

Dental Plans Comparison Chart

	SAFEGUARD	DELTACARE	DELTA DENTAL PLAN		
			PREFERRED PROVIDER OPTION (PPO) DENTIST	DELTA PARTICIPATING DENTIST IN-NETWORK	OUT-OF-NETWORK
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 DPO network)	\$1,500/person	\$1,500/person
TYPE OF SERVICES PREVENTIVE CARE					
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two/calendar year)	80% (no deductible on first two cleanings/calendar year)	80% of R&C (no deductible on first two cleaning/calendar year)
Exam	100%	100%	100% (two/calendar year)	80% (two/calendar year)	80% of R&C (two/calendar year)
Full Mouth X-Rays	100% (one every 24 months)	100% (one every 24 months)	100% (one every five years)	80% (one every five years)	80% of R&C (one every five years)
BASIC SERVICES					
Emergency Treatment	\$5 copay	\$5 copay	100%	80%	80% of R&C
Extractions	100% (except \$50 copay for bony impactions)	100% (except \$50 copay for bony impactions)	85%	80%	80% of R&C
Fillings	100%	100%	85%	80%	80% of R&C
General Anesthesia	30% copay for medically necessary extractions only	30% copay for medically necessary extractions only	85% for oral surgery only	80% for oral surgery only	80% of R&C for oral surgery only
Gingivectomy	\$55 copay/quadrant	\$55 copay/quadrant	85%	80%	80% of R&C
Root Canals	\$45 copay/canal	\$45 copay/canal	85%	80%	80% of R&C
MAJOR SERVICES					
Bridges	\$60 copay/unit	\$60 copay/unit	50% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Crowns	\$60 copay/crown	\$60 copay/crown	85% (once every 5 years)	50% (once every 5 years)	50% of R&C (once every 5 years)
Dentures	\$70 copay/denture	\$70 copay/denture	50% (once every 5 years)	50% (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% (\$1,200 lifetime maximum)	50% (\$1,200 lifetime maximum)	50% (\$1,200 lifetime maximum)
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered

Contact Information

Contact	Phone Number	Fax Number	Web Site
BENEFIT SYSTEM			
Benefit Enrollment	888-822-0487	310-788-8775	www.mylacountybenefits.com
COUNTY DEPARTMENT OF HUMAN RESOURCES			
Benefits Hotline	213-388-9982	N/A	http://dhr.lacounty.info/
MEDICAL			
Kaiser Permanente	800-464-4000	N/A	www.kp.org/countyofla
Anthem Blue Cross	866-940-8303	N/A	www.anthem.com/ca/countyoflosangeles
DENTAL			
SafeGuard	800-880-1800	N/A	www.safeguard.net
DeltaCare	800-422-4234	N/A	www.deltadentalins.com
Delta Dental	888-335-8227	N/A	www.deltadentalins.com
FLEXIBLE SPENDING ACCOUNTS			
Administrator (Ceridian)	866-300-2303	888-367-3305	www.mylacountybenefits.com
LIFE			
MetLife	800-846-0124	N/A	www.mylacountybenefits.com Click on the MetLife link
AD&D			
CIGNA Life	800-842-6635	N/A	www.cigna.com

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2011

medical and dental plans comparison chart

What's Inside

This comparison chart provides you with an overview of your Flex medical and dental plans. It's been designed to help you choose the plans that are right for you and your family — either during annual enrollment or as a new hire — and also for future reference.

Take some time to also review the Enrollment Highlights Guide and Personalized Enrollment Worksheet you received with this comparison chart for descriptions of your benefit plan options and information about premium rates.

This comparison chart provides a general overview of the Flex medical and dental plans. It is provided for your convenience and is not intended to be detailed or comprehensive. Additional details about your benefits are available in other official plan documents, including official summary plan descriptions. To request a copy of an official plan document, contact the plan's customer service department directly.

Once you've chosen your plans for 2011, you should save this comparison chart so you can refer to it throughout the year.

Remember, information about your Flex benefit plans is also available online 24 hours a day, seven days a week using **mylacountybenefits.com**.

