2014 Contra Costa County Health Plan Comparison Guide
Retiree Plans options - Early Retirees (Under Age 65)

	HMO PLANS						PPO PLANS			
	Kaiser Permanente		Health Net HMOs		Contra Costa Health Plan (CCHP) HMOs		Health Net PPOs*			
							Health Net PPO Plan A		Health Net PPO Plan B	
	Kaiser HMO Plan A	Kaiser HMO Plan B	Health Net HMO Plan A	Health Net HMO Plan B	CCHP Plan A	CCHP Plan B	In Network	Out of Network	In Network	Out of Network
Network Eligibility	You must live or work in a Kaiser service area at the time of enrollment.	You must live or work in a Kaiser service area at the time of enrollment.	You must reside in a Health Net service area.	You must reside in a Health Net service area.	You must have worked for or live in Contra Costa County.	You must have worked for or live in Contra Costa County.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.
Calendar Year Deductible										
Individual	None	$500	None	None	None	None	$250		$500	
Family	None	$1,000	None	None	None	None	$750		$1,500	
When does the Deductible apply?	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	N/A	N/A	N/A	N/A	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.		Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	
Max Calendar Year Out of Pocket (OOP) Expense										
Individual	$1,500	$3,000	$1,500	$2,000	N/A	$1,500	$1,500	$5,000	$3,000	$9,000
Family	$3,000	$6,000	$4,500	$6,000	N/A	$12,700	$3,000	N/A	$6,000	N/A
What counts towards the OOP Max?	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic	N/A	All Copays apply to OOP except those for: Prescriptions Drugs, Chiropractic, Acupuncture	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs
Hospital Services										
Inpatient	$0	10% after deductible	$0	$1,000	$0	$0	10%	30%	20%	40%
Outpatient Surgery (at a Facility)	$10	10% after deductible	$0	$500	$0	$0	10%	30%	20%	40%
Emergency Services										
Emergency Department Visits	$10	10% after deductible	$25	$100	$0	$20	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 30% Not admitted: $50 plus 30%	If admitted: 20% Not admitted: $100 plus 20%	If admitted: 40% Not admitted: $100 plus 40%
Ambulance	$0	$150	$0	$0	$0	$0	10%	10%	20%	40%

