What's Inside

This comparison chart provides you with an overview of your *Choices* medical and dental plans. Use this chart to compare the features and services offered by the different plans. It's designed to help you choose the right plans for you and your family during your annual enrollment, or as a new hire, and also for future reference throughout 2018.

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

Remember, information about your *Choices* benefits plans is also available online 24 hours a day, seven days a week using **mylacountybenefits.com**.

Dental Plans Comparison Chart

	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PPO PLAN			ALADS/BLUE CROSS PREMIER PPO PLANS[1]	
			PREFERRED PROVIDER OPTION (PPO)	DELTA PARTICIPATING DENTIST IN-NETWORK	OUT-OF-NETWORK[2]	IN-NETWORK	OUT-OF-NETWORK[2]
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			An indemnity plan with PPO incentive, offering in- and out-of-network benefits	
Annual Deductible	None	None	None	$50/person; $150/family	$50/person; $150/family	$50/person; $150/family	
Annual Maximum Benefit	None	None	$1,500/person (all care must be from PPO network)	$1,200/person	$1,200/person	$1,750/person	
PREVENTIVE CARE							
Cleaning	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)
Exam	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
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)	100%; no deductible (one every 36 months)	100% of R&C; no deductible (one every 36 months)
BASIC SERVICES							
Emergency Treatment	$5 copay	$5 copay	100%	80%	80% of R&C	Covered as regular treatment	Covered as regular treatment
Extractions	100% (except $50 copay for bony extractions)	100%	85%	80%	80% of R&C	90%	85% of R&C
Fillings	100%	100%	85%	80%	80% of R&C	90%	85% 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	90%	85% of R&C
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	85%	80%	80% of R&C	60%	50% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	85%	80%	80% of R&C	90%	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)	60% (once every five years)	50% of R&C (once every five years)
Crowns	$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)
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)	60% (once every five years)	50% of R&C (once every five years)
Orthodontia[3]	$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.	
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

[1] The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans provide the dental coverage listed on this chart.
[2] 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.
[3] 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
BENEFIT SYSTEM			
Benefit 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			
Cigna	800-842-6635	N/A	www.cigna.com
Kaiser Permanente	800-464-4000	N/A	www.kp.org/countyofla
ALADS/Anthem Blue Cross (HMO)	800-842-6635	N/A	www.anthem.com/ca/alads
ALADS/Anthem Blue Cross (PPO)	800-842-6635	N/A	www.anthem.com/ca/alads
CAPE/Blue Shield	800-487-3092	N/A	www.blueshieldca.com/cape
Fire Fighters Local 1014	800-660-1014	N/A	www.local1014medical.org
DENTAL			
MetLife (SafeGuard) HMO	800-880-1800	N/A	www.safeguard.net
DeltaCare HMO	800-422-4234	N/A	www.deltadentalins.com
Delta Dental PPO	888-335-8227	N/A	www.deltadentalins.com
ALADS/Blue Cross (dental)	800-842-6635	N/A	www.anthem.com/ca/alads
SPENDING ACCOUNTS			
Benefit Concepts, Inc.	866-629-6436	866-629-6390	www.mylacountybenefits.com
LIFE AND AD&D INSURANCE			
Cigna Life	800-842-6635	N/A	N/A

Is This Covered?

This comparison chart provides a general overview of the *Choices* medical and dental plans, but it is not comprehensive. Review the Evidence of Coverage document on each plan's website for details. For more information, or to request a copy of the document, contact the plan's customer service department. See below for contact information.

we are the county of
los angeles

choices

2018

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
Annual Deductible	None	None	None	$500/person $1,000/family
Annual Out-of-Pocket Maximum	$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
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
PREVENTIVE CARE				**PREVENTIVE CARE**
Immunizations	No charge for most common immunizations	No charge	No charge	60% of R&C after deductible
Periodic Health Evaluations	$10 copay/visit	No charge	No charge	60% of R&C after deductible
MEDICALLY NECESSARY CARE				**MEDICALLY NECESSARY CARE**
Ambulance	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
Doctor Office Visit	$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
Emergency Room	$50 copay; waived if admitted	$50 copay (waived if admitted)	$50 copay/visit (waived if admitted)	$50 copay/visit (waived if admitted)
Hospital Care	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)
Maternity	$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
Prescription Drugs	$5 copay generic and $20 copay brand name for up to 100-day supply ($20 copay specialty drugs for up to 30 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
Surgery	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)
X-Ray & Lab Tests	No charge	100% at a contracted provider	100% at a contracted provider	60% of R&C after deductible
MENTAL HEALTH CARE				**MENTAL HEALTH CARE**
Mental Health Outpatient	$10 copay per individual visit/$5 copay per group visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
Mental Health Inpatient	No charge	100%	$50 copay/day (up to $200/calendar year)	$1,000 deductible per admission plus 60% of R&C after deductible
OTHER PLAN BENEFITS				**OTHER PLAN BENEFITS**
Chiropractic Care	$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)
Home Health Care	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)
Hospice Care	No charge	100%	100%	100% of R&C after deductible
Physical Therapy	$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible (up to 60 days/condition)
Skilled Nursing Facility	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)
Vision Care	$10 copay for routine 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. 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.**

