Dental Plans Comparison Chart

	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PPO PLAN		
			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	$1,750/person	$1,750/person
COVERED SERVICES PREVENTIVE CARE					
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two per calendar year)	85% of covered charges (no deductible on first two cleanings per calendar year)	85% of R&C (no deductible on first two cleanings per calendar year)
Exam	100%	100%	100% (two per calendar year)	85% of covered charges (two per calendar year)	85% 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)	85% of covered charges (one every five years)	85% of R&C (one every five years)
BASIC SERVICES					
Emergency Treatment	$5 copay	$5 copay	100% of covered charges	85% of covered charges	85% of R&C
Extractions	100% (except $50 copay for bony impactions)	100% (except $50 copay for bony impactions)	85% of covered charges	85% of covered charges	85% of R&C
Fillings	100%	100%	85% of covered charges	85% of covered charges	85% of R&C
General Anesthesia	$30 copay for medically necessary extractions only (first 30 minutes)	$30 copay for medically necessary extractions only	85% of covered charges for oral surgery only	85% of covered charges for oral surgery only	85% of R&C for oral surgery only
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	85% of covered charges	85% of covered charges	85% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	85% of covered charges	85% of covered charges	85% of R&C
MAJOR SERVICES					
Bridges	$60 copay/unit	$60 copay/unit	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)
Crowns	$60 copay/crown	$60 copay/crown	85% (once every five years)	85% (once every five years)	85% of R&C (once every five years)
Dentures	$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)
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			
UnitedHealthcare HMO	800-367-2660	N/A	www.healthyatcola.com
UnitedHealthcare Select Plus PPO	800-367-2660	N/A	www.healthyatcola.com
Kaiser Permanente	800-464-4000	N/A	www.kp.org/countyofla
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 AND AD&D			
CIGNA Life	800-842-6635	N/A	N/A

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options

2017

medical and dental plans comparison chart

What's Inside

This benefits comparison chart provides you with an overview of your *Options* 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 *Options* 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 *Options* benefits 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 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 *Options* 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 *Options* Medical and Dental Plans Comparison Chart

Medical Plans Comparison Chart

	KAISER PERMANENTE HMO	UNITEDHEALTHCARE HMO	UNITEDHEALTHCARE SELECT PLUS PPO	
			IN-NETWORK	OUT-OF-NETWORK
Type of Plan	A group model HMO with its own hospitals, outpatient facilities, staff physicians, nurses and other health care professionals	An HMO that contracts with private hospitals, medical groups and individual private practice physicians for services at negotiated rates	A medical plan that allows you to choose an in-network PPO provider or an out-of-network provider each time you need care	
Annual Deductible	None	None	$300/person $1,500/family	$1,500/person $3,000/family
Annual Out-of-Pocket Maximum	$1,500/person $3,000/family	$1,000/person $2,000/family Includes copayments (including behavioral health and prescription drugs)	$5,000/person $13,700/family	$15,000/person $45,000/family
			Includes deductible, coinsurance and copayments (including behavioral health and prescription drugs) for both in- and out-of-network charges	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	
PREVENTIVE CARE				**PREVENTIVE CARE**
Immunizations	No charge	No charge	No charge	No charge for covered amounts
Periodic Health Evaluations	No charge	No charge	No charge	No charge for covered amounts
MEDICALLY NECESSARY CARE				**MEDICALLY NECESSARY CARE**
Ambulance	No charge if medically necessary	No charge if medically necessary	20% copay after deductible	20% copay after deductible
Doctor Office Visit	$10 copay/visit; no charge pediatric visit to age 5	$10 copay/visit; no charge pediatric visit to age 5	20% copay, no deductible	50% copay after deductible
Emergency Room	$50 copay; waived if admitted (see plan booklet for a description of emergency services)	$50 copay (waived if admitted)	20% copay after deductible	20% copay after deductible (50% if admitted)
Hospital Care	No charge	No charge	20% copay after deductible	50% copay after deductible
Maternity	$10 copay for office visit to confirm pregnancy; no charge thereafter	No charge	20% copay after deductible	50% copay after deductible
Prescription Drugs	$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)	Pharmacy: $5 copay generic; $20 copay brand name (30-day supply) Mail order: $10 copay generic; $40 copay brand name (90-day supply) Sexual dysfunction drugs: 50% copay (limitations apply)	Pharmacy: $5 copay Tier 1; $20 copay Tier 2; $35 copay Tier 3 (31-day supply) Mail order: $10 copay Tier 1; $40 copay Tier 2; $70 copay Tier 3 (90-day supply). Sexual dysfunction drugs: 50% copay (limitations apply)	Not covered
Surgery	Inpatient: No charge Outpatient: $10 copay	No charge	20% copay after deductible	50% copay after deductible
X-Ray & Lab Tests	No charge	No charge	20% copay, no deductible	50% copay, no deductible
MENTAL HEALTH CARE				**MENTAL HEALTH CARE**
Hospital Outpatient Care	$10 copay per individual visit/ $5 copay per group visit	$10 copay/visit	20% copay after deductible for covered charges	50% copay after deductible for covered charges
Hospital Inpatient Care	No charge	No charge	20% copay after deductible	50% copay after deductible
OTHER PLAN BENEFITS				**OTHER PLAN BENEFITS**
Home Health Care	No charge within Kaiser area (up to 2 hours/visit; 3 visits/day; 100 visits/calendar year)	$10 copay	20% copay/visit after deductible	50% copay after deductible preauthorization required
			(up to 100 visits/calendar year; combined in- and out-of-network)	
Hospice Care	No charge	No charge	20% copay after deductible	50% copay after deductible
Physical Therapy	$10 copay/visit	$10 copay/visit	20% copay, no deductible	Not covered
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	No charge (up to 100 days/condition)	20% copay after deductible	50% copay after deductible
			(up to 30 days; combined in- and out-of-network)	
Vision Care	No charge for refraction exam; does not cover glasses	$10 copay for eye exam (1 every 12 months) $10 copay for lenses and frames (1 pair every 24 months)	$10 copay for eye exam (1 every 12 months) $10 copay for lenses & frames (1 pair every 24 months), no deductible	Coverage limited to reimbursement provided under VSP out-of-network schedule

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 (Cafeteria Plan Name) 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 the Kaiser Permanente HMO plan is a "grandfathered health plan" 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.**