What's Inside

This benefits comparison chart provides you with an overview of your *Choices* benefits medical and dental plans. Use these charts to compare the features and services offered by the different plans. You can also use it for quick reference now and in the future about the benefits of the plans you select.

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

Once you've chosen your plans for 2013, you should save this comparison chart so you can refer to it throughout the year.

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

This comparison chart provides a general overview of the *Choices* benefits 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.

Is This Covered?

To find out if a specific benefit is covered or to learn more about a certain benefit, contact the plan provider or review the Evidence of Coverage document that can be found on each provider's website. You'll find phone numbers and website addresses in the Contact Information section of this chart.

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2013

Medical and Dental Plans Comparison Chart

Dental Plans Comparison Chart

	SAFEGUARD	DELTACARE	DELTA DENTAL PLAN			ALADS/BLUE CROSS PREMIER PLANS*	
			PREFERRED PROVIDER OPTION (PPO)	IN-NETWORK	OUT-OF-NETWORK**	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			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	$1,500/person (all care must be from PPO network)	$1,200/person	$1,200/person	$1,500/person	
PREVENTIVE CARE							
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two per calendar year)	80% (no deductible for first two per calendar year)	80% of R&C (no deductible for first two per calendar year)	100%; no deductible (two in 12 months)	100% of R&C; no deductible (two in 12 months)
Exam	100%	100%	100% (two per calendar year)	80% (two per calendar year)	80% of R&C (two per calendar year)	100%; no deductible	100% of R&C; no deductible
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)	100%; no deductible (one every 36 months)	100% of R&C; no deductible (one every 36 months)
BASIC SERVICES							
Emergency Treatment	$5 copay	$5 copay	100%	80%	80% of R&C	Covered as regular treatment	Covered as regular treatment
Extractions	100%	100%	85%	80%	80% of R&C	90%	85% of R&C
Fillings	100%	100%	85%	80%	80% of R&C	90%	85% 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	90%	85% of R&C
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	85%	80%	80% of R&C	60%	50% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	85%	80%	80% of R&C	90%	85% of R&C
MAJOR SERVICES							
Bridges	$60 copay/unit	$60 copay/unit	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Crowns	$60 copay/crown	$60 copay/crown	85% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Dentures	$70 copay/ complete upper or lower denture	$70 copay/denture	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)	60% (once every five years)	50% of R&C (once every five years)
Orthodontia* **	$1,000 copay + $150 start-up fees	$1,150 copay + $350 start-up fees	Not covered	Not covered	Not covered	50% of R&C up to $1,500 lifetime max.	
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

** The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans provide the dental coverage listed on this chart.*
*** 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.*
**** Fire Fighters Local 1014 Medical Plan provides a $2,000 lifetime orthodontia benefit as well as a $1,000 "excess dental" benefit for those participants who exceed their Delta Dental maximum in any year. The plan is only available to members of Local 1014.*

Contact Information

Contact	Phone Number	Fax Number	Website
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			
CIGNA	800-842-6635	N/A	www.cigna.com
Kaiser Permanente	800-464-4000	N/A	www.kp.org/countyofla
ALADS/Anthem Blue Cross (HMO)	800-842-6635	N/A	www.anthem.com/ca/alads
ALADS/Anthem Blue Cross (PPO)	800-842-6635	N/A	www.anthem.com/ca/alads
CAPE/Blue Shield	800-487-3092	N/A	www.blueshieldca.com
Fire Fighters Local 1014	800-660-1014	N/A	www.local1014medical.org
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
ALADS/Blue Cross (dental)	800-842-6635	N/A	www.anthem.com/ca/alads
SPENDING ACCOUNTS			
Benefit Concepts, Inc.	866-629-6436	866-629-6390	www.mylacountybenefits.com
LIFE AND AD&D			
CIGNA Life	800-842-6635	N/A	www.mycigna.com