2014 Contra Costa County Health Plan Comparison Guide
Retiree Plans options - Early Retirees (Under Age 65) - Continued

	HMO PLANS						PPO PLANS			
	Kaiser Permanente		Health Net HMOs		Contra Costa Health Plan (CCHP) HMOs		Health Net PPOs*			
							Health Net PPO Plan A		Health Net PPO Plan B	
	Kaiser HMO Plan A	Kaiser HMO Plan B	Health Net HMO Plan A	Health Net HMO Plan B	CCHP Plan A	CCHP Plan B	In Network	Out of Network	In Network	Out of Network
Physician Services										
Office Visits	$10	$20	$10	$20	$0	$5	$10	30%	$20	40%
Preventive Exams	$0	$0	$0	$0	$0	$0	$0	Not Covered	$0	Not Covered
Urgent Care Visits	$10	$20	$15	$50	$0	$5	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 30% Not admitted: $50 plus 30%	If admitted: 20% Not admitted: $100 plus 20%	If admitted: 40% Not admitted: $100 plus 40%
Allergy Injections	$3	$0	$0	$0	$0	$0	10%	30%	$20	40%
Physical, Occupational, Speech Therapy	$10	$20	$10	$0	$0	$5	10%	30%	20%; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
Diagnostic X-Ray & Lab	$0	$10	$0	$0	$0	$0	10%	30%	20%	40%
Prescription Drugs										
Retail Pharmacy - 30 (Kaiser or Health Net) or 90 (CCHP) day supply	$10 generic $20 brand	$10 generic $30 brand	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary	$0	$3 up to 90 day supply	$5	$5	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary
Mail-Order Pharmacy - 100 (Kaiser) or 90 (Health Net or CCHP) day supply	$10 generic $20 brand	$20 generic $60 brand	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary	Covered	$3 up to 90 day supply	$10	$10	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary
Additional Services										
Durable Medical Equipment	$0	20% (no deductible)	$0	$0	$0	$0	50%	50%	20% combined (PPO/OON) limit $2,000	40% combined (PPO/OON) limit $2,000
Vision Exams (Routine exam only, materials not covered)	$0	$0	$10	$20	$0; up to $65 allowance for glasses or contacts	$5; up to $65 allowance for glasses or contacts	$10 through age 16	Not Covered	$20 through age 16	Not Covered
Hearing Exams	$0	$0	$10	$20	$0	$5	$10 through age 16	Not Covered	$20 through age 16	Not Covered
Infertility - diagnosis and treatment only	$10	50% (no deductible)	50%	50%	$0	$5	50% after $500 Infertility deductible; up to $2500/yr & $10,000/lifetime	50% after $500 Infertility deductible; up to $2500/yr & $10,000/lifetime	20%; after $500 Infertility deductible; up to a combined $2,000/lifetime max	40%; after $500 Infertility deductible; up to a combined $2,000/lifetime max
Home Health Services	$0 up to 100 visits	$0 up to 100 visits	$0	$20 starting w/ 31st day	$0	$0	20% combined (PPO/OON); up to 100 visits	20% combined (PPO/OON); up to 100 visits	20%; up to 100 days combined PPO/OON	40%; up to 100 days combined PPO/OON
Skilled Nursing Care	$0 up to 100 days	10% (no deductible) up to 100 days	$0 up to 100 days	$1,000 up to 100 days	$0 up to 100 days per benefit period	$0 up to 100 days per benefit period	20% combined (PPO/OON); up to 100 days	20% combined (PPO/OON); up to 100 days	20%	40%
Hospice	$0	$0	$0	$0	$0	$0	20%	20%	20%	40%
Acupuncture	Not Covered	Not Covered	Discounts available	Discounts available	$0 up to 10 visits	$5 up to 10 visits	20%	20%	$20; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
Chiropractic	$15 up to 20 visits	$15 up to 20 visits	$10 up to 20 visits	$10 up to 20 visits	$0 up to 10 visits	$5 up to 20 visits	Not covered; Discounts available	Not covered; Discounts available	$20; limited to 20 visits (in and out of network combined) $25 max payable per visit	40%; limited to 20 visits (in and out of network combined) $25 max payable per visit

Notes:

*The PPO benefits available to non-California residents slightly differ from the above.
For non-California PPO plan design details, please refer to the Evidence of Coverage (EOC).

2014 Contra Costa County Health Plan Comparison Guide

Medicare Plans - Retirees on Medicare

	HMO PLANS							PPO PLANS			
	Kaiser Permanente Senior Advantage (KPSA)		Health Net Seniority Plus		Health Net HMO COB	Contra Costa Health Plan (CCHP) HMOs		Health Net PPO COB*			
								Health Net PPO COB Plan A		Health Net PPO COB Plan B	
	KPSA Plan A	KPSA Plan B	Health Net Seniority Plus Plan A	Health Net Seniority Plus Plan B	Health Net HMO COB	CCHP Plan A	CCHP Plan B	In Network	Out of Network	In Network	Out of Network
Network Eligibility	You must live in a Kaiser service area.	You must live in a Kaiser service area.	You must reside in the Health Net Seniority Plus service area.	You must reside in the Health Net Seniority Plus service area.	You must reside in a Health Net service area.	You must have worked for or live in Contra Costa County.	You must have worked for or live in Contra Costa County.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.
Calendar Year Deductible											
Individual	None	None	None	None	None	None	None	$250		$500	
Family	None	None	None	None	None	None	None	$750		$1,500	
When does the Deductible apply?	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.		Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	
Max Calendar Year Out of Pocket (OOP) Expense											
Individual	$1,500	$1,500	$3,400	$3,400	$1,500	N/A	$1,500	$1,500	$5,000	$3,000	$9,000
Family	$3,000	$3,000	N/A	N/A	$4,500	N/A	$12,700	$3,000	N/A	$6,000	N/A
What counts towards the OOP Max?	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs Chiropractic	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs Chiropractic	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs Chiropractic	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs Chiropractic	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs Chiropractic	N/A	All Copays apply to OOP except those for: Prescriptions, Chiropractic Acupuncture	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required, Prescription Drugs
Hospital Services											
Inpatient	$0	$250	$0	$0	$0	$0	$0	10%	30%	20%	40%
Outpatient Surgery (at a Facility)	$10	$25	$0	$20	$0	$0	$0	10%	30%	20%	40%
Emergency Services											
Emergency Department Visits	$10	$50	$20 (waived if admitted)	$50 (waived if admitted)	$25	$0	$20	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 30% Not admitted: $50 plus 30%	If admitted: 20% Not admitted: $100 plus 20%	If admitted: 40% Not admitted: $100 plus 40%
Ambulance	$0	$50	$0	$0	$0	$0	$0	10%	10%	20%	40%

