What You Pay Under the Dental Plans

	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PPO PLAN		
			PREFERRED PROVIDER OPTION (PPO)	DELTA PARTICIPATING DENTIST IN-NETWORK	OUT-OF-NETWORK[1]
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	No charge (two every 12 months)	No charge (two every 12 months)	No charge (two per calendar year)	15% coinsurance (no deductible on first two cleanings per calendar year)	15% of R&C (no deductible on first two cleanings per calendar year)
Exam	No charge	No charge	No charge (two per calendar year)	15% coinsurance (two per calendar year)	15% of R&C (two per calendar year)
Full Mouth X-Rays	No charge (one every 24 months)	No charge (one every 24 months)	No charge (one every five years)	15% coinsurance (one every five years)	15% of R&C (one every five years)
BASIC SERVICES					
Emergency Treatment	$5 copay	$5 copay	No charge	15% coinsurance	15% of R&C
Extractions	No charge (except $50 copay for bony impactions)	No charge (except $50 copay for bony impactions)	15% coinsurance	15% coinsurance	15% of R&C
Fillings	No charge	No charge	15% coinsurance	15% coinsurance	15% of R&C
General Anesthesia	$30 copay for medically necessary extractions only (first 30 minutes)	$30 copay for medically necessary extractions only	15% coinsurance for oral surgery only	15% coinsurance for oral surgery only	15% of R&C for oral surgery only
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	15% coinsurance	15% coinsurance	15% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	15% coinsurance	15% coinsurance	15% of R&C
MAJOR SERVICES					
Bridges	$60 copay/unit	$60 copay/unit	50% coinsurance (once every five years)	50% coinsurance (once every five years)	50% of R&C (once every five years)
Crowns	$60 copay/crown	$60 copay/crown	15% coinsurance (once every five years)	15% coinsurance (once every five years)	15% of R&C (once every five years)
Dentures	$70 copay/complete upper or lower denture	$70 copay/denture	50% coinsurance (once every five years)	50% coinsurance (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% coinsurance ($1,200 lifetime maximum)	50% coinsurance ($1,200 lifetime maximum)	50% coinsurance ($1,200 lifetime maximum)
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered

[1] 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.

Contact Information

Contact	Phone Number	Group Number	Website
BENEFITS SYSTEM			
Benefits Enrollment	888-822-0487 Fax: 310-788-8775	N/A	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	HMO 401056	www.healthyatcola.com
UnitedHealthcare Harmony HMO	800-367-2660	HMO 252014	www.healthyatcola.com
UnitedHealthcare Select Plus PPO	800-367-2660	716822-0005	www.healthyatcola.com
Kaiser Permanente HMO	800-464-4000	101000-0	www.kp.org/countyofla
DENTAL			
MetLife (SafeGuard) HMO	800-880-1800	3417	www.safeguard.net
DeltaCare HMO	800-422-4234	70831-00001	www.deltadentalins.com
Delta Dental PPO	888-335-8227	4915-10001	www.deltadentalins.com
SPENDING ACCOUNTS			
WageWorks	877-924-3967 Fax: 877-353-9236	N/A	www.mylacountybenefits.com Click on Spending Accounts
LIFE AND AD&D INSURANCE			
Cigna Life	800-842-6635	Life: FLI52070 AD&D: OK819451	N/A

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2020
medical and dental plans comparison chart

What's Inside

This comparison chart shows what you pay under the *Options* medical and dental plans. Use this chart to compare the plans' features and services. It can help you choose the right plans during annual enrollment, or as a new hire. And, you can reference this chart throughout 2020.

Be sure to review the Enrollment Highlights Guide and other materials you received with this chart. You'll find descriptions of your plan options, including information about premium rates and the *Options* monthly benefits allowance.

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?

This comparison chart offers an overview of the *Options* medical and dental plans, but it is not comprehensive. Review the Evidence of Coverage document on each plan's website for details. To learn more or request a copy of the document, contact the plan's customer service department. See the back page for contact information.

