What You Pay Under the Dental Plans

	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PLAN PPO		
			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 (all care must be in PPO network)	$1,500/person	$1,500/person
PREVENTIVE CARE					
Cleaning	No charge (two every 12 months)	No charge (two every 12 months)	No charge (two per calendar year)	20% coinsurance (no deductible on first two cleanings per calendar year)	20% of R&C (no deductible on first two cleanings per calendar year)
Exam	No charge	No charge	No charge (two per calendar year)	20% coinsurance (two per calendar year)	20% 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)	20% coinsurance (one every five years)	20% of R&C (one every five years)
BASIC SERVICES					
Emergency Treatment	$5 copay	$5 copay	No charge	20% coinsurance	20% of R&C
Extractions	No charge (except $50 copay per bony extraction)	No charge (except $50 copay per bony extraction)	15% coinsurance	20% coinsurance	20% of R&C
Fillings	No charge	No charge	15% coinsurance	20% coinsurance	20% of R&C
General Anesthesia	$30 copay for medically necessary extractions only (first 30 minutes)	$22 copay for medically necessary extractions only	15% coinsurance for oral surgery only	20% coinsurance for oral surgery only	20% of R&C for oral surgery only
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	15% coinsurance	20% coinsurance	20% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	15% coinsurance	20% coinsurance	20% of R&C
MAJOR SERVICES					
Bridges	$60 copay/unit	$60 copay/unit	50% coinsurance (once every 5 years)	50% coinsurance (once every 5 years)	50% of R&C (once every 5 years)
Crowns	$60 copay/crown	$60 copay/crown	15% coinsurance (once every 5 years)	50% coinsurance (once every 5 years)	50% of R&C (once every 5 years)
Dentures	$70 copay/complete upper or lower denture	$70 copay/denture	50% coinsurance (once every 5 years)	50% coinsurance (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% 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	App
BENEFITS SYSTEM				
Benefits Enrollment	888-822-0487 Fax: 310-788-8775	N/A	www.mylacountybenefits.com	N/A
COUNTY DEPARTMENT OF HUMAN RESOURCES				
Benefits Hotline	213-388-9982	N/A	http://employee.hr.lacounty.gov	N/A
MEDICAL				
Kaiser Permanente HMO	800-464-4000	101000-3	www.kp.org/countyofla	Kaiser Permanente
Anthem Blue Cross	844-730-1931	HMO: 56089A PPO: 1284EH POS: 56061A Catastrophic: 1313GD	www.anthem.com/ca/countyoflosangeles	Sydney Health
DENTAL				
MetLife (SafeGuard) HMO	800-880-1800	70334	www.safeguard.net	MetLife US App
DeltaCare HMO	800-422-4234	70831-00003	www.deltadentalins.com	Delta Dental
Delta Dental PPO	888-335-8227	4915-10002	www.deltadentalins.com	Delta Dental
SPENDING ACCOUNTS				
HealthEquity	877-924-3967 Fax: 877-353-9236	N/A	www.mylacountybenefits.com Click on Spending Accounts	EZ Receipts
LIFE INSURANCE				
MetLife	800-846-0124	N/A	www.mylacountybenefits.com Click on the MetLife link	MetLife US App
AD&D AND BASIC LIFE INSURANCE				
New York Life	800-842-6635 Fax: 818-477-1494	Life: FLI52070 AD&D: OK819451	N/A	N/A

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2022
medical and dental plans comparison chart

What's Inside

This comparison chart shows what you pay under the *Flex* medical and dental plans. Use this chart to compare the plans' features and services. It can help you choose the right plans during annual benefits enrollment, or as a new hire. And, you can reference this chart throughout 2022.

Be sure to review the Enrollment Highlights Guide and Personalized Enrollment Worksheet in your benefits enrollment packet; you'll find descriptions of your plan options, including information about premium rates.

Information about your *Flex* plans is also available at **mylacountybenefits.com**.

Department of Health Services Specialty Access
As a County employee enrolled in the Anthem PPO or POS medical plans, you may 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 offers an 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. To learn more or request a copy of the document, contact the plan's customer service department. See the back page for contact information.

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 Maximum Benefit
This is the most your dental plan will pay for care, for you and covered dependents, in a Plan Year. If you reach the maximum-benefit amount, you are responsible for paying any other dental care costs for the rest of the Plan Year.

Annual Out-of-Pocket Maximum
The total amount you pay for medical care in one Plan Year. When you reach this maximum, the plan will pay 100% of your covered costs for the rest of the Plan Year. Generally, deductibles, coinsurance, and copays count toward the out-of-pocket maximum.

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

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) charge 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 above R&C.