Medical Plans Comparison Chart — County-Sponsored Plans

	KAISER PERMANENTE HMO	CIGNA NETWORK HMO	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 party-$1,000 2 party-$2,000 Family-$3,000	1 party-$1,000 2 party-$2,000 Family-$3,000	None
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
PREVENTIVE CARE				**PREVENTIVE CARE**
Immunizations	No charge for most common immunizations	No charge	No charge	60% of R&C after deductible
Periodic Health Evaluations	$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
MEDICALLY NECESSARY CARE				**MEDICALLY NECESSARY CARE**
Ambulance	No charge if medically necessary	100% when ordered/approved by CIGNA	100% when ordered/approved by CIGNA	Paid as in-network if true emergency, otherwise 60% of R&C after deductible
Doctor Office Visit	$10 copay/visit; no charge pediatric visit to age 5 except routine physical exam	$10 copay/visit	$10 copay/visit	60% of R&C after deductible
Emergency Room	$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	100%	$50 copay/day; $200 copay annual max	60% of R&C after deductible and after $1,000 fee/admission (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
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	Outpatient: $10 copay for visit to confirm pregnancy, no charge thereafter	60% of R&C after deductible
Prescription Drugs	$5 copay generic and $20 copay brand name for up to 100-day supply for each medication prescribed by a Kaiser physician or any dentist and filled at a Kaiser pharmacy Sexual dysfunction drugs: 50% co-pay (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	60% of R&C after deductible; mail order not covered
Surgery	Inpatient: No charge Outpatient: $10 copay/visit	Inpatient: 100% Outpatient: $50 copay	Inpatient: 100% after $50 copay ($200 out-of-pocket max/year) Outpatient: $50 copay	60% of R&C after deductible (precertification required for non-emergency hospitalization or $500 penalty and 50% reduction in benefits)
X-Ray & Lab Tests	No charge	100% at a contracted provider	100%	60% of R&C after deductible
MENTAL HEALTH CARE				**MENTAL HEALTH CARE**
Mental Health Outpatient	$10 copay per individual visit/$5 copay per group visit	$10 copay/visit	$10 copay/visit	$50 copay
Mental Health Inpatient	No charge	100%	$50 copay/day (up to $200/calendar year)	$1,000 deductible per admission plus 60% of R&C after deductible
OTHER PLAN BENEFITS				**OTHER PLAN BENEFITS**
Chiropractic Care	Not covered	Not covered	Not covered	60% of R&C after deductible if medically necessary (up to 25 visits/calendar year)
Home Health Care	No charge if within Kaiser service area (up to 2 hrs/visit; 3 visits/day; 100 visits/calendar year)	100% (approved medical provider only)	100% (up to 100 visits/calendar year)	60% of R&C after deductible (up to 60 days/calendar year, reduced by in-network visits)
Hospice Care	No charge	100%	100%	100% of R&C after deductible
Physical Therapy	$10 copay/visit	$10 copay/visit	$10 copay/visit	60% of R&C after deductible (up to 60 days/condition)
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	100% 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)	60% of R&C after deductible for semiprivate room rate, plus $1,000 fee/admission (up to 60 days/calendar year)
Vision Care	$10 copay for eye exam at Kaiser facility (glasses not covered)	$10 copay for eye exam at contracted facility (one non-medical refraction every 12 months) $10 copay for glasses (1 pair every 12 months) $45 maximum for frames	Not covered	Not covered

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 213-388-9982. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov and www.healthcare.gov.

