WHAT YOU PAY UNDER THE DENTAL PLANS

	METLIFE (SAFEGUARD) HMO	DELTACARE HMO	DELTA DENTAL PPO PLAN		
			PREFERRED PROVIDER OPTION (PPO)	DELTA PARTICIPATING DENTIST	OUT-OF-NETWORK[1]
Type of Plan	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers 2 provider networks plus out-of-network benefits		
Annual Deductible	None	None	None	$50/person; $150/family	$50/person; $150/family
Annual Maximum Benefit	None	None	$2,000/person	$2,000/person	$2,000/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 on first 2 cleanings per calendar year)	15% of R&C (no deductible on first 2 cleanings per calendar year)
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)
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)
BASIC SERVICES					
Emergency Treatment	$5 copay	$5 copay	No charge	15% coinsurance	15% of R&C
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
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)	$22 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–$135 copay/canal	15% coinsurance	15% 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)
Crowns	$60 copay/crown	$60 copay/crown	15% coinsurance (once every 5 years)	15% coinsurance (once every 5 years)	15% 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	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				
UnitedHealthcare Vision: VSP, 800-877-7195 or vsp.com	800-367-2660	HMO: 401056 Harmony HMO: 252014 Select Plus PPO: 716822-0005	healthyatcola.com	Health4Me
Kaiser Permanente HMO Vision: Contact Kaiser	800-464-4000	101000-0	kp.org/countyofla	Kaiser Permanente
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	4915-10001	deltadentalins.com	Delta Dental Mobile App
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

OPTIONS

2024 MEDICAL AND DENTAL PLANS COMPARISON CHART

WHAT'S INSIDE

This comparison chart shows what you pay under the *Options* medical and dental plans. Use it 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 *Options* plans is also available at **mylacountybenefits.com**.

WHERE TO LEARN MORE

This comparison chart is an overview of the *Options* 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 the back page.

2024 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 copays (including behavioral health and prescription drugs)	$5,000/person $13,700/family	$15,000/person $45,000/family
			Includes deductible, coinsurance, and copays for in- and out-of-network charges (including behavioral/mental health and prescription drugs)	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	
PREVENTIVE CARE				**PREVENTIVE CARE**
Periodic Health Evaluations, Immunizations	No charge	No charge	No charge	No charge for covered amounts
NON-PREVENTIVE CARE (MEDICALLY NECESSARY)				**NON-PREVENTIVE CARE (MEDICALLY NECESSARY)**
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 for pediatric visits to age 5	20% coinsurance, no deductible	50% coinsurance
Emergency Care	$50 copay; waived if admitted (see plan booklet for a description of emergency services)	$50 copay (waived if admitted)	20% coinsurance	20% coinsurance (50% coinsurance 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
BEHAVIORAL/MENTAL HEALTH CARE				**BEHAVIORAL/MENTAL HEALTH CARE**
Behavioral/Mental Health Outpatient	$10 copay/individual visit $5 copay/group visit	$10 copay/visit	20% coinsurance for covered charges	50% coinsurance for covered charges
Behavioral/Mental Health Inpatient	No charge	No charge	20% coinsurance	50% coinsurance
OTHER PLAN BENEFITS				**OTHER PLAN BENEFITS**
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	50% coinsurance for medically necessary medical and diagnostic services, procedures, medications	20% coinsurance for medically necessary medical and diagnostic services, procedures, and medications (preauthorization required or you pay 50% coinsurance) $15,000 lifetime maximum (physician office visits not included)	Not covered
Home Health Care	No charge within Kaiser service 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)	
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 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)	$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

[1] **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 provider group, except for urgent care and emergencies. Before you enroll, make sure your providers and facilities are in the provider group you choose. If you enroll in this plan, you must choose a provider group based on where you live or work: LA County: Optum, Optum Care Network, Torrance Memorial IPA • Orange County: Optum, Optum Care Network, Edinger Medical Group, MemorialCare Medical Group, Greater Newport MemorialCare • Riverside County: Optum Care Network • San Bernardino County: Optum Care Network, Beaver Medical Group, PrimeCare of Chino • San Diego County: Optum Care Network, Sharp Community, SCMG. See the most up-to-date list of provider groups at **healthyatcola.com**.

The Affordable Care Act requires 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 can download medical and dental SBCs from **mylacountybenefits.com** or request a hard copy by calling the medical or dental plan directly; see 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
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're 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 a 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're 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 (R&C) Charges
The amount a health plan determines is the normal fee for specific health-related care in the area where you seek services. For out-of-network care, you pay a percentage of R&C, plus any amount the provider charges above R&C.