Dental Plans Comparison Chart

	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PLAN PPO		
			PREFERRED PROVIDER OPTION (PPO)	DELTA PARTICIPATING DENTIST IN-NETWORK	OUT-OF-NETWORK
Type of Plan	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers two provider networks and out-of-network benefits		
Annual Deductible	None	None	None	$50/person; $150/family	$50/person; $150/family
Annual Maximum Benefit	None	None	$1,750/person (all care must be in PPO network)	$1,500/person	$1,500/person
TYPE OF SERVICES PREVENTIVE CARE					
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two per calendar year)	80% (no deductible on first two cleanings per calendar year)	80% of R&C (no deductible on first two cleaning per calendar year)
Exam	100%	100%	100% (two per calendar year)	80% (two per calendar year)	80% of R&C (two per calendar year)
Full Mouth X-Rays	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)
BASIC SERVICES					
Emergency Treatment	$5 copay	$5 copay	100%	80%	80% of R&C
Extractions	100% (except $50 copay for bony impactions)	100% (except $50 copay for bony impactions)	85%	80%	80% of R&C
Fillings	100%	100%	85%	80%	80% of R&C
General Anesthesia	$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
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	85%	80%	80% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	85%	80%	80% of R&C
MAJOR SERVICES					
Bridges	$60 copay/unit	$60 copay/unit	50% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Crowns	$60 copay/crown	$60 copay/crown	85% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Dentures	$70 copay/complete upper or lower denture	$70 copay/denture	50% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Orthodontia	$1,000 copay + $150 start-up fees	$1,150 copay + $350 start-up fees	50% ($1,200 lifetime maximum)	50% ($1,200 lifetime maximum)	50% ($1,200 lifetime maximum)
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered

Contact Information

Contact	Phone Number	Fax Number	Website
BENEFITS SYSTEM			
Benefits Enrollment	888-822-0487	310-788-8775	www.mylacountybenefits.com
COUNTY DEPARTMENT OF HUMAN RESOURCES			
Benefits Hotline	213-388-9982	N/A	http://employee.hr.lacounty.gov
MEDICAL			
Kaiser Permanente HMO	800-464-4000	N/A	www.kp.org/countyofla
Anthem Blue Cross	844-730-1931	N/A	www.anthem.com/ca/countyoflosangeles
DENTAL			
MetLife (SafeGuard)	800-880-1800	N/A	www.safeguard.net
DeltaCare	800-422-4234	N/A	www.deltadentalins.com
Delta Dental	888-335-8227	N/A	www.deltadentalins.com
SPENDING ACCOUNTS			
Benefit Concepts, Inc.	866-629-6436	866-629-6390	www.mylacountybenefits.com
LIFE			
MetLife	800-846-0124	N/A	www.mylacountybenefits.com Click on the MetLife link
AD&D			
CIGNA Life	800-842-6635	N/A	N/A

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2017
medical and dental plans comparison chart

What's Inside

This comparison chart provides you with an overview of your *Flex* medical and dental plans. It's been designed to help you choose the plans that are right for you and your family — either during annual enrollment or as a new hire — and also for future reference.

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

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 *Flex* benefit plans is also available online 24 hours a day, seven days a week using **mylacountybenefits.com**.

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 available 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.

This comparison chart provides a general overview of the *Flex* 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. See back page for plan contact information.

