2024 MEDICAL AND DENTAL PLANS COMPARISON CHART

WHAT'S INSIDE

This comparison chart shows what you pay under the *Choices* medical and dental plans. Use this chart to compare the plans' features and services so you can choose the plans that are best for you and your family. Keep this chart so you can reference it throughout 2024.

Review the Benefits Guide and other materials in your benefits enrollment packet for information about your plan options, premium rates, and the monthly benefits allowance.

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

CONTACT INFORMATION				
CONTACT	**PHONE NUMBER**	**GROUP NUMBERS**	**WEBSITE**	**APP**
BENEFITS SYSTEM				
Benefits Enrollment	N/A	N/A	mylacountybenefits.com	N/A
Submit copies of required documents: Upload: mylacountybenefits.com • Email: documents@mylacountybenefits.com • Fax: 310-788-8775 • Mail: County of Los Angeles Benefits Plan Administrator, P.O. Box 9005, Norfolk, VA 23501-9005				
COUNTY DEPARTMENT OF HUMAN RESOURCES				
Benefits Hotline	213-388-9982	N/A	employee.hr.lacounty.gov	N/A
MEDICAL				
Cigna Vision: 877-478-7557	800-842-6635	3212364	cigna.com	myCigna
Kaiser Permanente Vision: Contact Kaiser	800-464-4000	101000-4	kp.org/countyofla	Kaiser Permanente
ALADS/Anthem Blue Cross Vision: VSP, 800-877-7195 or vsp.com	800-842-6635	Prudent Buyer PPO: 67915 CaliforniaCare HMO: 57726	mybenefitchoices.com/alads	N/A
CAPE/Blue Shield Vision: VSP, 800-877-7195 or vsp.com	800-487-3092	Classic: POSX0001 Lite: POSX0002	blueshieldca.com/cape	Blue Shield of California
Fire Fighters Local 1014 Vision: VSP, 800-877-7195 or vsp.com	800-660-1014	N/A	local1014medical.org	N/A
DENTAL				
MetLife (SafeGuard) HMO	800-880-1800	3417	metlife.com/safeguard	MetLife US App
DeltaCare HMO	800-422-4234	70831-00001	deltadentalins.com	Delta Dental Mobile App
Delta Dental PPO	888-335-8227	4915-10006	deltadentalins.com	Delta Dental Mobile App
ALADS/Anthem Blue Cross (dental)	800-842-6635	6791500000	mybenefitchoices.com/alads	N/A
SPENDING ACCOUNTS				
BenefitWallet	866-225-0067 Fax: 877-841-1152	N/A	mylacountybenefits.com	BenefitWallet+
LIFE AND AD&D INSURANCE				
New York Life	800-842-6635 Fax: 818-477-1494	Life: FLI52070 AD&D: OK819451	bsc4lac.com	N/A

This comparison chart is an overview of the *Choices* medical and dental plans, but it doesn't include all covered services. Review the Evidence of Coverage document on each plan's website for complete details. To learn more or request a copy of that document, contact the plan at the website or phone number listed on this page.