2020 *Options* Medical and Dental Plans Comparison Chart

What You Pay Under the Medical Plans

	KAISER PERMANENTE HMO	UNITEDHEALTHCARE HMO UNITEDHEALTHCARE HARMONY HMO[1]	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% coinsurance	20% coinsurance
Doctor Office Visit	$10 copay/visit	$10 copay/visit; no charge pediatric visit to age 5	20% coinsurance, no deductible	50% coinsurance
Emergency Room	$50 copay; waived if admitted (see plan booklet for a description of emergency services)	$50 copay (waived if admitted)	20% coinsurance	20% coinsurance (50% if admitted)
Hospital Care	No charge	No charge	20% coinsurance	50% coinsurance
Maternity	$10 copay for office visit to confirm pregnancy; no charge thereafter	No charge	20% coinsurance	50% coinsurance
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% coinsurance (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% coinsurance (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% coinsurance (limitations apply)	Not covered
Surgery	Inpatient: No charge Outpatient: $10 copay	No charge	20% coinsurance	50% coinsurance
X-Ray & Lab Tests	No charge	No charge	20% coinsurance, no deductible	50% coinsurance, 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% coinsurance for covered charges	50% coinsurance for covered charges
Hospital Inpatient Care	No charge	No charge	20% coinsurance	50% coinsurance
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% coinsurance/visit	50% coinsurance, preauthorization required
			(up to 100 visits/calendar year; combined in- and out-of-network)	
Hospice Care	No charge	No charge	20% coinsurance	50% coinsurance
Physical Therapy	$10 copay/visit	$10 copay/visit	20% coinsurance, no deductible	Not covered
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	No charge (up to 100 days/condition)	20% coinsurance	50% coinsurance
			(up to 30 days; combined in- and out-of-network)	
Vision Care	At a Kaiser Vision Essentials optical center: No charge for routine eye exams; $150 allowance for frames with lenses (1 pair every 24 months) or contact lenses in lieu of eyeglasses every 12 months; regular eyeglass lenses will be covered at no cost (1 pair every 12 months)	$10 copay for eye exam (1 every 12 months) $10 copay for lenses and frames (1 pair every 24 months) $105 allowance for lenses and frames (1 pair every 24 months)	$10 copay for eye exam (1 every 12 months) $10 copay for lenses and frames (1 pair every 24 months), no deductible	Coverage limited to reimbursement provided under VSP out-of-network schedule

Glossary of Terms

Annual Deductible

The amount you pay out-of-pocket for covered care and services before the plan starts to pay benefits. The deductible amount varies by plan. There is a per person and/or a per family deductible.

Annual Out-of-Pocket Maximum

The total amount you pay for medical care in one plan year. Generally, deductibles, coinsurance and copays count toward the out-of-pocket maximum. When you reach this maximum, the plan will pay 100 percent of your covered costs for the rest of the plan year.

Coinsurance

The percentage of the cost you're responsible for paying after you meet the deductible (if applicable). For example, if the plan pays 80 percent coinsurance for in-network care, you pay 20 percent.

Copay

A flat fee you pay at the time you receive a covered service or product.

Reasonable and Customary Charges

The reasonable and customary (R&C) is the amount a health plan determines is the normal fee for specific health-related care in the area you are seeking services. For out-of-network care, you pay a percentage of R&C, plus any amount the provider charges that's over R&C.

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 *Options* may be downloaded at mylacountybenefits.com. You may request a hard copy by calling the medical plan directly; see back page for contact information.

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

[1] **New for 2020:** The UnitedHealthcare (UHC) Harmony HMO. This plan has a smaller network of doctors, specialists, and facilities than the UHC HMO. Similar to the UHC HMO, you must get all care from providers in your chosen network, except for urgent care and emergencies. Before you enroll, make sure the network you select includes your preferred providers and facilities. If you enroll in this plan, you must choose a provider group based on where you live or work: • LA County: AppleCare Medical Group, HealthCare Partners, or Physicians Associates IPA • Orange County: HealthCare Partners or Monarch HealthCare • Riverside County: Empire Physicians Medical Group Inc., PrimeCare, or Valley Physicians Network • San Bernardino County: PrimeCare.

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