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 cleanings 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	Group Numbers	Website
BENEFITS SYSTEM				
Benefits Enrollment	888-822-0487	310-788-8775	N/A	www.mylacountybenefits.com
COUNTY DEPARTMENT OF HUMAN RESOURCES				
Benefits Hotline	213-388-9982	N/A	N/A	http://employee.hr.lacounty.gov
MEDICAL				
Kaiser Permanente HMO	800-464-4000	N/A	101000-3	www.kp.org/countyofla
Anthem Blue Cross	844-730-1931	N/A	HMO: 56089A POS: 56061A PPO: 1284EH Catastrophic: 1313GD	www.anthem.com/ca/countyoflosangeles
DENTAL				
MetLife (SafeGuard) HMO	800-880-1800	N/A	70334	www.safeguard.net
DeltaCare HMO	800-422-4234	N/A	70831-00003	www.deltadentalins.com
Delta Dental PPO	888-335-8227	N/A	4915-10002	www.deltadentalins.com
SPENDING ACCOUNTS				
WageWorks	877-924-3967	877-353-9236	N/A	www.mylacountybenefits.com Click on Spending Accounts
LIFE INSURANCE				
MetLife	800-846-0124	N/A	N/A	www.mylacountybenefits.com Click on the MetLife link
AD&D AND BASIC LIFE INSURANCE				
Cigna Life	800-842-6635	N/A	Life: FLI52070 AD&D: OK819451	N/A

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2019
medical and dental plans comparison chart

What's Inside

This comparison chart provides you with an overview of your *Flex* 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, and also for future reference throughout 2019.

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.

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

Department of Health Services Specialty Access
As a County employee enrolled in the Anthem PPO or POS medical plans, you have the opportunity to choose the Department of Health Services as a specialty provider and access their facilities Countywide. Specialty services include women's services, pediatrics, and rehabilitation services. For more information, call 1-888-DHS-1222.

Is This Covered?

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

2019 *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 $450/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	No charge	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	$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	$15 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 and $20 copay brand name for up to a 100-day supply; ($20 copay specialty drugs for up to 30 day supply) of each medication prescribed by Kaiser physician or any dentist and filled at a Kaiser pharmacy; sexual dysfunction drugs: 50% copay (limitations apply)	$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 60 consecutive days/illness or injury combined with physical therapy (combined Tiers 1, 2, and 3)	80%	70% after deductible	90% after deductible; maximum 15 visits/calendar year	70% after deductible; maximum 15 visits/calendar year	75% after deductible (up to 30 visits/calendar year)
Home Health Care	No charge if within Kaiser service area (up to 100 visits per calendar year)	$15 copay/visit	No charge up to 100 visits/calendar year (combined for Tiers 1, 2, and 3)	80%	70% after deductible	90% after deductible (100 visits/calendar year combined maximum)	70% after deductible	75% after deductible (up to 100 visits/calendar year)
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 60 consecutive days/illness or injury combined with chiropractic care (combined for Tiers 1, 2, and 3)	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	No charge (up to 100 days/calendar year)	No charge (up to 100 days/calendar year combined for Tiers 1, 2, and 3)	80%	70% after deductible	90% after deductible (100 days/calendar year combined maximum)	70% after deductible	75% after deductible (up to 100 days/calendar year)
Vision Care	No charge for routine 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 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 *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.

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

Indicates plan change