WHAT YOU PAY UNDER COUNTY-SPONSORED MEDICAL PLANS

	KAISER PERMANENTE HMO	CIGNA NETWORK HMO	CIGNA SELECT NETWORK HMO[1]	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	$1,000 – 1 person; $2,000 – 2 persons; $3,000 – family		$1,000 – 1 person; $2,000 – 2 persons; $3,000 – family	Unlimited
Lifetime Maximum Benefit	Unlimited	Unlimited		Unlimited	Unlimited
PREVENTIVE CARE					**PREVENTIVE CARE**
Periodic Health Evaluations, Immunizations	No charge, including most common immunizations	No charge		No charge	40% of R&C after deductible
NON-PREVENTIVE CARE (MEDICALLY NECESSARY)					**NON-PREVENTIVE CARE (MEDICALLY NECESSARY)**
Ambulance	No charge if medically necessary	No charge when ordered/approved by Cigna		No charge when ordered/approved by Cigna	You pay as in-network if true emergency, otherwise 40% of R&C after deductible
Doctor Office Visit	$10 copay/visit	$10 copay/visit		$10 copay/visit	40% of R&C after deductible
Emergency Care	$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	No charge		$50 copay/day; $200 copay annual max	40% of R&C after deductible and after $1,000 fee/admission (precertification required for non-emergency hospitalization or you pay a $500 penalty and 50% more)
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		$10 copay for visit to confirm pregnancy; no charge thereafter	40% 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	40% of R&C after deductible; mail order not covered
Surgery	Inpatient: No charge Outpatient: $10 copay/visit	Inpatient: No charge Outpatient: $50 copay		Inpatient: No charge after $50 copay ($200 out-of-pocket max/year) Outpatient: $50 copay	40% of R&C after deductible (precertification required for non-emergency hospitalization or you pay a $500 penalty and 50% more)
X-Ray & Lab Tests	No charge	No charge at a contracted provider		No charge at a contracted provider	40% of R&C after deductible
BEHAVIORAL/MENTAL HEALTH CARE					**BEHAVIORAL/MENTAL HEALTH CARE**
Behavioral/Mental Health Outpatient	$10 copay per individual visit/$5 copay per group visit	$10 copay/visit		$10 copay/visit	40% of R&C after deductible
Behavioral/Mental Health Inpatient	No charge	No charge		$50 copay/day (up to $200/calendar year)	$1,000 deductible per admission plus 40% 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	$10 copay/visit (up to 20 days/calendar year, in-network)		$10 copay/visit	40% of R&C after deductible
				Up to 20 days/calendar year; combined in- and out-of-network	
Fertility Care	Diagnosis and treatment of infertility, and artificial insemination: Office visits: $10 copay/visit; outpatient care: $10 copay/procedure No charge: Outpatient imaging, lab, inpatient care Not covered: ART services, such as IVF, GIFT, ZIFT	Covered if medically necessary: Lab, radiology, counseling, surgical treatment, artificial insemination; office visits: $20 copay/visit; inpatient procedure: no charge; outpatient procedure: $50 copay/procedure; surgeon's fee: 40% after deductible Not covered: IVF, GIFT, ZIFT		Doctor visits: $20 copay; inpatient: $50 copay/day up to $200/Plan Year; outpatient: $50 copay/procedure; $200 copay for surgeon's services Not covered: IVF, GIFT, ZIFT	Doctor visits: 40% coinsurance after deductible; inpatient: $1,000/admission deductible then 40% coinsurance; outpatient: 40% coinsurance after deductible for covered services Not covered: IVF, GIFT, ZIFT
Home Health Care	No charge within Kaiser service area (up to 2 hrs/visit; 3 visits/day; 100 visits/calendar year)	No charge (approved medical provider only)		No charge (up to 100 visits/calendar year, reduced by out-of-network visits)	40% of R&C after deductible (up to 60 days/calendar year reduced by in-network visits)
Physical Therapy	$10 copay/visit	$10 copay/visit		$10 copay/visit	40% of R&C after deductible (up to 60 days/condition)
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	No charge 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)	40% 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	At a Kaiser Vision Essentials optical center: No charge for routine eye exam $150 for frames every 24 months or for contact lenses every 12 months No charge for basic lenses for eyeglasses every 12 months (design: single vision, bi- or tri-focal, basic progressive, computer lens; material: plastic, polycarbonate for pediatrics)	Through a Cigna Vision Care Provider, you pay $10 copay for eye exam (1 non-medical refraction per calendar year), $10 copay for glasses (1 pair per calendar year); plan pays $120 maximum for frames or contact lenses		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. You may download medical and dental SBCs from **mylacountybenefits.com** or request a hard copy by calling the medical or dental plan directly; see front 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.