2022 *Flex* Medical and Dental Plans Comparison Chart

What You Pay Under the Medical Plans

	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 outpatient 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	In-network: $6,600/person; $13,200/family Out-of-network: $15,000/person; $45,000/family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited		Unlimited
PREVENTIVE CARE								**PREVENTIVE CARE**
Periodic Health Evaluations, Immunizations	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
NON-PREVENTIVE CARE (MEDICALLY NECESSARY)								**NON-PREVENTIVE CARE (MEDICALLY NECESSARY)**
Ambulance	No charge if medically necessary	No charge	No charge	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Doctor Office Visit	$15 copay	$15 copay/visit; no charge for pediatric visits to age 5	$15 copay/visit; no charge for pediatric visits to age 5	$25 copay/visit; no charge for pediatric visits to age 5	30% coinsurance	$15 copay, no deductible; no charge for pediatric visits to age 5	30% coinsurance	25% coinsurance
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 10% coinsurance	$50 copay, waived if admitted, then 10% coinsurance	25% coinsurance plus $100 copay/visit that is waived if admitted
Hospital Care	No charge	No charge	No charge	20% coinsurance	30% coinsurance plus $500 deductible/admission and $500 penalty/admission if not pre-certified that are waived for emergency room admission	10% coinsurance; no deductible	30% coinsurance plus $500 deductible/admission and $500 penalty/admission if not pre-certified that are waived for emergency admission	In-network: 25% coinsurance Out-of-network: 25% coinsurance plus $500 deductible/admission and $500 penalty/admission if not pre-certified that are waived for 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: 20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance
Surgery	Inpatient: No charge Outpatient: $15 copay	No charge	No charge	20% coinsurance	30% coinsurance plus $500 outpatient surgical center deductible/admission and $500 penalty/admission if not pre-certified that are waived for emergency room admission	10% coinsurance	30% coinsurance	In-network: 25% coinsurance Out-of-network: 25% coinsurance plus $500 outpatient surgical center deductible/admission and $500 penalty/admission if not pre-certified that are waived for emergency room admission
X-Ray & Lab Tests	No charge for services at a Kaiser facility	No charge	No charge	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance
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% coinsurance (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	25% coinsurance after annual $200 prescription drug deductible
MENTAL HEALTH CARE								**MENTAL HEALTH CARE**
Mental Health Outpatient	$15 copay/individual visit $7 copay/group visit	$15 copay/visit	$15 copay/visit	$25 copay/visit	30% coinsurance	$15 copay/visit	30% coinsurance	25% coinsurance
Mental Health Inpatient	No charge	No charge	No charge	20% coinsurance	30% coinsurance plus $500 deductible/admission and $500 penalty/admission if not pre-certified that are waived for emergency room admission	10% coinsurance; no deductible	30% coinsurance plus $500 deductible/admission and $500 penalty/admission if not pre-certified that are waived for emergency room admission	In-network: 25% coinsurance Out-of-network: 25% coinsurance plus $500 deductible/admission and $500 penalty/admission if not pre-certified that are waived for 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	20% coinsurance	30% coinsurance	10% coinsurance (maximum 15 visits/calendar year)	30% coinsurance (maximum 15 visits/calendar year)	25% coinsurance (up to 30 visits/calendar year)
			60 consecutive days/illness or injury combined with physical therapy (combined Tiers 1, 2, and 3)					
Fertility Care	Diagnosis and treatment of infertility, and artificial insemination: Office visits: $15 copay/visit; outpatient care: $15 copay/procedure No charge: Outpatient imaging, lab, inpatient care Not covered: ART services, such as IVF, GIFT, ZIFT	Covered: 50% copay for diagnosis and testing; medically necessary fertility preservation for iatrogenic infertility Not covered: Artificial insemination, sperm banks, Rx, IVF, GIFT	Covered: 50% copay for diagnosis and testing; medically necessary fertility preservation for iatrogenic infertility Not covered: Artificial insemination, sperm banks, tests, Rx, IVF, GIFT	Covered: Medically necessary fertility preservation for iatrogenic infertility Not covered: Diagnosis, treatment, surgery, sperm banks, tests, artificial insemination, Rx, IVF, GIFT		Covered: Medically necessary fertility preservation for iatrogenic infertility Not covered: Diagnosis, treatment, surgery, sperm banks, tests, Rx, artificial insemination, IVF, GIFT		Covered: Medically necessary fertility preservation for iatrogenic infertility Not covered: Diagnosis, treatment, surgery, sperm banks, tests, Rx, artificial insemination, IVF, GIFT
Home Health Care	No charge within Kaiser service area (up to 100 visits per calendar year)	$15 copay/visit	No charge	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance (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		
Physical Therapy	$15 copay/visit	$15 copay/visit (up to 60 consecutive days/illness or injury; combined with chiropractic care)	$15 copay/visit	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance
			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	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance (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 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); LASIK surgery: up to $1,500 benefit (lifetime max) for both eyes	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); LASIK surgery: up to $1,500 benefit (lifetime max) for both eyes	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); LASIK surgery: up to $1,500 benefit (lifetime max) for both eyes	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); LASIK surgery: up to $1,500 benefit (lifetime max) for both eyes	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. You may download SBCs from mylacountybenefits.com or 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.