CONTRA COSTA COUNTY

2014 Retiree/Survivor

Information and Open Enrollment Guide

Benefit Elections for Plan Year January 1, 2014 through December 31, 2014

Open Enrollment Period is October 7, 2013 through November 1, 2013

Contra Costa County Department of Human Resources
Employee Benefits Services Unit
651 Pine Street, Fifth Floor
Martinez, CA 94553-1292
(925) 335-1746

Dear Retirees and Retiree Survivors:

We are pleased to provide you with the 2014 Benefits Information and Open Enrollment Guide for eligible retirees and retiree survivors of Contra Costa County. Open Enrollment will begin at 8:00 AM on Monday October 7, 2013 and end at 5:00 PM on Friday November 1, 2013. All original enrollment forms and required dependent documentation must be received by the Human Resources Department, Employee Benefits Services Unit during the Open Enrollment Period.

New for Plan Year 2014:

- The 2010 Patient Protection and Affordable Care Act (ACA) provides for uniform Summary of Benefits & Coverage (SBC) for non-Medicare Health Plans. See page 4 for additional information.
- The 2010 Patient Protection and Affordable Care Act (ACA) also provides for the Health Insurance Marketplace. See page 4 for additional information.

Please refer to page 9 of this guide to determine your eligibility for the various medical plan options.

The elections you make during this Open Enrollment period are effective for the Plan Year January 1, 2014 through December 31, 2014. If you are not making any changes to your current plans or to those who are covered by your current medical and dental plans, you do not need to complete any forms.

Please make sure you review all the information carefully.

- Refer to your 2013 Benefits Statement that you received in the mail to confirm in which plans you currently participate and which family members are covered by your plans.
- Refer to the comparison charts in this guide to understand varying plan provisions
- Review the online SBCs for non-Medicare health plans to understand the differences in the non-Medicare health plans

Be sure to complete and submit all enrollment forms and required documentation during the Open Enrollment period of October 7, 2013 through November 1, 2013.

As always, should you have any questions, please contact the Human Resources Department, Employee Benefits Services Unit by phone at (925) 335-1746 or by email at Benefits@hrd.cccounty.us or visiting our office at 651 Pine Street, Fifth Floor, Martinez, CA 94553. Our office is open Monday through Friday from 8 AM until 5 PM.

Best regards,

Your Human Resources Department
Employee Benefits Services Unit

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Open Enrollment Period

The open enrollment period begins at 8:00 AM on Monday October 7, 2013 and ends at 5:00 PM on Friday November 1, 2013.

During this period, eligible Retirees/Survivors may:

- Change your medical or dental plan
- Add or drop eligible dependents for medical or dental coverage.

When enrolling in plans, remember:

- The enclosed rate sheets are for calendar year 2014. Premiums are deducted from your monthly retirement benefit from CCCERA. If you do not have enough money in your retirement benefit for the full deduction, a partial deduction will not be taken. It will be your responsibility to pay the full monthly premium due in the form of a check payable to Contra Costa County and received in the Contra Costa County Auditor Controller's Office by the 10th of the month.
- If you do not make any changes during the open enrollment period, your current medical and dental plan elections will remain in effect for calendar year 2014.
- Retirees who add their spouse, domestic partner and /or dependent child(ren) on their medical or dental plan must submit dependent eligibility documention verifying dependent eligibility.
- Survivors must submit dependent eligibility documentation verifying eligibility when a dependent is added to their medical or dental plan. Survivors may not add a spouse/domestic partner.

Dependent Eligibility - For Basic HMO – PPO Plans. Does not include Medicare Supplement/Coordinated Plans.

The following dependents of an enrolled retiree or retiree survivor are eligible for health insurance:

- Legal Spouse (Survivors may not enroll a spouse)
- Qualified domestic partner (requires the completing and submitting of certification forms)(Survivors may not enroll a domestic partner)
- Child to age 26
- Disabled child beyond age 26 who is unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19. The disabled adult dependent must meet the disabled dependent requirements as defined by the health insurance carrier.