[1] The Cigna Southern California Select Network HMO is available only in certain areas of LA, Orange, San Diego, San Bernardino, and Riverside counties. It has a smaller network of providers than the Cigna Network HMO, which does not include facilities that are a part of most County-sponsored medical plans. Before you enroll, make sure the network available to you includes your preferred providers and facilities. If you enroll in this plan, you must choose one of five provider groups: Heritage Provider Network and MemorialCare (LA County), MemorialCare, Hoag, and Providence (Orange County), Scripps Health (San Diego County), or Heritage Provider Network (San Bernardino and Riverside Counties). All care must be received within your chosen provider group, except for urgent care and emergencies.

WHAT YOU PAY UNDER UNION-SPONSORED MEDICAL PLANS

	CAPE/BLUE SHIELD LITE POS PLAN[1]			CAPE/BLUE SHIELD CLASSIC POS PLAN[1]		
	HMO	IN-NETWORK	OUT-OF-NETWORK	HMO	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	$400/person; $800/family (in- and out-of-network)		None	$300/person; $600/family (in- and out-of-network)	
Annual Out-Of-Pocket Maximum	$1,500/person; $3,000/family	After deductible: $4,000/person; $8,000/family	After deductible: $6,000/person; $12,000/family	$1,500/person; $3,000/family	After deductible: $4,000/person; $8,000/family	After deductible: $6,000/person; $12,000/family
Lifetime Maximum Benefit	Unlimited	Unlimited		Unlimited	Unlimited	
PREVENTIVE CARE						**PREVENTIVE CARE**
Periodic Health Evaluations, Immunizations	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 after $50 copay	20% after deductible	20% of allowable amount after deductible	No charge after $50 copay	10% after deductible	10% of allowable amount after deductible
Doctor Office Visit	No charge after $10 copay	No charge after $25 copay (for consultation only, not subject to deductible)	30% of allowable amount after deductible	No charge after $10 copay	No charge after $20 copay (for consultation only, not subject to deductible)	30% of allowable amount after deductible
Emergency Care	No charge after $50 copay (waived if admitted)	No charge after $50 copay (waived if admitted)	No charge after $50 copay (waived if admitted)	No charge after $50 copay (waived if admitted)	No charge after $50 copay (waived if admitted)	No charge after $50 copay (waived if admitted)
Hospital Care	No charge	20% after deductible	30% of allowable amount after deductible; plan pays up to $600/day	No charge	10% after deductible	30% of allowable amount after deductible; plan pays up to $600/day
Maternity	No charge	No charge after $25 copay/visit (for consultation and follow-up, not subject to deductible)	30% of allowable amount after deductible	No charge	No charge after $20 copay/visit (for consultation and follow-up, not subject to deductible)	30% of allowable amount after deductible
Prescription Drugs	$5 generic; $15 brand; $30 non-formulary Mail order (90-day supply): $10 generic; $30 brand; $60 non-formulary	$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	$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
	Non-formulary must be preapproved by Blue Shield			Non-formulary must be preapproved by Blue Shield		
Surgery	No charge (outpatient $75 copay)	20% after deductible	30% of allowable amount after deductible Outpatient: Plan pays up to $600/day	No charge (outpatient $50 copay)	10% after deductible	30% of allowable amount after deductible Outpatient: Plan pays up to $600/day