2011 Flex Medical and Dental Plans Comparison Chart

Medical Plans Comparison Chart								
	KAISER PERMANENTE HMO	ANTHEM BLUE CROSS CALIFORNIACARE 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 ambulatory 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	\$10,000/person \$15,000/family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited		Unlimited
Ambulance	No charge if deemed medically necessary	No charge	No charge	80%	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Chiropractic Care	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 Tiers 1, 2, and 3)	80%	70% after deductible	90% after deductible; maximum 15 visits/calendar year	70% after deductible; maximum 15 visits/calendar year	Covered as part of physical therapy, see below
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 90% after deductible	\$50 copay (waived if admitted) then 90% after deductible; 70% after 48 hours unless the patient cannot be moved	\$100 copay/visit (waived if admitted) then 75%
Home Health Care	No charge if within Kaiser service area	\$15 copay/visit	No charge up to 100 visits/calendar year (combined for Tiers 1, 2, and 3)	80%	70% after deductible	90% after deductible (100 visits/calendar year combined maximum)	70% after deductible	75% after deductible (up to 100 visits/calendar year)
Hospice Care	No charge at an authorized facility	No charge	No charge	80%	80% after deductible	80% after deductible	80% after deductible	75% after deductible
Hospital Care	No charge	No charge	No charge	80%	70% after deductible; plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	90% (no deductible)	70% after deductible; plus \$500 deductible/admission (waived for emergency admission), \$500 penalty/admission if not pre-certified	75% after deductible; plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified (non-participating provider only); waived if emergency room admission
Immunizations	No charge	No charge	No charge	No charge	No charge	No charge	Up to \$12 (non-participating provider only)	Up to \$12 (non-participating provider only)
Maternity	No charge	\$15 copay/office visit Delivery no charge	\$15 copay/office visit Delivery no charge	\$25 copay/office visit, delivery 80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible
Mental Health Inpatient	No charge	No charge	No charge	80%	70% after deductible, plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	90% (no deductible)	70% after deductible, plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	75% after deductible, plus \$500 hospital admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission
Mental Health Outpatient	\$15 copay/visit	\$15 copay/visit	\$15 copay/visit	\$25 copay/visit	70% after deductible	\$15 copay/visit	70% after deductible	75% after deductible
Periodic Health Evaluations	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Physical Therapy	\$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)	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible; maximum benefit of \$25/visit; maximum of 24 visits/calendar year (non-participating provider only)
Physician Office Visit	\$15 copay/visit; no charge/pediatric visit to age 5 \$10 copay generic; \$20 copay brand name (for up to a 100-day supply of each medication prescribed by Kaiser physician or any dentist and filled at a Kaiser pharmacy)	\$15 copay/visit; no charge/pediatric visit to age 5	\$15 copay/visit; no charge/pediatric visit to age 5	\$25 copay/visit; no charge/pediatric visit to age 5	70% after deductible	\$15 copay (no deductible); no charge/pediatric visit to age 5	70% after deductible	75% after deductible
Prescription Drug	\$10 copay generic; \$20 copay brand name (for up to a 100-day supply of each medication prescribed by Kaiser physician or any dentist and filled at a Kaiser pharmacy)	\$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	75% (after separate \$200 annual deductible)
Skilled Nursing Facility	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)	80%	70% after deductible	90% after deductible (100 days/calendar year combined maximum)	70% after deductible	75% after deductible (up to 100 days/ calendar year)
Surgery	Inpatient: no charge Outpatient: \$15 copay	No charge	No charge	80%	70% after deductible; plus \$500 ambulatory surgical center admission deductible and \$500 penalty/admission if not pre-certified; waived if emergency room admission	90% after deductible	70% after deductible	75% after deductible; plus \$500 ambulatory surgical center admission deductible and \$500 penalty/admission if not pre-certified (non-participating provider only); waived if emergency room admission
Vision Care	No charge for eye exam at a Kaiser facility; \$250 allowance/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); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	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); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	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); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	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); up to \$1,500 benefit (lifetime max) for both eyes for Lasik surgery	Coverage limited to reimbursement provided under VSP out-of-network schedule	Not covered
X-Ray & Lab	No charge for services at a Kaiser facility	No charge	No charge	80%	70% after deductible	90% after deductible	70% after deductible	75% after deductible

Important Note: The County believes each of these plans is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, 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 your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Hotline at 1-213-388-9982. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov and www.healthcare.gov.

■ Indicates Plan Changes

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