The definition of a dependent child includes natural child, step-child, adopted child, child of a qualified domestic partner and a child specified in a Qualified Medical Child Support Order (QMCSO) or similar mandating court order.

Dependent Eligibility - For Medicare Supplement/Coordinated Health Plans

The following dependents of an enrolled Retiree/Survivor are eligible for health insurance:

- Legal Spouse (Survivors may not enroll a spouse)
- Qualified domestic partner (qualified domestic partner enrollment requires the completing and submitting certification forms that are available in the Employee Benefits Services Unit) (Survivors may not enroll a domestic partner)
- Unmarried children who are dependent on you, your spouse or qualified domestic partner for support who are
  - ✓ Under age 19;

- ✓ Age 19 up to age 24, who are full-time students, dependent upon you for at least 50% of their support, unmarried and living with you (except when away at school).
- ✓ Disabled child who is over age 19, unmarried, incapable of sustaining employment due to a physical or mental handicap that existed prior to the child's attainment of age 19 and is your dependent as defined by the Internal Revenue Service

The definition of dependent child includes natural child, step-child, adopted child, child of a domestic partner and any child specified in a Qualified Medical Child Support Order (QMCSO)or similar court order.

Dependent Eligibility - Dental Plans

Dependent Eligibility for Dental Plans is the same as the Dependent Eligibility for Medicare Supplement/Coordinated Health Plans. This eligibility provision applies to all retirees and retiree survivors.

Note: It is against County Policy for Retirees/Survivors to enroll ineligible persons as dependents; to do so may subject the Retiree/Survivor to the obligation to reimburse the plan for all costs associated with the delivery of medical or dental care services to an ineligible person. If you have any questions about dependent eligibility, please call the Employee Benefits Services Unit.

Changes During 2014

Medical and dental benefit elections may be changed during the plan year only if you have a qualified life status change event, such as:

- A change in your legal marital status, including marriage, divorce, death of your spouse or domestic partner, legal separation or annulment; (Survivors may not enroll a spouse or domestic partner)
- A change in the number of your dependents through birth, adoption, placement for adoption, or death;
- Your dependent's ability to satisfy dependent eligibility requirements;
- Termination or commencement of employment of a spouse, domestic partner or eligible dependent;
- A change in work schedule, such as a reduction or increase in hours by your spouse, domestic partner or eligible dependent.
- The taking of an unpaid leave of absence by your spouse;
- A significant change in your or your spouse's coverage that is attributable to the spouse's employment.
- A change in residence or work site by you, your spouse, domestic partner or dependents that causes you to lose access to providers in your HMO plan's network.
- A change as the result of the enrollment or disenrollment of a retiree/survivor, spouse or dependent for either Part A or Part B of Title XVIII of the Social Security Act (Medicare) or under Title XIX of the Social Security Act (Medicaid).

Both the revoking of a benefit and the new benefit election must be on account of and consistent with the change in family status. A benefit election change is considered to be consistent with a family status change only if the election is necessary or appropriate as a result of the family status change. Family status change forms must be completed and approved within 60 days of the qualifying event date. The change will become effective the first of the month coincident with or next following the date the completed and approved change form is received by the Employee Benefits Services Unit. If you do not complete, submit and receive approval within 60 days of the qualifying event date, you will not be able to add a dependent or make any other changes until the next open enrollment period, with benefits effective on the January 1 following that open enrollment period. Contact the Employee Benefits Services Unit as soon as you experience any of the family status changes listed above.

Healthcare Options

Summary of Benefits and Coverage (SBC) for Non-Medicare Health Plan

In accordance with the 2010 Patient Protection and Affordable Care Act, health insurance companies and group health plans are required to provide you with an easy-to-understand annual summary about a health plan's benefits and coverage. All insurance companies and group health plans must use the same standard SBC form to help you compare health plans. The SBC form also includes details called "coverage examples" which are comparison tools that allow you to see what the plan would generally cover in two common medical situations.

