved by Blue Shield)			(non-formulary must be preapproved by Blue Shield)						
<b>Surgery</b>	100% (outpatient \$75 copay)	80% after deductible	70% of allowable amount (after deductible) Outpatient: up to \$360 carrier max/day	100% (outpatient \$50 copay)	90% after deductible	70% of allowable amount (after deductible) Outpatient: up to \$360 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible <sup>2</sup>
<b>X-Ray &amp; Lab Tests</b>	100%	80% after deductible	70% of allowable amount (after deductible)	100%	90% after deductible	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	100%	90% after deductible (other than periodic health exams) <sup>2</sup>
<b>MENTAL HEALTH CARE</b>										
<b>Mental Health Outpatient</b>	100% after \$10 copay	100% after \$10 copay	70% of allowable amount (after deductible)	100% after \$10 copay	100% after \$10 copay	70% of allowable amount (after deductible)	90% after deductible	70% after deductible (non-emergency), 90% after deductible (emergency only)	\$10 copay/visit	90% after deductible <sup>2</sup>
	Provided by Magellan. Must be arranged through MHSA			Provided by Magellan. Must be arranged through MHSA			Provided by The Holman Group (Mental Health and Substance Abuse combined)			
<b>Mental Health Inpatient</b>	100%	100%	70% of allowable amount (after deductible), up to \$360 carrier max/day	100%	100%	70% of allowable amount (after deductible), up to \$360 carrier max/day	90% after deductible	70% after deductible (non-emergency), 90% after deductible (emergency only)	100%	90% after deductible <sup>2</sup>
	Provided by Magellan. Must be arranged through MHSA			Provided by Magellan. Must be arranged through MHSA			Provided by The Holman Group (Mental Health and Substance Abuse combined)			
<b>OTHER PLAN BENEFITS</b>										
<b>Chiropractic Care</b>	100% after \$15 copay	100% after \$15 copay	Not covered	100% after \$10 copay	100% after \$10 copay	Not covered	90% after deductible	70% after deductible	\$10 copay (up to 20 visits/calendar year)	90% after deductible <sup>2</sup> (up to 30 total visits/calendar year; combined limit for chiropractic and acupuncture)
	Includes acupuncture; unlimited/calendar year (based on medical necessity); Provided through American Specialty Health Plans			Includes acupuncture; unlimited/calendar year (based on medical necessity); Provided through American Specialty Health Plans						
<b>Home Health Care</b>	100% after \$10 copay	80% after deductible	70% of allowable amount (after deductible)	100% after \$10 copay	90% after deductible	70% of allowable amount (after deductible)	90% after deductible (up to 100 combined visits/calendar year)	70% after deductible (up to 100 combined visits/calendar year)	\$10 copay (up to 4 hrs/day max)	90% after deductible (maximum 100 visits/calendar year)
	(up to 100 combined visits/calendar year)			(up to 100 combined visits/calendar year)						
<b>Hospice Care</b>	100% when provided by authorized hospice agency			100% when provided by authorized hospice agency			90% after deductible	70% after deductible	100%	90% after deductible (\$2,000 lifetime max)
<b>Physical Therapy</b>	100% after \$10 copay	80% after deductible	70% of allowable amount (after deductible)	100% after \$10 copay	90% after deductible	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	\$10 copay (up to 60 days/illness or injury)	90% after deductible (30 visits/calendar year)
<b>Skilled Nursing Facility</b>	100%	80% after deductible	70% of allowable amount (after deductible)	100%	90% after deductible	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	100% (up to 100 days/calendar year)	90% after deductible <sup>2</sup>
	(up to 100 combined days/calendar year)			(up to 100 combined days/calendar year)						
<b>Vision Care</b>	Child eye exam at 100% through Blue Shield (under age 18). Through VSP — employees and dependents — one eye exam every 12 months after \$10 copay; \$10 material copay for standard lenses, frames up to \$120, or contacts (no copay) up to \$120 (+ up to \$60 fitting exam) every 12 months.	Child eye exam 100% through Blue Shield (under age 18). Through VSP — employees and dependents — one eye exam every 12 months after \$10 copay; \$10 material copay for standard lenses, frames up to \$120, or contacts (no copay) up to \$120 (+ up to \$60 fitting exam) every 12 months.	Child eye exam 100% through Blue Shield (under age 18). Through Non-VSP providers — employees and dependents — reimbursements up to \$45 for exam, from \$30-\$65 for lenses, up to \$70 for frames, up to \$105 for contacts every 12 months.	Child eye exam at 100% through Blue Shield (under age 18). Through VSP — employees and dependents — one eye exam every 12 months after \$10 copay; \$10 material copay for standard lenses, frames up to \$120, or contacts (no copay) up to \$120 (+ up to \$60 fitting exam) every 12 months.	Child eye exam 100% through Blue Shield (under age 18). Through VSP — employees and dependents — one eye exam every 12 months after \$10 copay; \$10 material copay for standard lenses, frames up to \$120, or contacts (no copay) up to \$120 (+ up to \$60 fitting exam) every 12 months.	Child eye exam 100% through Blue Shield (under age 18). Through Non-VSP providers — employees and dependents — reimbursements up to \$45 for exam, from \$30-\$65 for lenses, up to \$70 for frames, up to \$105 for contacts every 12 months.	PPO in-network and HMO — Exams, lenses, frames and contacts are covered through VSP; 100% annual eye exam and lenses every 24 months; \$120 allowance for frames or contacts every 24 months; 90% after deductible up to \$1,500/eye for radial keratotomy	PPO out-of-network — For non VSP providers, up to \$50 reimbursement for annual eye exam; Up to \$50 reimbursement for single lenses every 24 months. Up to \$70 reimbursement for frames every 24 months; Up to \$105 reimbursement for elective contacts every 24 months; 70% after deductible up to \$1,500/eye for radial keratotomy	PPO in-network and HMO — Exams, lenses, frames and contacts are covered through VSP; 100% annual eye exam and lenses every 24 months; \$120 allowance for frames or contacts every 24 months	Exams, lenses, frames or contacts covered through VSP. See medical plan SPD for details. LASIK benefit 90% after deductible; up to \$1,500/eye

This comparison chart provides a general overview of the *Choices* benefits medical and dental plans. It is provided for your convenience and is not intended to be detailed or comprehensive. Additional details about your benefits are available in other official plan documents, including official summary plan descriptions (SPD). To request a copy of an official plan document, contact the plan's Customer Service department directly.

Should you note any difference between what you read in this comparison chart and an official plan document, the official plan document will rule.

<sup>1</sup> The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans offer full dental coverage; the Basic plans do not.

<sup>2</sup> For out-of-network care, the plan pays 70% after deductible. Refer to the Local 1014 Medical Plan Summary Plan Description (SPD) for a complete description of plan benefits.

<sup>†</sup> Sworn Peace Officers eligible to be members of ALADS (Bargaining Unit 611) — or employees in Bargaining Units 612, 614, 621, 631, 632, 641, and 642 — who do not waive or enroll in medical coverage, or whose medical coverage information is not approved, will be automatically enrolled in the ALADS/Anthem Blue Cross CaliforniaCare HMO.