2020 Contra Costa County Health Plan Comparison Guide
Active Employees

	HMO PLANS										PPO PLANS	
	Contra Costa Health Plan (CCHP) HMOs		Kaiser Permanente				Health Net HMOs				Health Net PPOs*	
	CCHP Plan A	CCHP Plan B	Kaiser HMO Plan A	Kaiser HMO Plan B	HDHP	Teamsters 856 Trust Fund KP	Health Net HMO Plan A	Health Net HMO Plan B	Health Net Smart-Care HMO A	Health Net Smart-Care HMO B	Health Net PPO Plan A	
											In Network	Out of Network
Network Eligibility	You must reside in or work for or have worked for Contra Costa County.	You must reside in or work for or have worked for Contra Costa County.	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 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 reside in a Health Net service area.	You must reside in a Health Net service area.	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	$500	$1,500	None	None	None	None	None	$250	$250
Family	None	None	None	$500/Member $1,000/Family	$2,600/ Member $3,000/Family	None	None	None	None	None	$750	$750
When does the Deductible apply?	N/A	N/A	N/A	Deductible applies to all hospital related services as noted below. Dollar copays are not subject to the deductible.	Deductible applies to all services requiring a coinsurance % or copay	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	N/A	$1,500	$1,500	$3,000	$3,000	$1,500	$1,500	$2,000	$1,500	$2,000	$1,500	$5,000
Family	N/A	$3,000	$1,500/Member $3,000/Family	$3,000/Member $6,000/Family	$3,000/Member $6,000/Family	$3,000	$4,500	$6,000	$3,000	$4,000	$3,000	$10,000
What counts towards the OOP Max?	N/A	All Copays apply to OOP except those for: Chiropractic, Acupuncture	All Copays/Coinsurance apply to OOP except those for: Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP except those for: Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP	All Copays/Coinsurance apply to OOP	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required	All Copays/ Coinsurance and deductibles apply to the OOP except those for: Services not certified as required
Hospital Services												
Inpatient	$0	$0	$0	10% after deductible	10% after deductible	$0	$0	$1,000	$0	$1,500	10%	30%
Outpatient Surgery (at a Facility)	$0	$0	$10	10% after deductible	10% after deductible	$15 per procedure	$0	$500	$0	$250 hospital; $100 surgical center	10%	30%
Emergency Services												
Emergency Department Visits	$0	$0	$10	10% after deductible	10% after deductible	$35 per visit (Waived if admitted)	$25	$100	$50	$100	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 10% Not admitted: $50 plus 10%
Ambulance	$0	$0	$0	$150	10% after deductible	$0	$0	$0	$0	$100	10%	10%

* For the purpose of Deductible and Out of Pocket Maximum limits "Family" means any coverage level other than Individual including Employee + 1 and Employee + 2 or more

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Active Employees - Continued