The SBCs for Contra Costa Health Plan A, Contra Costa Health Plan B, Kaiser Permanente Plan A, Kaiser Permanente Plan B, Health Net HMO Plan A, Health Net HMO Plan B, Health PPO Plan A and Health Net PPO Plan B are available on the Employee Benefits Website.

If you do not have access to read or print the SBCs directly from our website, please call the Employee Benefits Office (925-335-1746) and request that a hard copy of the information be sent to you. Or, you may email your request to Benefits@hrd.cccounty.us and your reply email will include the SBC requested.

You should review the SBC documents before electing your medical coverage for Plan Year 2014.

Health Insurance Marketplace

Contra Costa County is committed to offering comprehensive medical coverage to all eligible employees and retirees, which meets or exceeds the legal requirements of federal health care reform. Coverage is intended to be affordable, based on your salary. Therefore, if you are enrolled in medical coverage through Contra Costa County, you are not likely to be eligible for a federal subsidy or tax credit to buy insurance through the law's Health Insurance Marketplaces (known as Covered CA in this State). The same is generally true for retirees who are not eligible for Medicare. Contra Costa County is required to provide the following notice from the Department of Labor.

Health Insurance Marketplace – Required Notice provided by the Department of Labor

General Information - When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace? - The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace? - You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? - Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? - For more information about your coverage offered by Contra Costa County, please check the County's online employee benefits webpage, your summary plan description (SPD) or call the Benefits Department at (925) 335-1746.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **Coveredca.com** or **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Healthcare Plans

You may choose from a variety of healthcare plans and coverage levels based on your individual needs (if service area applies). A comparison of the healthcare plans is included in the Guide. The healthcare plan in which to enroll is a personal choice. Evaluating the plan alternatives is never easy. The following questions are samples of questions you could consider in determining in which healthcare plan you should elect to participate:

- Which healthcare plan network includes the physician(s) that provide medical services to you and your family members?
- Which healthcare plan network includes the hospital and urgent care centers where your physician(s) have privileges?
- Is the cost or premium deduction amount affordable?
- How often do you expect to use services that include a co-payment ? How much do you anticipate paying in co-payments for the calendar year?
- Are ancillary services such as on-line information, preventive care programs, on-line provider ratings or comparisons, and, on-line provider searches, etc. important to you?
- Do you and all eligible family members reside within the network service area?
- Do you or your family members always use physicians that are not in any of the healthcare provider networks?
- Don't forget to include the monthly cost for Medicare Part B when comparing plan costs and benefits.

Options

- Retirees, spouses, domestic partner, children and surviving spouses under age 65 and not otherwise eligible for Medicare Parts A & B, may elect to participate in one of the following healthcare plans:
    1. Contra Costa Health Plan Basic Plan A or B
    2. Kaiser Permanente Basic Plan A or B
    3. Health Net HMO Basic Plan A or B
    4. Health Net CA PPO Basic Plan A or B
    5. Health Net National PPO Basic Plan (for non-CA residents) A or B
- Retirees, spouses, domestic partner and surviving spouses age 65 and over and other dependents who are otherwise eligible for Medicare Parts A & B by reason of disability, may elect to participate in one of the following healthcare plans:
    6. Contra Costa Health Plan Medicare Coordination of Benefits Plan A or B
    7. Kaiser Permanente Senior Advantage Plan A or B
    8. Health Net Medicare Coordination of Benefits Plan
    9. Health Net Seniority Plus Plan A or B
    10. Health Net CA PPO Coordination of Benefits Plan A or B
    11. Health Net National PPO Coordination of Benefits Plan A or B (for non-CA residents).