Medical Plans Comparison Chart—Union-Sponsored Plans

	CAPE/BLUE SHIELD LITE POS PLAN			CAPE/BLUE SHIELD CLASSIC POS PLAN			ALADS/ANTHEM BLUE CROSS PRUDENT BUYER BASIC AND PREMIER PLANS*		ALADS/ANTHEM BLUE CROSS CALIFORNIACARE BASIC AND PREMIER PLANS*	FIRE FIGHTERS LOCAL 1014 MEDICAL PLAN
	HMO	IN-NETWORK	OUT-OF-NETWORK	HMO	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK		
Annual Deductible	None	$400/person; $800/family		None	$300/person; $600/family		$300/person; $900/family	$300/person; $900/family	None	$200/person; $600/family
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	$450/person (after deductible)	$6,000/person (after deductible)	$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
		(combined in- and out-of-network)			(combined in- and out-of-network)					
Lifetime Maximum Benefit	Unlimited	Unlimited		Unlimited	Unlimited		Unlimited		Unlimited	Unlimited
PREVENTIVE CARE										PREVENTIVE CARE
Immunizations	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Periodic Health Evaluations	100% (including well baby, well woman exam, Pap smear and mammography)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100% (including well baby, well woman exam, Pap smear and mammography; no deductible)	100%	100%	100%	100%, No deductible, routine exams and screenings, including well-woman, well-man and well-child benefits
MEDICALLY NECESSARY CARE										MEDICALLY NECESSARY CARE
Ambulance	100% after $50 copay	80% after deductible	80% of allowable amount (after deductible)	100% after $50 copay	90% after deductible	90% of allowable amount (after deductible)	80% after deductible	80% after deductible	100%	90% after deductible**
Doctor Office Visit	100% after $10 copay	100% after $25 copay (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	100% after $10 copay	100% after $20 copay (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	$10 copay/visit	90% after deductible**
Emergency Room	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	100% after $50 copay (waived if admitted)	90% after deductible	90% after deductible	No charge if admitted as inpatient; $25 copay/visit if outpatient	$50 copay/visit (waived if admitted)
Hospital Care	100%	80% after deductible	70% of allowable amount (after deductible), up to $360 carrier max/day	100%	90% after deductible	70% of allowable amount (after deductible), up to $360 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible; preauthorization required**
Maternity	100%	100% after $25 copay/visit (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	100%	100% after $20 copay/visit (for consultation only, not subject to deductible)	70% of allowable amount (after deductible)	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	$10 copay/visit	90% 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	$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)
	(non-formulary must be preapproved by Blue Shield)			(non-formulary must be preapproved by Blue Shield)						
Surgery	100% (outpatient $75 copay)	80% after deductible	70% of allowable amount (after deductible) Outpatient: up to $360 carrier max/day	100% (outpatient $50 copay)	90% after deductible	70% of allowable amount (after deductible) Outpatient: up to $360 carrier max/day	90% after deductible (precertification required or coverage reduced by 20%)	70% after deductible (precertification required or coverage reduced by 20%)	100%	90% after deductible**
X-Ray & Lab Tests	100%	80% after deductible	70% of allowable amount (after deductible)	100%	90% after deductible	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	100%	90% after deductible (other than periodic health exams)**
MENTAL HEALTH CARE										MENTAL HEALTH CARE
Mental Health Outpatient	100% after $10 copay	100% after $25 copay for consultation only (not subject to deductible)	70% of allowable amount (after deductible)	100% after $10 copay	100% after $20 copay for consultation only (not subject to deductible)	70% of allowable amount (after deductible)	90% copay/ visit after deductible	70% copay/ visit after deductible (non-emergency), 90% copay/ visit after deductible (emergency only)	$10 copay/visit	90% after deductible**
	Provided by Magellan. Must be arranged through MHSA			Provided by Magellan. Must be arranged through MHSA			*Provided by The Holman Group*			
Mental Health Inpatient	100%	80% after deductible	70% of allowable amount (after deductible), up to $360 carrier max/day	100%	90% after deductible	70% of allowable amount (after deductible), up to $360 carrier max/day	90% copay/ visit after deductible	70% copay/ visit after deductible (non-emergency), 90% copay/ visit after deductible (emergency only)	100%	90% after deductible**
	Provided by Magellan. Must be arranged through MHSA			Provided by Magellan. Must be arranged through MHSA			*Provided by The Holman Group*			
OTHER PLAN BENEFITS										OTHER PLAN BENEFITS