2017 *Flex* Medical and Dental Plans Comparison Chart

Medical Plans Comparison Chart

	KAISER PERMANENTE HMO	ANTHEM BLUE CROSS HMO	ANTHEM BLUE CROSS PLUS POS			ANTHEM BLUE CROSS PRUDENT BUYER PPO		ANTHEM BLUE CROSS CATASTROPHIC
			TIER 1—HMO	TIER 2—IN-NETWORK	TIER 3—OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible	None	None	None	None	$400/person; $800/family plus $500 deductible for each hospital and ambulatory surgical center admission	$150/person up to a maximum of $400/family	$400/person up to a maximum of $800/family	$2,000/person $4,000/family
Annual Out-of-Pocket Maximum	$1,500/person $3,000/family	$1,000/employee $2,000/employee+1 dependent $3,000/family	$1,500/person $3,000/family	$3,000/person, $9,000/family combined for Tiers 2 and 3		$1,000/person $2,000/family	$3,600/person $7,200/family	$6,600/person; $13,200/family $15,000/person; $45,000/family (out-of-network PPO providers)
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited		Unlimited
PREVENTIVE CARE								**PREVENTIVE CARE**
Immunizations	No charge	No charge	No charge	No charge	No charge	No charge	Up to $12 (out-of-network provider only)	No charge
Periodic Health Evaluations	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
MEDICALLY NECESSARY CARE								**MEDICALLY NECESSARY CARE**
Ambulance	No charge if deemed medically necessary	No charge	No charge	80%	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Doctor Office Visit	$15 copay/visit; no charge/pediatric visit to age 5	$15 copay/visit; no charge/pediatric visit to age 5	$15 copay/visit; no charge/pediatric visit to age 5	$25 copay/visit; no charge/pediatric visit to age 5	70% after deductible	$15 copay (no deductible); no charge/pediatric visit to age 5	70% after deductible	75% after deductible
Emergency Care	$50 copay (waived if admitted)	$50 copay/visit (waived if admitted)	$50 copay (waived if admitted immediately)	$50 copay (waived if admitted immediately)	$50 copay (waived if admitted immediately)	$50 copay (waived if admitted) then 90% after deductible	$50 copay (waived if admitted) then 90% after deductible	$100 copay/visit (waived if admitted) then 75%
Hospital Care	No charge	No charge	No charge	80%	70% after deductible; plus $500 hospital admission deductible and $500 penalty/admission if not pre-certified; waived if emergency room admission	90% (no deductible)	70% after deductible; plus $500 deductible/admission (waived for emergency admission), $500 penalty/admission if not pre-certified	75% after deductible; plus $500 hospital admission deductible and $500 penalty/admission if not pre-certified (out-of-network provider only); waived if emergency room admission
Maternity	$10 copay for visit to office to confirm pregnancy; no charge thereafter	$15 copay/office visit Delivery no charge	$15 copay/office visit Delivery no charge	$25 copay/office visit, delivery 80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible
Surgery	Inpatient: no charge Outpatient: $15 copay	No charge	No charge	80%	70% after deductible; plus $500 ambulatory surgical center admission deductible and $500 penalty/admission if not pre-certified; waived if emergency room admission	90% after deductible	70% after deductible	75% after deductible; plus $500 ambulatory surgical center admission deductible and $500 penalty/admission if not pre-certified (out-of-network provider only); waived if emergency room admission
X-Ray & Lab	No charge for services at a Kaiser facility	No charge	No charge	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible
Prescription Drug	$10 copay generic; $20 copay brand name (for up to a 100-day supply of each medication prescribed by Kaiser physician or any dentist and filled at a Kaiser pharmacy)	$10 copay generic $20 copay brand name	$10 copay generic $20 copay brand name	$10 copay generic $20 copay brand name	$10 copay generic $20 copay brand name	$10 copay generic $20 copay brand name	$10 copay generic $20 copay brand name	75% (after separate $200 annual deductible)
MENTAL HEALTH CARE								**MENTAL HEALTH CARE**
Mental Health Outpatient	$15 copay per individual visit or $7 copay per group visit	$15 copay/visit	$15 copay/visit	$25 copay/visit	70% after deductible	$15 copay/visit	70% after deductible	75% after deductible
Mental Health Inpatient	No charge	No charge	No charge	80%	70% after deductible, plus $500 hospital admission deductible and $500 penalty/admission if not pre-certified; waived if emergency room admission	90% (no deductible)	70% after deductible, plus $500 hospital admission deductible and $500 penalty/admission if not pre-certified; waived if emergency room admission	75% after deductible, plus $500 hospital admission deductible and $500 penalty/admission if not pre-certified; waived if emergency room admission
OTHER PLAN BENEFITS								**OTHER PLAN BENEFITS**
Chiropractic Care	Not covered	$15 copay/visit (60 consecutive days/illness or injury combined with physical therapy)	$15 copay/visit	80%	70% after deductible	90% after deductible; maximum 15 visits/calendar year	70% after deductible; maximum 15 visits/calendar year	Covered as part of physical therapy, see below
			60 consecutive days/illness or injury combined with physical therapy (combined Tiers 1, 2, and 3)					
Home Health Care	No charge if within Kaiser service area (up to 100 visits per calendar year)	$15 copay/visit	No charge	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible (up to 100 visits/calendar year)
			up to 100 visits/calendar year (combined for Tiers 1, 2, and 3)			(100 visits/calendar year combined maximum)		
Hospice Care	No charge at an authorized facility	No charge	No charge	80%	80% after deductible	80% after deductible	80% after deductible	75% after deductible
Physical Therapy	$15 copay/visit	$15 copay/visit (up to 60 consecutive days/illness or injury; combined with chiropractic care)	$15 copay/visit	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible
			60 consecutive days/illness or injury combined with chiropractic care (combined for Tiers 1, 2, and 3)					
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	No charge (up to 100 days/calendar year)	No charge	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible (up to 100 days/calendar year)
			(up to 100 days/calendar year combined for Tiers 1, 2, and 3)			(100 days/calendar year combined maximum)		
Vision Care	No charge for eye exam at a Kaiser facility; $250 allowance every 24 months for eyeglass lenses, frames, and contacts at a Kaiser facility	VSP vision benefits: $15 copay for eye exam every 12 months; $15 copay for lenses (1 pair every 12 months); $15 copay for frames every 12 months ($100 maximum benefit); up to $1,500 benefit (lifetime max) for both eyes for Lasik surgery	VSP vision benefits: $15 copay for eye exam every 12 months; $15 copay for lenses (1 pair every 12 months); $15 copay for frames every 12 months ($100 maximum benefit); up to $1,500 benefit (lifetime max) for both eyes for Lasik surgery	VSP vision benefits: $15 copay for eye exam every 12 months; $15 copay for lenses (1 pair every 12 months); $15 copay for frames every 12 months ($100 maximum benefit); up to $1,500 benefit (lifetime max) for both eyes for Lasik surgery	Coverage limited to reimbursement provided under VSP out-of-network schedule	VSP vision benefits: $15 copay for eye exam every 12 months; $15 copay for lenses (1 pair every 12 months); $15 copay for frames every 12 months ($100 maximum benefit); up to $1,500 benefit (lifetime max) for both eyes for Lasik surgery	Coverage limited to reimbursement provided under VSP out-of-network schedule	Not covered

The Affordable Care Act requires that a Summary of Benefits and Coverage (SBC) for each medial 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 *Flex* may be downloaded at 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 that the Kaiser Permanente HMO and Anthem Blue Cross Prudent Buyer PPO medical 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.**