Differences Between The Healthcare Plans

- Health Maintenance Organizations (HMO) plans (Contra Costa Health Plans, Kaiser Permanente, and Health Net) offer members a range of health benefits, including preventive care. The HMO will give you a list of doctors from which you select a primary care provider (PCP). Your PCP coordinates your care, including referrals to specialists.
- HMO Medicare Managed Care Health Plans (Contra Costa Health Plans and Health Net COB Plan) reimburse providers for some services not covered by Medicare. You may use your Medicare card to obtain services outside of your HMO network. However, when you use non-participating providers, you are responsible for any co-payments or deductibles not covered by Medicare (except for emergency or out-of-area urgent care services).
- Preferred Provider Organization (PPO) Basic Plan (Health Net CA and Nat'l. PPO) allows you to select a primary care provider and specialists without referral. You must use doctors in the PPO network or pay higher co-insurance (percentage of charges). In a PPO health plan, you must meet an annual deductible before some benefits apply. You are responsible for a certain co-insurance amount, and the health plan pays the balance up to the allowable amount. When you use a non-participating provider you are responsible for any charges above the amount allowed.
- With a PPO Supplement to Medicare plan (Health Net CA and Nat'l. PPO), your provider bills Medicare for most services and your health plan pays for some services not covered by Medicare. If your providers participate in Medicare, your health plan will pay most bills for Medicare approved services. If any of your providers do not accept Medicare payments. you will have to pay a larger portion of your health care bills. You can find out if you will have to pay more by asking your providers.

Medicare Advantage Plans

- Medicare Advantage Plans (Kaiser Senior Advantage and Health Net Seniority Plus) are HMO Plans. Medicare Advantage plans are approved by the Medicare program and receive a monthly premium directly from Medicare to provide your Medicare benefits. Therefore, you must elect to have the health plan administer your Medicare benefits by completing the plan's Medicare Advantage Election form. To obtain this form, contact Employee Benefits Service Unit at 925-335-1746.

Prescription Drug/Pharmacy Benefit Information

CCHP: Contra Costa Health Plan's Preferred Drug List (PDL) includes a list of drugs that have been approved by the Pharmacy and Therapeutics Committee for members. The PDL is available on line at www.contracostahealthplan.org. Outpatient drugs will be covered that meet patient needs when prescribed by a physician and obtained from a participating pharmacy. If a provider feels that a medication not on the PDL is clinically indicated for a specific patient, he or she always has recourse to the Prior Authorization process. CCHP also has mail order pharmacy service through Walgreens. This service can be accessed at www.walgreensmail.com.

Kaiser Permanente: Kaiser Permanente's formulary uses generic drugs when they are available to meet the patient needs. In addition, Kaiser Permanente will cover brand name drugs and non formulary drugs when medically necessary. Kaiser Permanente's prescription drug formulary is available on line at www.kp.org under the section entitles Health and Wellness tab, and then Drugs and Natural Medicines.

Health Net HMO and PPO: By logging on to HealthNet.com, selections, I'm a member, California, my pharmacy benefits, Individual, family and group plans, and find a pharmacy, participants may view or print the brochure Pharmacy Benefits Members Guide: Making the Most of Your Pharmacy Benefits. This guide provides information on the formulary, the mail order drug program, pharmacy network, prior authorization, generic drugs, and most importantly, how to navigate the My Pharmacy Benefits section of HealthNet.com.

Medicare Supplement/Coordinated Plans for CCHP, Kaiser and Health Net have a different formulary than the basic HMO and PPO Plans. The formulary for Medicare Supplement Plans is regulated by the Centers for Medicare and Medicaid Services (CMS).

Additional Medicare Information

Medicare Parts A&B:

If you are age 65 or older or are otherwise eligible for Medicare Parts A & B, you should be enrolled in Medicare Part A & B.