X-Ray & Lab Tests	No charge	20% after deductible	30% of allowable amount after deductible	No charge	10% after deductible	30% of allowable amount after deductible
BEHAVIORAL/MENTAL HEALTH CARE						**BEHAVIORAL/MENTAL HEALTH CARE**
Behavioral/Mental Health Outpatient	No charge after $10 copay	No charge after $10 copay	30% of allowable amount after deductible	No charge after $10 copay	No charge after $10 copay	30% of allowable amount after deductible
	Provided by Magellan; must be arranged through MHSA			Provided by Magellan; must be arranged through MHSA		
Behavioral/Mental Health Inpatient	No charge	No charge	30% of allowable amount after deductible; plan pays up to $600/day	No charge	No charge	30% of allowable amount after deductible; plan pays up to $600/day
	Provided by Magellan; must be arranged through MHSA			Provided by Magellan; must be arranged through MHSA		
OTHER PLAN BENEFITS						**OTHER PLAN BENEFITS**
Chiropractic Care	No charge after $15 copay	No charge after $15 copay	Not covered	No charge after $10 copay	No charge after $10 copay	Not covered
	Includes acupuncture; unlimited/calendar year (based on medical necessity); provided through American Specialty Health Plans			Includes acupuncture; unlimited/calendar year (based on medical necessity); provided through American Specialty Health Plans		
Fertility Care	Covered: Diagnosis, evaluation; not covered: All infertility treatment including IVF, GIFT, ZIFT			Covered: Diagnosis, evaluation; not covered: All infertility treatment including IVF, GIFT, ZIFT		
Home Health Care	No charge after $10 copay	20% after deductible	Covered as in-network, pre-approval required	No charge after $10 copay	10% after deductible	Covered as in-network, pre-approval required
	Up to 100 combined visits/calendar year			Up to 100 combined visits/calendar year		
Physical Therapy	No charge after $10 copay	20% after deductible	30% of allowable amount after deductible	No charge after $10 copay	10% after deductible	30% of allowable amount after deductible
Skilled Nursing Facility	No charge	20% after deductible	30% of allowable amount after deductible	No charge	10% after deductible	30% of allowable amount after deductible
	Up to 100 combined days/calendar year			Up to 100 combined days/calendar year		
Vision Care	No charge for child eye exam through Blue Shield (under age 18). Through VSP: employees and dependents — 1 eye exam every 12 months after $10 copay; $10 material copay for standard lenses, frames up to $130-$150, or contacts up to $120 (+ up to $60 fitting exam) every 12 months.	No charge for child eye exam through Blue Shield (under age 18). Through VSP: employees and dependents — 1 eye exam every 12 months after $10 copay; $10 material copay for standard lenses, frames up to $130-$150, or contacts up to $120 (+ up to $60 fitting exam) every 12 months.	No charge for child eye exam 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.	No charge for child eye exam through Blue Shield (under age 18). Through VSP: employees and dependents — 1 eye exam every 12 months after $10 copay; $10 material copay for standard lenses, frames up to $130-$150, or contacts up to $120 (+ up to $60 fitting exam) every 12 months.	No charge for child eye exam through Blue Shield (under age 18). Through VSP: employees and dependents — 1 eye exam every 12 months after $10 copay; $10 material copay for standard lenses, frames up to $130-$150, or contacts up to $120 (+ up to $60 fitting exam) every 12 months.	No charge for child eye exam 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.