2014 Contra Costa County Health Plan Comparison Guide

Medicare Plans - Retirees on Medicare (Continued)

	HMO PLANS							PPO PLANS			
	Kaiser Permanente Senior Advantage (KPSA)		Health Net Seniority Plus		Health Net HMO COB	Contra Costa Health Plan (CCHP) HMOs		Health Net PPO COB**			
								Health Net PPO COB Plan A		Health Net PPO COB Plan B	
	KPSA Plan A	KPSA Plan B	Health Net Seniority Plus Plan A	Health Net Seniority Plus Plan B	Health Net HMO COB	CCHP Plan A	CCHP Plan B	In Network	Out of Network	In Network	Out of Network
Office Visits	$10	$25	$5	$20	$10	$0	$5	$10	30%	$20	40%
Preventive Exams	$0	$0	$0	$0	$0	$0	$0	$0	Not Covered	$0	Not Covered
Urgent Care Visits	$10	$25	$20	$20	$15	$0	$5	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 30% Not admitted: $50 plus 30%	If admitted: 20% Not admitted: $100 plus 20%	If admitted: 40% Not admitted: $100 plus 40%
Allergy Injections	$3	$0	$0	$0	$0	$0	$0	10%	30%	$20	40%
Physical, Occupational, Speech Therapy	$10	$25	$0	$0	$10	$0	$5	10%	30%	20%; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
Diagnostic X-Ray & Lab	$0	$0	$0	$0	$0	$0	$0	10%	30%	20%	40%
Prescription Drugs											
Retail Pharmacy - 30 (Kaiser or Health Net) or 90 (CCHP) day supply	$10 generic $20 brand	$10 generic $20 brand	$5 generic $5 brand	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary	$0	$3 up to 100 pills or 90 day supply	$5	$5	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary
Mail –Order Pharmacy – 100 day supply (Kaiser) or 90 (Health Net or CCHP) day supply	$10 generic $20 brand	$10 generic $20 brand	$5 generic $5 brand	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary	Covered	$3 up to 100 pills or 90 day supply	$10	$10	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary
Additional Services											
Durable Medical Equipment	$0	20%	$0	$0	$0	$0	$0	50%	50%	20%	40%
Vision Exams	$10	$25	$5	$20	$10	$0; up to $65 allowance for glasses or contacts	$5; up to $65 allowance for glasses or contacts	$10 through age 16	Not Covered	$20 through age 16	Not Covered
Vision Materials	$150 allowance (including contacts) every 24 months	$150 allowance (including contacts) every 24 months	$100 frame allowance every 24 months	$100 frame allowance every 24 months	Discounts available	$0	$5	Discounts available	Discounts available	Discounts available	Discounts available
Hearing Exams	$10	$25	$5	$20	$10	$0	$5	$10 through age 16	Not Covered	$20 through age 16	Not Covered
Home Health Services	$0 part-time, intermittent	$0 part-time, intermittent	$0	$0	$0	$0	$0	20%; up to 100 visits combined PPO/OON	20%; up to 100 visits combined PPO/OON	20%; up to 100 visits combined PPO/OON	40%; up to 100 visits combined PPO/OON
Skilled Nursing Care	$0 up to 100 days	$0 up to 100 days	$0 up to 100 days	$0 up to 100 days	$0 up to 100 days	$0 up to 100 days for each spell of illness	$0 up to 100 days for each spell of illness	20%; up to 100 days combined PPO/OON	20%; up to 100 days combined PPO/OON	20%	40%
Hospice	$0	$0	Through Medicare	Through Medicare	$0	$0	$0	20%	20%	20%	40%
Acupuncture	Not Covered	Not Covered	Discounts available	Discounts available	Discounts available	$0 up to 10 visits	$5 up to 10 visits	20%	20%	$20; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
Chiropractic	$15 up to 20 visits	$15 up to 20 visits	$5 up to 20 visits	$5 up to 20 visits	$10 up to 20 visits	$0 up to 10 visits	$5 up to 20 visits	Not covered; Discounts available	Not covered; Discounts available	$20; limited to 20 visits (in and out of network combined) $25 max payable per visit	40%; limited to 20 visits (in and out of network combined) $25 max payable per visit

Note:

** The PPO benefits available to non-California residents slightly differ from the above.
For non-California PPO plan design details, please refer to the Evidence of Coverage (EOC).

