

## 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 <sup>1</sup>
<b>Type of Plan</b>	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers two provider networks and out-of-network benefits		
<b>Annual Deductible</b>	None	None	None	\$50/person; \$150/family	\$50/person; \$150/family
<b>Annual Maximum Benefit</b>	None	None	\$1,750/person (all care must be in PPO network)	\$1,500/person	\$1,500/person
<b>PREVENTIVE CARE</b>					
<b>Cleaning</b>	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/calendar year)	20% of R&C (no deductible on first two cleanings/calendar year)
<b>Exam</b>	No charge	No charge	No charge (two per calendar year)	20% coinsurance (two per calendar year)	20% of R&C (two per calendar year)
<b>Full Mouth X-Rays</b>	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)
<b>BASIC SERVICES</b>					
<b>Emergency Treatment</b>	\$5 copay	\$5 copay	No charge	20% coinsurance	20% of R&C
<b>Extractions</b>	No charge (except \$50 copay per bony extraction)	No charge (except \$50 copay per bony extraction)	15% coinsurance	20% coinsurance	20% of R&C
<b>Fillings</b>	No charge	No charge	15% coinsurance	20% coinsurance	20% of R&C
<b>General Anesthesia</b>	\$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
<b>Gingivectomy</b>	\$55 copay/quadrant	\$55 copay/quadrant	15% coinsurance	20% coinsurance	20% of R&C
<b>Root Canals</b>	\$45 copay/canal	\$45 copay/canal	15% coinsurance	20% coinsurance	20% of R&C
<b>MAJOR SERVICES</b>					
<b>Bridges</b>	\$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)
<b>Crowns</b>	\$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)
<b>Dentures</b>	\$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)
<b>Orthodontia</b>	\$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)
<b>TMJ</b>	Not covered	Not covered	Not covered	Not covered	Not covered

<sup>1</sup> 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
<b>BENEFITS SYSTEM</b>				
Benefits Enrollment	888-822-0487 Fax: 310-788-8775	N/A	www.mylacountybenefits.com	N/A
<b>COUNTY DEPARTMENT OF HUMAN RESOURCES</b>				
Benefits Hotline	213-388-9982	N/A	http://employee.hr.lacounty.gov	N/A
<b>MEDICAL</b>				
Kaiser Permanente HMO	800-464-4000	101000-3	www.kp.org/countyofla	Kaiser Permanente
Anthem Blue Cross	844-730-1931	HMO: 56089A POS: 56061A	PPO: 1284EH Catastrophic: 1313GD www.anthem.com/ca/countyoflosangeles	Sydney Health
<b>DENTAL</b>				
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
<b>SPENDING ACCOUNTS</b>				
HealthEquity	877-924-3967 Fax: 877-353-9236	N/A	www.mylacountybenefits.com Click on Spending Accounts	EZ Receipts
<b>LIFE INSURANCE</b>				
MetLife	800-846-0124	N/A	www.mylacountybenefits.com Click on the MetLife link	MetLife US App
<b>AD&amp;D INSURANCE</b>				
New York Life	800-842-6635 Fax: 818-477-1494	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 *MegaFlex* 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 *MegaFlex* plans is also available at [mylacountybenefits.com](http://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 *MegaFlex* 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 MegaFlex 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	
<b>Annual Deductible</b>	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
<b>Annual Out-of-Pocket Maximum</b>	\$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
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited		Unlimited
<b>PREVENTIVE CARE</b>								
<b>Periodic Health Evaluations, Immunizations</b>	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
<b>NON-PREVENTIVE CARE (MEDICALLY NECESSARY)</b>								
<b>Ambulance</b>	No charge if medically necessary	No charge	No charge	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
<b>Doctor Office Visit</b>	\$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
<b>Emergency Care</b>	\$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 deductible/visit that is waived if admitted
<b>Hospital Care</b>	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
<b>Maternity</b>	\$15 copay for office visit 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
<b>Surgery</b>	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
<b>X-Ray &amp; Lab Tests</b>	No charge for services at a Kaiser facility	No charge	No charge	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance
<b>Prescription Drug</b>	\$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
<b>MENTAL HEALTH CARE</b>								
<b>Mental Health Outpatient</b>	\$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
<b>Mental Health Inpatient</b>	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
<b>OTHER PLAN BENEFITS</b>								
<b>Chiropractic Care</b>	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 for Tiers 1, 2, and 3)	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)
<b>Fertility Care</b>	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, 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		Covered: Medically necessary fertility preservation for iatrogenic infertility Not covered: Diagnosis, treatment, surgery, sperm banks, tests, Rx, artificial insemination, IVF, GIFT
<b>Home Health Care</b>	No charge 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)	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance (up to 100 visits/calendar year)
<b>Physical Therapy</b>	\$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)	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance
<b>Skilled Nursing Facility</b>	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)	20% coinsurance	30% coinsurance	10% coinsurance	30% coinsurance	25% coinsurance (up to 100 days/calendar year)
<b>Vision Care</b>	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](http://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.