Important Note: The County believes the 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**.

[1] CAPE/Blue Shield Lite and Classic POS Plans provide a 50% lifetime orthodontia benefit, up to $2,500 per person, preventive and basic services at 25% and/or dental implants at 60%, up to a combined $1,500 per calendar year maximum through Ameritas; to be used in addition to your County dental plan. For Ameritas Customer Connections, call 800-487-5553.

WHAT YOU PAY UNDER UNION-SPONSORED MEDICAL PLANS

	ALADS/ANTHEM BLUE CROSS PRUDENT BUYER PPO BASIC[1] AND PREMIER[2] PLANS		ALADS/ANTHEM BLUE CROSS CALIFORNIACARE HMO BASIC[1] AND PREMIER[2] PLANS[†]	FIRE FIGHTERS LOCAL 1014 HEALTH PLAN[3]
	IN-NETWORK	OUT-OF-NETWORK		
Annual Deductible	$300/person; $900/family		None	$200/person; $600/family
Annual Out-Of-Pocket Maximum	$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
PREVENTIVE CARE				**PREVENTIVE CARE**
Periodic Health Evaluations, Immunizations	No charge	30%	No charge	No charge
NON-PREVENTIVE CARE (MEDICALLY NECESSARY)				**NON-PREVENTIVE CARE (MEDICALLY NECESSARY)**
Ambulance	20% after deductible	20% after deductible	No charge	10% after deductible[4]
Doctor Office Visit	10% after deductible	30% after deductible	No charge	10% after deductible[4]
Emergency Care	10% after deductible	10% after deductible	No charge if admitted as inpatient; $25 copay/visit if outpatient	$50 copay/visit (waived if admitted)
Hospital Care	10% after deductible (precertification required or you pay 20% more)	30% after deductible (precertification required or you pay 20% more)	No charge	10% after deductible; preauthorization required[4]
Maternity	10% after deductible (precertification required or you pay 20% more)	30% after deductible (precertification required or you pay 20% more)	No charge	10% after deductible[4]
Prescription Drugs	$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	10% after deductible (precertification required or you pay 20% more)	30% after deductible (precertification required or you pay 20% more)	No charge	10% after deductible[4]
X-Ray & Lab Tests	10% after deductible	30% after deductible	No charge	10% after deductible (other than periodic health exams)[4]
BEHAVIORAL/MENTAL HEALTH CARE				**BEHAVIORAL/MENTAL HEALTH CARE**
Behavioral/Mental Health Outpatient	10% after deductible	30% after deductible (non-emergency); 10% after deductible (emergency only)	No charge	10% after deductible[4]
	Provided by The Holman Group (mental health and substance-use disorder treatment combined)			
Behavioral/Mental Health Inpatient	10% after deductible	30% after deductible (non-emergency); 10% after deductible (emergency only)	No charge	10% after deductible[4]
	Provided by The Holman Group (mental health and substance-use disorder treatment combined)			
OTHER PLAN BENEFITS				**OTHER PLAN BENEFITS**
Chiropractic Care	10% after deductible	30% after deductible	$10 copay (up to 35 visits/calendar year)	10% after deductible[4] (up to 30 total visits/calendar year; and 30 total visits/calendar year for acupuncture)
Fertility Care	Covered: Medically necessary fertility preservation for iatrogenic infertility Not covered: All other infertility treatment including diagnosis, testing, IVF, GIFT, ZIFT		Covered: Diagnosis, testing, and medically necessary fertility preservation for iatrogenic infertility Not covered: All other infertility treatment including IVF, GIFT, ZIFT	Medically necessary IUI, IVF lifetime limits: diagnosis: $15,000; treatment: $50,000; Rx: $37,500; pre-authorization required for all benefits
Home Health Care	10% after deductible (up to 100 combined visits/calendar year)	30% after deductible (up to 100 combined visits/calendar year)	No charge (up to 4 hrs/day max)	10% after deductible (maximum 100 visits/calendar year)
Physical Therapy	10% after deductible	30% after deductible	No charge (up to 60 days/illness or injury)	10% after deductible (30 visits/calendar year)
Skilled Nursing Facility	10% after deductible	30% after deductible	No charge (up to 100 days/calendar year)	10% after deductible[4]
Vision Care	PPO in-network and HMO: Exams, lenses, frames, and contacts are covered through VSP; no charge for annual eye exam (includes retinal imaging) and lenses every 12 months; $175 allowance for frames or contacts every 12 months; in-network UV and anti-reflective coatings covered at no copay; radial keratotomy: You pay 10% after deductible, plan pays up to $1,500/eye	PPO out-of-network: For non-VSP providers, plan pays up to $50 reimbursement for annual eye exam; up to $50 reimbursement for single lenses every 12 months; up to $70 reimbursement for frames every 12 months; up to $105 reimbursement for elective contacts every 12 months; radial keratotomy: You pay 30% after deductible, plan pays up to $1,500/eye	PPO in-network and HMO: Exams, lenses, frames, and contacts are covered through VSP; no charge for annual eye exam (includes retinal imaging) and lenses every 12 months; $175 allowance for frames or contacts every 12 months; in-network UV and anti-reflective coatings covered at no copay; radial keratotomy: Plan pays up to $1,500/eye	Exams, lenses, frames, or contacts covered through VSP. See medical plan SPD for details; LASIK surgery: You pay 10% after deductible, plan pays up to $1,500/eye

Important Note: The County believes the Firefighters Local 1014 health plan is a "grandfathered health plan" 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**.