Chiropractic Care	100% after $15 copay	100% after $15 copay	Not covered	100% after $10 copay	100% after $10 copay	Not covered	90% after deductible	70% after deductible	$10 copay (up to 20 visits/calendar year)	90% after deductible** (up to 30 total visits/calendar year; combined limit for chiropractic and acupuncture)
	Includes acupuncture; unlimited/calender year (based on medical necessity); Provided through American Specialty Health Plans			Includes acupuncture; unlimited/calender year (based on medical necessity); Provided through American Specialty Health Plans						
Home Health Care	100% after $10 copay	80% after deductible	70% of allowable amount (after deductible)	100% after $10 copay	90% after deductible	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	$10 copay (up to 4 hrs/day max)	90% after deductible (maximum 100 visits/ calendar year)
	(up to 100 combined visits/calendar year)			(up to 100 combined visits/calendar year)						
Hospice Care	100% when provided by authorized hospice agency			100% when provided by authorized hospice agency			80% after deductible (up to 100 combined visits/calendar year)	80% after deductible (up to 100 combined visits/calendar year)	100%	90% after deductible ($20,000 lifetime max)
Physical Therapy	100% after $10 copay	80% after deductible	70% of allowable amount (after deductible)	100% after $10 copay	90% after deductible	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	$10 copay (up to 60 days/illness or injury)	90% after deductible (30 visits/calendar year)
Skilled Nursing Facility	100%	80% after deductible	70% of allowable amount (after deductible)	100%	90% after deductible	70% of allowable amount (after deductible)	90% after deductible	70% after deductible	100% (up to 100 days/calendar year)	90% after deductible**
	(up to 100 combined days/calendar year)			(up to 100 combined days/calendar year)						
Vision Care	100% (up to age 18 for screenings only); Through MES providers: one eye exam every 12 months after $10 copay; After $10 material copay lenses every 24 months, frames every 24 months up to $120, elective contacts up to $120 every 24 months	100% (up to age 18 for screenings only); Through MES providers: one eye exam every 12 months after $10 copay; After $10 material copay lenses every 24 months, frames every 24 months up to $120, elective contacts up to $120 every 24 months	Through Non-MES providers: reimbursement up to $60 for one ophthalmologist exam or an optometrist exam up to $50 reimbursement every 12 months; lenses reimbursement of $43-$200 every 24 months; frames up to $40 reimbursement every 24 months; elective contacts reimbursement up to $100 every 24 months	100% (up to age 18 for screenings only); Through MES providers: one eye exam every 12 months after $10 copay; After $10 material copay lenses every 24 months, frames every 24 months up to $120, elective contacts up to $120 every 24 months	100% (up to age 18 for screenings only); Through MES providers: one eye exam every 12 months after $10 copay; After $10 material copay lenses every 24 months, frames every 24 months up to $120, elective contacts up to $120 every 24 months	Through Non-MES providers: reimbursement up to $60 for one ophthalmologist exam or an optometrist exam up to $50 reimbursement every 12 months; lenses reimbursement of $43-$200 every 24 months; frames up to $40 reimbursement every 24 months; elective contacts reimbursement up to $100 every 24 months	PPO in-network and HMO—Exams, lenses, frames and contacts are covered through VSP; 100% annual eye exam and lenses every 24 months; $120 allowance for frames or contacts every 24 months	PPO out-of-network—For non VSP providers, up to $50 reimbursement for annual eye exam; Up to $50 reimbursement for lenses every 24 months; Up to $70 reimbursement for frames every 24 months; Up to $105 reimbursement for contacts every 24 months	PO in-network and HMO—Exams, lenses, frames and contacts are covered through VSP; 100% annual eye exam and lenses every 24 months; $120 allowance for frames or contacts every 24 months	Exams, lenses, frames or contacts covered through VSP. See medical plan SPD for details. LASIK benefit 90% after deductible; up to $1,500/eye

This comparison chart provides a general overview of the *Choices* benefits 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 (SPD). To request a copy of an official plan document, contact the plan's Customer Service department directly.

Should you note any difference between what you read in this comparison chart and an official plan document, the official plan document will rule.

* The ALADS Blue Cross CaliforniaCare and Prudent Buyer Premier Plans offer full dental coverage; the Basic plans do not.

** For out-of-network care, the plan pays 70% after deductible. Refer to the Local 1014 Medical Plan Summary Plan Description (SPD) for a complete description of plan benefits.

Indicates Plan Changes