Medicare Part D:

Effective January 1, 2006, the Medicare Part D Prescription Drug coverage became available to everyone enrolled in Medicare. Because Contra Costa County has creditable coverage and the prescription drug coverage you receive through the County sponsored health plans is "on average at least as good as the standard Medicare prescription drug coverage", you cannot be enrolled in both Medicare Part D and the County health coverage. If you enroll in any Medicare Part D plan, you will then no longer be eligible for health and prescription coverage under the County's health plans and your coverage with us will be terminated. See 2014 Notice of Creditable Coverage.

Dental Options

You may elect to participate in one of the two dental plan options and elect the coverage levels based on your individual and family needs.The dental plan in which to enroll is also a choice.

The following questions are samples of questions you could consider in determining in which dental care plan you should elect to participate:

- Which dental plan network includes the dentist(s) that provide services to you and your family members?
- Is the cost or premium deduction amount affordable?
- How often do you expect to use services that include a co-payment or co-insurance amount that is your responsibility? How much do you anticipate paying in co-payments or co-insurance for the calendar year?
- Do you and all eligible family members reside within the network service area?
- Do you or your family members frequently use dentists that are not in any of the provider networks?

Differences Between Dental Plans

- The Delta Dental Premier Plan offers the freedom to choose any licensed dentist; however, maximum out-of-pocket savings is available by choosing a Delta Dentist. Approximantly 92% of California dentists are also Delta dentists whose fees are pre-negotiated to keep down costs.
- The DeltaCare USA (PMI) Plan includes a more select number of private and group dental offices. There are minimal out of pocket costs when using Delta Care. And, there is an orthodontic benefit included in the Plan. This plan is limited to CA residents.
- A comparison of the dental plans is included in the Guide.

Open Enrollment Procedures

Before completing enrollment forms, consider the following:

1) Review your personalized 2013 Benefit Statement.
   a) The statement reflects the plans in which you currently participate; and,
   b) Family members currently enrolled in your health care and dental plans.
2) Confirm that all dependents listed satisfy and will continue to satisfy the definition of "eligible dependent" as defined earlier in this Guide.
3) See page 9 to verify in which plans you and your dependents are eligible to participate.
4) Decide whether or not you are going to continue the same health care and dental care plan as listed on your Benefits Statement.
   a) If you are changing a health care plan or dental care plan or are adding or deleting family members, then you will need to complete the enclosed 2014 Benefits Open Enrollment Medical & Dental Change Form and return the form to the Employee Benefits Services Unit on or before 5 PM on November 1, 2013.

Contact List

	Phone Number	Web Site
Health Net HMO Plans A & B	1-800-522-0088	www.healthnet.com
Health Net Seniority Plus	1-800-275-4737	www.healthnet.com
Health Net PPO Plans A & B	1-800-676-6976	www.healthnet.com
Health Net PPO CA	1-800-676-6976	www.healthnet.com
Health Net PPO National	1-800-861-7214	www.healthnet.com
CCHP Plans A & B	1-877-661-6230	www.contracostahealthplan.org
Kaiser Permanente	1-800-464-4000	www.kp.org
Kaiser Permanente Serior Advantage	1-800-464-4000	www.kp.org
Delta Dental	1-800-765-6003	www.deltadentalins.com
DeltaCare USA (PMI)	1-800-422-4234	www.deltadentalins.com
MassMutual	1-888-435-9670	www.retirement.massmutual.com
Health Insurance Marketplace		www.coveredca.com www.healthcare.gov www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions

Eligibility Chart

RETIREES AND RETIREE SURVIVORS WHO WERE REPRESENTED BY THE FOLLOWING AT THE TIME OF RETIREMENT:	CCHP A+B Kaiser Basic A Kaiser Senior Advantage A HN HMO Basic A HN Seniority Plus A HN Medicare COB HN CA PPO A HN National PPO A HN PPO Medicare A	Kaiser Basic B Kaiser Senior Advantage B HN HMO Basic B HN Seniority Plus B HN CA + National PPO B HN CA + National PPO Medicare PPO B	DELTA DENTAL DELTA CARE (PMI)
AFSCME LOCAL 2700 - UNITED CLERICAL, TECHNICAL & SPECIALIZED EMPLOYEES	●		●
AFSCME LOCAL 512 - PROFESSIONAL & TECHNICAL EMPLOYEES	●	●	●
SEIU LOCAL 1021 - SOCIAL SERVICES UNION	●		●
PUBLIC EMPLOYEES UNION, LOCAL 1	●		●
CALIFORNIA NURSES ASSOCIATION - WORKING AT LEAST 16 HRS/WK.	●		●
PHYSICIANS' & DENTISTS' ORGANIZATION OF CONTRA COSTA COUNTY	●		●
WESTERN COUNCIL OF ENGINEERS	●		●
UNREPRESENTED EMPLOYEES	●	●	●
UNREPRESENTED MANAGEMENT EMPLOYEES	●	●	●
DEPUTY SHERIFFS' ASSOCIATION			●
DISTRICT ATTORNEY INVESTIGATORS' ASSOCIATION			●
IAFF LOCAL 1230			●
UNITED CHIEF OFFICERS ASSOCIATION			●
UNREPRESENTED UNIFORMED FIRE MANAGEMENT			●
UNREPRESENTED EXEC. SHERIFF MANAGEMENT			●
PUBLIC DEFENDERS ATTORNEY AND INVESTIGATORS	●	●	●
DEPUTY DISTRICT ATTORNEYS ASSOCIATION	●	●	●
PROBATION PEACE OFFICERS ASSOCIATION	●	●	●
IPTFE LOCAL 21	●	●	●

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.

FOR YOUR NOTES

LEGISLATION

LEGISLATION

MICHELLE'S LAW

Michelle's Law requires group health plans to continue dependent health coverage during a dependent's medically necessary leave of absence from post-secondary education if that dependent would have otherwise lost coverage due to lack of student status.

You are required to notify Contra Costa County 30 days before the leave begins if the leave dates are known in advance, or, within 30 days after the start date of the unplanned medical leave of absence. You will need to provide a signed note from your dependent's physician that includes the following notification details:

1. the medical necessity
2. ICD code (diagnosis code)
3. leave start date
4. expected end date
5. physician's name and address
6. physician's signature and date signed

MENTAL HEALTH PARITY AND ADDITION EQUITY ACT (MHPAEA)

Mental Health Parity is designed to remove any day or dollar limitations to treatment for mental health and substance abuse conditions. Some highlights of this law are:

- Applies to group health plans
- Includes both mental health and substance abuse benefits
- If the plan covers mental health and substance abuse disorders, employers are required to cover mental illness and addiction treatment under the same conditions and terms as for other medical conditions.

The Health Plan Comparison Guides have been updated to reflect the required changes.

In addition, Contra Costa County provides an Employee Assistance Program that can help employees and their families with securing appropriate treatment for mental health and substance abuse conditions.

Contra
Costa
County

Human Resources
Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and de pendent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or if the Plan provides retiree health coverage: commencement of a proceeding in a bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs.

Human Resources Department
Employee Benefits Service Unit
651 Pine Street, 5th Floor, Martinez, CA 94553
Phone Number 925-335-1746

Duration of COBRA Coverage

18-month period Generally, when there has been a termination of employment or a reduction in hours that causes coverage to be lost, COBRA coverage for a Qualified Beneficiary begins the day after County-provided health plan coverage is lost, or begins as of the first day of the next month, and continues for up to 18 months.

36-month period. COBRA coverage for your covered spouse or dependent child is 36 months from the date plan coverage is lost due to any of the following events: medicare eligibility of the employee; former employee dies; the employee and spouse are divorced or legally separated; or, for the dependent child only, the dependent child loses status as a dependent under the County's health plan. You, your spouse, or any dependent(s) must notify us, the Employee Benefits Services Unit, within 60 days in writing in case of divorce or the dependent child ceasing to be eligible.