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

330 This chart is printed on recycled paper to support the County's commitment to the environment.

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[1†]		ALADS/ANTHEM BLUE CROSS CALIFORNIACARE BASIC AND PREMIER PLANS[1]	FIRE FIGHTERS LOCAL 1014 MEDICAL PLAN
	HMO	IN-NETWORK	OUT-OF-NETWORK	HMO	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK		
Annual Deductible	None	$400/person; $800/family		None	$300/person; $600/family		$300/person; $900/family	$300/person; $900/family	None	$200/person; $600/family
Annual Out-Of-Pocket Maximum	$1,500/person; $3,000/family	After deductible, $4,000/person; $8,000/family (combined in- and out-of-network)	After deductible, $6,000/person; $12,000/family	$1,500/person; $3,000/family	After deductible, $4,000/person; $8,000/family (combined in- and out-of-network)	After deductible, $6,000/person; $12,000/family	$450/person; $1,350/family	$6,000/person; $18,000/family	$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
Lifetime Maximum Benefit	Unlimited	Unlimited		Unlimited	Unlimited		Unlimited		Unlimited	Unlimited
PREVENTIVE CARE										**PREVENTIVE CARE**
Immunizations	100%	100%	100%	100%	100%	100%	100%	70%	100%	100%
Periodic Health Evaluations	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)	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
MEDICALLY NECESSARY CARE										**MEDICALLY NECESSARY CARE**
Ambulance	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[2]
Doctor Office Visit	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[2]
Emergency Room	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)
Hospital Care	100%	80% after deductible	70% of allowable amount (after deductible), up to $600 carrier max/day	100%	90% after deductible	70% of allowable amount (after deductible), up to $600 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[2]
Maternity	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[2]
Prescription Drugs	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary (non-formulary must be preapproved by Blue Shield)	$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 (non-formulary must be preapproved by Blue Shield)	$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)
Surgery	100% (outpatient $75 copay)	80% after deductible	70% of allowable amount (after deductible) Outpatient: up to $600 carrier max/day	100% (outpatient $50 copay)	90% after deductible	70% of allowable amount (after deductible) Outpatient: up to $600 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[2]
X-Ray & Lab Tests	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)[2]
MENTAL HEALTH CARE										**MENTAL HEALTH CARE**
Mental Health Outpatient	100% after $10 copay Provided by Magellan. Must be arranged through MHSA	100% after $10 copay	70% of allowable amount (after deductible)	100% after $10 copay Provided by Magellan. Must be arranged through MHSA	100% after $10 copay	70% of allowable amount (after deductible)	90% after deductible Provided by The Holman Group (Mental Health and Substance Abuse combined)	70% after deductible (non-emergency), 90% after deductible (emergency only)	$10 copay/visit	90% after deductible[2]
Mental Health Inpatient	100% Provided by Magellan. Must be arranged through MHSA	100%	70% of allowable amount (after deductible), up to $600 carrier max/day	100% Provided by Magellan. Must be arranged through MHSA	100%	70% of allowable amount (after deductible), up to $600 carrier max/day	90% after deductible Provided by The Holman Group (Mental Health and Substance Abuse combined)	70% after deductible (non-emergency), 90% after deductible (emergency only)	100%	90% after deductible[2]
OTHER PLAN BENEFITS										**OTHER PLAN BENEFITS**
Chiropractic Care	100% after $15 copay Includes acupuncture; unlimited/calender year (based on medical necessity); Provided through American Specialty Health Plans	100% after $15 copay	Not covered	100% after $10 copay Includes acupuncture; unlimited/calender year (based on medical necessity); Provided through American Specialty Health Plans	100% after $10 copay	Not covered	90% after deductible	70% after deductible	$10 copay (up to 35 visits/calendar year)	90% after deductible[2] (up to 30 total visits/calendar year; combined limit for chiropractic and acupuncture)
Home Health Care	100% after $10 copay (up to 100 combined visits/calendar year)	80% after deductible	70% of allowable amount (after deductible)	100% after $10 copay (up to 100 combined visits/calendar year)	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)
Hospice Care	100% when provided by authorized hospice agency			100% when provided by authorized hospice agency			90% after deductible	70% after deductible	100%	90% after deductible ($20,000 lifetime max)
Physical Therapy	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)
Skilled Nursing Facility	100% (up to 100 combined days/calendar year)	80% after deductible	70% of allowable amount (after deductible)	100% (up to 100 combined days/calendar year)	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[2]
Vision Care	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 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 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 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 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; up to $1,500/ eye for radial keratotomy	Exams, lenses, frames or contacts covered through VSP. See medical plan SPD for details. LASIK benefit 90% after deductible; up to $1,500/eye

Indicates plan change

[1] The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans offer full dental coverage; the Basic plans do not.

[2] 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.

† 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.