2014 Dental Plan Comparison Guide - All Retirees

PLAN NAME	DELTA DENTAL PREMIER (800) 765-6003 www.deltadentalins.com	DELTA DENTAL PREMIER (800) 765-6003 www.deltadentalins.com	DELTACARE USA- PLAN CA AA16 (800) 422-4234 www.deltadentalins.com
ELIGIBILITY	You may receive services from any licensed dentist. The amount paid is determined on whether the dentist is a participating or a non-participating dentist.		You must visit a dentist from the current list of DeltaCare USA network dentists. If a dentist who is NOT on the list provides treatment, it will not be covered by your DeltaCare USA program. DeltaCare USA is offered and administered by PMI Dental Health Plan, Delta Dental's HMO affiliate.
HOW TO FIND OR CONFIRM IF A DENTIST IS A MEMBER	800-765-6003		Refer to the DeltaCare USA Evidence of Coverage (EOC) or contact PMI at 800-422-4234
SPECIALTY REFERRALS	Free choice by member		Specialist Services must be referred by an assigned DeltaCare USA dentist.
DEDUCTIBLE	One time $50 per family		None
MEMBER SERVICES	Participating Dentist PLAN PAYS:	Non-Participating Dentist Plan pays up to 70% of maximum plan allowance:	FEE
DIAGNOSTICS:			
ORAL EXAMINATION AND DIAGNOSIS	70%	Up to 70%	No Cost
OFFICE VISITS	70%	Up to 70%	No Cost
FULL MOUTH X-RAYS:	70%	Up to 70%	No Cost
SINGLE FILM	70%	Up to 70%	No Cost
EACH ADDITIONAL FILM	70%	Up to 70%	No Cost
TEETH CLEANING (PROPHYLAXIS-TREATMENT TO INCLUDE SCALING AND POLISHING)	70% (1)	Up to 70% (1)	No Cost (2)
SEALANTS PER TOOTH (3)	70%	Up to 70%	No Cost
ORAL HYGIENE INSTRUCTION	Not Covered	Not Covered	No Cost
TOPICAL FLUORIDE	70%	Up to 70%	No Cost
SPACE MAINTAINERS	70%	Up to 70%	No Cost
SPECIALIST CONSULTATION	70%	Up to 70%	No Cost
BIOPSY OF ORAL TISSUE (SOFT)	70%	Up to 70%	No Cost
EMERGENCY TREATMENT	70%	Up to 70%	No Cost
EMERGENCY TREATMENT (AFTER NORMAL WORKING HOURS)	70%	Up to 70%	No Cost
BROKEN APPOINTMENT CHARGE (LESS THAN 24 HOUR NOTICE)	Determined by Dentist	Determined by Dentist	$10 per 15 minutes of appointment time
PERIODONTICS:			
SUBGINGIVAL CURETTAGE - PER QUADRANT	70%	Up to 70%	No Cost
GINGIVECTOMY - PER QUADRANT	70%	Up to 70%	No Cost
OSSEOUS SURGERY - PER QUADRANT	70%	Up to 70%	No Cost
ENDODONTICS:			
PULP CAPPING	70%	Up to 70%	No Cost
PULPOTOMY	70%	Up to 70%	No Cost
ROOT CANAL THERAPY - PER CANAL:			
EXCLUDING SECOND OR THIRD MOLARS	70%	Up to 70%	No Cost
SECOND OR THIRD MOLARS	70%	Up to 70%	No Cost
APICOECTOMY AND FILLING CANAL	70%	Up to 70%	No Cost
APICOECTOMY ON SEPARATE APPOINTMENT	70%	Up to 70%	No Cost
RESTORATIVE:			
PIN BUILD UP UNDER FILLING	70%	Up to 70%	No Cost
ALL FILLINGS OF PERMANENT AND PRIMARY TEETH	70%	Up to 70%	No Cost

(1) Teeth Cleaning is limited to twice per calendar year. One additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant if pregnant.
(2) Teeth Cleaning is limited to one procedure each six month period
(3) Sealants limited on first molars up to age 9 and second molars up to age 16

For additional information, please refer to the Evidence of Coverage/Summary Plan Description from carrier or contact the Employee Benefits Services Unit at (925) 335-1746. This comparison is intended only as a general description of the plan benefits.