29-month period for disabled qualified beneficiaries. If a Qualified Beneficiary (including you) is disabled, COBRA coverage for all Qualified Beneficiaries continues for up to 29 months from the date COBRA coverage would begin. A 29 month period applies under federal COBRA only if the following conditions are satisfied: (1) the Social Security Administration determines the Qualified Beneficiary is disabled at the time of the qualifying event or within 60 days of when COBRA coverage begins; and (2) the Qualified Beneficiary provides the County a copy of the determination within the initial 18 month coverage period and not later than 60 days after the determination is made. The premium for COBRA coverage increases after the 18th month of coverage to 150% of the applicable premium for the disabled Qualified Beneficiary, as well as other Qualified Beneficiaries, if they are in the same rate band.

Early Termination of COBRA Coverage

COBRA coverage can terminate before the period described above expires. COBRA coverage for a Qualified Beneficiary terminates on the earliest of: the month for which the premium for the Qualified Beneficiary's COBRA coverage is not timely paid; the date the County ceases to maintain any group health plan; after electing COBRA coverage, the date the Qualified Beneficiary becomes (a) entitled to Medicare or (b) covered by another group health plan that contains no exclusion or limitation for pre-existing conditions of the Qualified Beneficiary, or which exclusion or limitation does not apply due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If a Qualified Beneficiary is entitled to 29 months of COBRA coverage on account of disability, but is later determined not to be disabled, coverage ends with the first month beginning more than 30 days after that determination. For further information, please contact the Contra Costa County plan administrator:

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified or the second qualifying event within 60 days of the second qualifying event.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Employee Benefits Service Unit at 925-335-1746 or you may contact the nearest Regional or District Office of the U.S Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Contra Costa County

Human Resources Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

DATE: For **Plan Year January 1, 2014 – December 31, 2014**

NOTICE TO: **Participants in Contra Costa County Employee/Retiree Health Plans (non CalPERS)**

FROM: **Christine J. Penkala, Employee Benefits Manager**

Important Notice from Contra Costa County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Contra Costa County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Contra Costa County has determined that the prescription drug coverage offered by the Contra Costa County Employee/Retiree health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

NOTICE OF CREDITABLE COVERAGE FOR PLAN YEAR JANUARY 1, 2014 – DECEMBER 31, 2014

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Contra Costa County coverage will be terminated.

If you do decide to join a Medicare drug plan and drop your current Contra Costa County coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Contra Costa County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Call Employee Benefits Service Unit at (925) 335-1746.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Contra Costa County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- **Visit www.medicare.gov**
- **Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help**
- **Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contra Costa County

Human Resources Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

NOTICE TO: Participants in Contra Costa County Employee Health Plans

FROM: Christine J. Penkala, Employee Benefits Manager

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	

ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

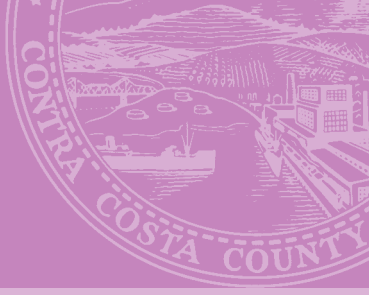
OMB Control Number 1210-0137 (expires 09/30/2013)

FOR YOUR NOTES

The benefit plan information and comparison charts in this Open Enrollment Guide are meant only as a summary of benefits. This information does not fully describe your benefit coverage. For details on benefit coverage, please refer to the Evidence of Coverage documents provided by Contra Costa Health Plan, Health Net, Kaiser Permanente and Delta Dental.

For additional information on the benefit and claims review process and adjudication procedures, please refer to the Evidence of Coverage documents.

If there are any discrepancies between the information included in this 2014 Open Enrollment Guide and the 2014 Evidence of Coverage from the carriers, the Evidence of Coverage will prevail.



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