Indicates a plan change for 2024.

[1] The ALADS CaliforniaCare HMO and Prudent Buyer PPO Basic plans offer a limited dental benefit to supplement the County dental plan of your choosing. The supplemental dental benefit has an annual maximum benefit of $1,250 per person as well as a lifetime orthodontia benefit of 50% up to $1,800 per person; and has an annual deductible of $50 per person (up to $150 per family). See ALADS Premier PPO Plan dental chart for coinsurance schedule.

[2] The ALADS Premier Plans provide dental coverage; see the dental plans chart.

[3] Fire Fighters Local 1014 Health Plan provides a $5,000 lifetime orthodontia benefit, a $12,000 lifetime dental implant benefit, and a $1,500 "excess dental" benefit for those participants who have out-of-pocket expenses incurred through their County dental plan.

[4] For out-of-network care, you pay 30% after deductible. See the Local 1014 Health Plan Summary Plan Description (SPD) for a complete description of plan benefits.

[†] Sworn Peace Officers eligible to be members of ALADS (Bargaining Unit 611) — and 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 Basic Plan.

WHAT YOU PAY UNDER DENTAL PLANS

	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PPO PLAN			ALADS/BLUE CROSS PREMIER PPO PLANS[1]	
			PREFERRED PROVIDER OPTION (PPO)	DELTA PARTICIPATING DENTIST	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 2 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	$1,750/person	$1,750/person	$1,750/person	$3,000/person	
PREVENTIVE CARE							
Cleaning	No charge (2 every 12 months)	No charge (2 every 12 months)	No charge (2 per calendar year)	15% coinsurance (no deductible for first 2 per calendar year)	15% of R&C (no deductible for first 2 per calendar year)	No charge; no deductible (2 in 12 months)	No charge for R&C; no deductible (2 in 12 months)
Exam	No charge	No charge	No charge (2 per calendar year)	15% coinsurance (2 per calendar year)	15% of R&C (2 per calendar year)	No charge; no deductible	No charge for R&C; no deductible
Full Mouth X-Rays	No charge (once every 24 months)	No charge (once every 24 months)	No charge (once every 5 years)	15% coinsurance (once every 5 years)	15% of R&C (once every 5 years)	No charge; no deductible (once every 36 months)	No charge for R&C; no deductible (once every 36 months)
BASIC SERVICES							
Emergency Treatment	$5 copay	$5 copay	No charge	15% coinsurance	15% of R&C	Covered as regular treatment	Covered as regular treatment
Extractions	No charge (except $50 copay per bony extraction)	No charge (except $50 copay per bony extraction)	15% coinsurance	15% coinsurance	15% of R&C	10% coinsurance	15% of R&C
Fillings	No charge	No charge	15% coinsurance	15% coinsurance	15% of R&C	10% 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	10% coinsurance	15% of R&C
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	15% coinsurance	15% coinsurance	15% of R&C	40% coinsurance	50% of R&C
Root Canals	$45 copay/canal	$45-$135 copay/canal	15% coinsurance	15% coinsurance	15% of R&C	10% coinsurance	15% 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)	40% 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)	40% 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)	40% 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)	50% of R&C up to $3,000 lifetime max	
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

Note: The Fire Fighters Local 1014 Health Plan, and CAPE/Blue Shield Lite and Classic POS Plans offer limited dental benefits; see the medical plan chart.

[1] The medical ALADS Blue Cross CaliforniaCare HMO and Prudent Buyer PPO Premier Plans provide the dental coverage listed on this chart. The medical ALADS Basic plans offer a limited dental benefit; see the medical plan chart.

[2] Out-of-network benefits are based on "reasonable and customary" (R&C) amount. You pay your percentage of R&C, if any, plus any amount the provider charges above R&C.