2014 Dental Plan Comparison Guide - All Retirees- Continued

PLAN NAME	DELTA DENTAL PREMIER (800) 765-6003 www.deltadentalins.com		DELTA DENTAL PREMIER (800) 765-6003 www.deltadentalins.com	DELTACARE - PLAN CA AA16 (800) 422-4234 www.deltadentalins.com
MEMBER SERVICES	Participating Dentist PLAN PAYS:		Non-Participating Dentist Plan pays up to 70% of maximum plan allowance:	FEE
CROWNS AND BRIDGES: (4):				
CROWNS - PER UNIT	70%		Up to 70%	No Cost
BRIDGES - PER UNIT ****	50%		Up to 50%	No Cost
STAINLESS STEEL CROWNS	70%		Up to 70%	No Cost
DOWEL PIN (SUBJECT TO DENTIST CONSULTANT REVIEW)	70%		Up to 70%	No Cost
PIN BUILD UP	70%		Up to 70%	No Cost
POST AND CORE (SUBJECT TO DENTIST CONSULTANT REVIEW)	70%		Up to 70%	No Cost
RECEMENTATION:				
INLAY	70%		Up to 70%	No Cost
CROWN	70%		Up to 70%	No Cost
BRIDGE	70%		Up to 70%	No Cost
PROSTHETICS: (5)				
DENTURES:				
COMPLETE UPPER OR LOWER DENTURE - PER DENTURE	50%		Up to 50%	No Cost
PARTIAL UPPER OR LOWER DENTURE - PER DENTURE	50%		Up to 50%	No Cost
STAYPLATE	50%		Up to 50%	No Cost
DENTURE ADJUSTMENTS	50%		Up to 50%	No Cost
DENTURE RELINE	50%		Up to 50%	
DENTURE AND PARTIAL REPAIRS	50%		Up to 50%	No Cost
DENTURE DUPLICATION (REBASE)	50%		Up to 50%	No Cost
ADDING TEETH OR CLASPS TO PARTIAL DENTURE - PER UNIT	50%		Up to 50%	No Cost
IMPLANTS	50%		Up to 50%	Not Covered
ORAL SURGERY:				
EXTRACTIONS; LOCAL ANESTHESIA (SIMPLE)	70%		Up to 70%	No Cost
SURGICAL EXTRACTION	70%		Up to 70%	No Cost
IMPACTIONS:				
SOFT TISSUE	70%		Up to 70%	No Cost
PARTIAL BONY	70%		Up to 70%	No Cost
FULL BONY	70%		Up to 70%	No Cost
FRENECTOMY	70%		Up to 70%	No Cost
ALVEOLECTOMY - PER QUADRANT	70%		Up to 70%	No Cost
GENERAL ANESTHESIA WITH ORAL SURGERY	70%		Up to 70%	Not Covered
ORTHODONTIA:				
FULL BANDED CASE	Not Covered		Not Covered	$350.00 Start up fee
				$1,250/children
				$1,450/adults
MAXIMUM BENEFIT PAYMENTS PER CALENDAR YEAR Bargaining Unit DSA, DAIA, IAFF, UCOA & PDOC Unrepresented and All Other Bargaining Units	$1,600.00 Per Member $1,800.00 for certain bargaining units (refer to MOU)			NO MAXIMUM

(4) Gold, if used, will be an additional charge to the member.
(5) Benefits are subject to a maximum allowance and there is a six month waiting period on these services for new enrollees.

For additional information, please refer to the Evidence of Coverage/Summary Plan Description or contact the Employee Benefits Services Unit at (925) 335-1746.
This comparison is intended only as a general description of the plan benefits.