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	CCHP Plan A	CCHP Plan B	Kaiser HMO Plan A	Kaiser HMO Plan B	HDHP	Teamsters 856 Trust Fund KP	Health Net HMO Plan A	Health Net HMO Plan B	Health Net Smart-Care HMO A	Health Net Smart-Care HMO B	Health Net PPO Plan A	
											In Network	Out of Network
Physician Services												
Office Visits	$0	$5	$10	$20	10% after deductible	$15	$10	$20	$15	$30	$10	30%
Preventive Exams	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	Not Covered
Urgent Care Visits	$0	$5	$15	$20	10% after deductible	$15	$15	$50	$25	$50	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 10% Not admitted: $50 plus 10%
Allergy Injections	$0	$0	$0	$0	10% after deductible	$0	$0	$0	$0	$0	10%	30%
Physical, Occupational, Speech Therapy	$0	$5	$10	$20	10% after deductible	$15	$10	$0	$15	30	10%	30%
Diagnostic X-Ray & Lab	$0	$0	$0	$10	10% after deductible	$0	$0	$0	$0	$0 copay; $100 copay for complex radiology (CT, SPECT, MRI MUGA and PET)	10%	30%
Prescription Drugs												
Retail Pharmacy - 30 (Kaiser or Health Net) or 90 (CCHP) day supply	$0	$3 up to 90 day supply	$10 generic $20 brand	$10 generic $30 brand	$10 generic $30 brand after deductible	$10 generic (up to 100 day supply) $20 brand (up to 100 day supply)	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary	$10 generic, $20 brand, $35 non-formulary, Self-injectables 30%, $250 max per script	$10 generic, $30 brand, $50 non-formulary, Self-injectables 30%, $250 max per script	$5	$5
Mail-Order Pharmacy - 100 (Kaiser) or 90 (Health Net or CCHP) day supply	Covered	$3 up to 90 day supply	$10 generic $20 brand	$20 generic $60 brand	$20 generic $60 brand after deductible	$10 generic $20 brand	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary	$20 generic, $40 brand $70 non-formulary	$20 generic, $75 brand $125 non-formulary	$10	$10
Additional Services												
Durable Medical Equipment	$0	$0	$0	20% (no deductible)	10% after deductible	$0	$0	$0	$0	$0	50%	50%
Vision (Routine exam only, materials not covered except as noted)	$0; up to $65 allowance annually for glasses or contacts	$5; up to $65 allowance annually for glasses or contacts	$0	$0	10% after deductible	$0	$10	$20	$15	$30	$10 through age 16	Not Covered
Hearing Exams	$0 *	$5 *	$0	$0	$0	$0	$10	$20	$15	$30	$10 through age 16	Not Covered
Infertility - diagnosis and treatment only	$0 Infertility – diagnosis and artificial insemination only	$5 Infertility – diagnosis and artificial insemina-tion only	$10	50% (no deductible)	Not Covered	Subject to applicable copays	50%	50%	50%	50%	50% after $500 Infertility deductible; (maximum benefit of $2500 per calendar year and lifetime maximum benefit of $10,000)	50% after $500 Infertility deductible; (maximum benefit of $2500 per calendar year and lifetime maximum benefit of $10,000)
Home Health Services	$0	$0	$0 up to 100 visits	$0 up to 100 visits	$0 up to 100 visits	$0	$0	$20 starting w/ 31st day	$15 starting w/ 31st day,up to 100 days	$30 starting w/ 31st day,up to 100 days	20%; up to 100 visits com-bined PPO/OON	20%; up to 100 visits combined PPO/OON
Skilled Nursing Care	$0 up to 100 days per benefit period	$0 up to 100 days per benefit period	$0 up to 100 days	10% (no deductible) up to 100 days	10% after deductible, 100 days	$0	$0 up to 100 days	$1,000 up to 100 days	$500 up to 100 days	$1,500 up to 100 days	20%; up to 100 days com-bined PPO/OON	20%; up to 100 days combined PPO/OON
Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	20%	20%
Acupuncture	$0 up to 10 visits	$5 up to 10 visits	Not Covered	Not Covered	Not Covered	$15	Discounts available	Discounts available	$10 up to 20 visits (Com-bined with chiropractic)	$10 up to 20 visits (Com-bined with chiropractic)	20%	20%
Chiropractic	$0 up to 10 visits	$5 up to 20 visits	$15 up to 20 visits	$15 up to 20 visits	Not Covered	$15	$10 up to 20 visits	$10 up to 20 visits	$10 up to 20 visits (Com-bined with chiropractic)	$10 up to 20 visits (Com-bined with chiropractic)	Not covered; Discounts available	Not covered; Discounts available

Notes: * CCHP Plans allow 1 standard hearing aid every 5 years

**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).

2020 Dental Plan Comparison Guide

PLAN NAME	DELTA DENTAL Premier Plan (PPO)		DELTACARE USA- PLAN (HMO)
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 Delta Dental Insurance Company.
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 DeltaCare 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 INCLUDE ROUTINE AND PERIODONTAL MAINTENANCE PROCEDURES	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

2020 Dental Plan Comparison Guide (Continued)

PLAN NAME	DELTA DENTAL Premier Plan (PPO)		DELTACARE - PLAN (HMO)
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
ORTHODONTIA: For Deputy Sheriff's Assoc. (DSA) and District Attorney Investigators Assoc. (DAIA)			$1,450/adults
FULL BANDED CASE	50%/ Up to 50%	50% up to $ 2,000 lifetime maximum per person	
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.