CONTRA COSTA COUNTY

2021 Retiree/Survivor

Information and Open Enrollment Guide

Benefit Elections for Plan Year January 1, 2021 through December 31, 2021

Contra Costa County Department of Human Resources
Employee Benefits Services
1025 Escobar Street, 2nd Floor
Martinez, CA 94553
(925) 655-2100

Dear Retirees and Retiree Survivors:

We are pleased to provide you with the 2021 Benefits Information for eligible retirees and retiree survivors of Contra Costa County. Open Enrollment will begin at 8:00 AM on Monday, October 21, 2020 and ends at 5:00 PM on Friday, November 6, 2020. All original enrollment forms and required dependent documentation must be received by the Employee Benefits Services Unit of the Human Resources Department during the Open Enrollment Period.

NEW OPTIONS AVAILABLE

For 2021, we will be implementing a new PPO Network for our Delta Dental PPO plan which will provide our Retirees/Survivors with access to additional Dentists and savings on dental procedures. No action is necessary if you are enrolled in the Delta Dental PPO plan already.

Please make sure you review all the information carefully.

- Refer to your 2020 Employee Benefit 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 the Open Enrollment 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.

The elections you make during this Open Enrollment period are effective for the Plan Year of January 1, 2021 through December 31, 2021. **If you are not making any changes to your current plans or those who are covered by your medical and dental plans, you do not need to complete any forms.** If you are changing carriers, adding or deleting dependents, you do need to complete the appropriate forms and provide the required documentation.

Remember to be sure to complete and submit all enrollment forms and required documentation during the Open Enrollment period of October 21, 2020 through November 6, 2020. As always, should you have any questions, please contact the Human Resources Department, Employee Benefits Services at (925) 655-2100 or send your questions to benefits@hrd.cccounty.us.

Note: If you don't wish to make a change to your current plan no action is necessary.

Best regards,

Your Human Resources Department, Employee Benefits Services

Table of Contents

Open Enrollment Period 2
Eligibility 2
Summary of Benefits and Coverage (SBC) 4
Medical Plans 4
Prescription Drug/Pharmacy Benefit Information 6
Additional Medicare Information 6
Dental Plan Options 6
Open Enrollment Procedures 7
Contact List 8
Former Bargaining Unit Eligibility Chart 9
Medical Comparison Chart - Early Retirees under 65 10
Medical Comparison Chart - Medicare Plans 14
Dental Comparison Chart 18
Legislation and Required Notices 24

Open Enrollment Period

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 2021. 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 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 2021.
- 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.

A. 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.

B. 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 Delta Dental (PPO) is the same as the B(pg.2) Dependent Eligibility for Medicare Supplement/ Coordinated Health Plans. This eligibility provision applies to all retirees and retiree survivors.

Dependent Eligibility for DeltaCare USA (HMO) is the same as the A(pg.2) Dependent that are not 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 at 925-655-2100.

Changes During 2021

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;
- Your spouse, domestic partner or eligible dependent experiences a change in work schedule, such as a reduction or increase in hours which results in loss of coverage or access to new coverage outside County plans.
- 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 30 days of the qualifying event date. The change will become effective the first of the month after the 30-day enrollment period. **If you do not complete, submit and receive approval within 30 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.

Medical Plan Options

Summary of Benefits and Coverage (SBC) for Non-Medicare Medical Plans

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.

You should review the SBC documents before electing your medical coverage for Plan Year 2021.

If you do not have access to read or print the SBCs directly from our website, please call the Employee Benefits Office (925) 655-2100 and request a hard copy of the information be sent to you. Or, email your request to Benefits@hrd.cccounty.us and your reply email will include the requested SBC.

Medical Plans

You may choose from a variety of medical plans and coverage levels based on your individual needs (if service area applies). A comparison of the medical plans is included in the Guide. The medical 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 which medical plan you should elect:

- Which medical plan network includes the physician(s) that provide medical services to you and your family members?
- Which medical 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 – Pre-Medicare Plans:

- 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 SmartCare HMO Basic Plan A or B
    5. Health Net CA PPO Basic Plan A
    6. Health Net OOS PPO Basic Plan (for non-CA residents) A
    7. Teamsters 856 Trust Fund KP Health Plan
    8. High Deductible Health Plan (HDHP)

Medicare Plans:

- Retirees, spouses, domestic partner and surviving spouses age 65 and over who are otherwise eligible for Medicare Parts A & B or under age 65 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
    11. Health Net OOS PPO Coordination of Benefits Plan A (for non-CA residents).

Differences Between The Medical 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 Plans) 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).
- High Deductible Health Plan (HDHP) is a Kaiser Permanente HMO that combines lower premiums with a higher deductible. The Individual or Family deductible must be met before co-insurance and co-pays apply. All Preventive Services (Annual Wellness Physical, Well Child Visits, Immunizations, Preventive Screenings like Mammograms and Colonoscopies) are covered at 100% and are not subject to the deductible. (Not eligible for retirees/survivors over age 65).
- Preferred Provider Organization (PPO) Basic Plan (Health Net CA and OOS 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 OOS 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 925-655-2100.

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 online 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 list 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 entitled Health and Wellness tab, Drugs and Natural Medicines.

Health Net HMOs 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 (Required):

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 (Not Required):

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 a County health plan. If you enroll on a Medicare Part D plan, you will no longer be eligible for health and prescription coverage under the County's health plans and your coverage with us will terminate. See 2021 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 (PPO) Plan offers the freedom to choose any licensed dentist; however, maximum out-of-pocket savings are 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 (HMO) 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. (pg. 18-21)

Open Enrollment Procedures

Before completing enrollment forms, consider the following:

1) Review your personalized 2020 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. (pg. 2 A&B)
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, you will need to complete the enclosed 2021 Benefits Open Enrollment Medical & Dental Change Form and return the form to the Employee Benefits Services Unit.

Contact List

	Phone Number	Web Site
Health Net HMO Plans A & B	1-800-522-0088	www.healthnet.com
Health Net SmartCare HMO A & B	1-800-522-0088	www.healthnet.com
Health Net Seniority Plus	1-800-275-4737	www.healthnet.com
Health Net PPO Plan A	1-800-676-6976	www.healthnet.com
Health Net PPO OOS	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 Senior Advantage	1-800-464-4000	www.kp.org
Delta Dental Premier (PPO)	1-800-765-6003	www.deltadentalins.com
DeltaCare USA (HMO)	1-800-422-4234	www.deltadentalins.com
Kaiser Teamsters 856 Plan Northwest Administrators	1-800-297-4595	
Empower - 457 Deferred Compensation Plan	1-833-457-2626	www.contracosta457.com
Health Insurance Marketplace	1-800-300-1506	www.coveredca.com www.healthcare.gov www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions
Medicare	1-800-633-4227	Medicare.gov

Eligibility Chart

RETIREES AND RETIREE SURVIVORS WHO WERE REPRESENTED BY THE FOLLOWING AT THE TIME OF RETIREMENT:	CCHP A Kaiser Basic A Kaiser Senior Advantage A HN HMO Basic A HN Seniority Plus A HN Medicare COB HN CA PPO A HN OOS PPO A HN SmartCare A HN PPO Medicare A Teamsters 856 HDHP	CCHP B Kaiser Basic B Kaiser Senior Advantage B HN HMO Basic B HN Seniority Plus B HN CA + OOS PPO A HN SmartCare B	DELTA DENTAL PPO DELTA CARE HMO
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	●	●	●
DSA PROBATION PEACE OFFICERS	●	●	●
IPTFE LOCAL 21	●	●	●

CalPERS Medical

* Not eligible for Teamsters 856 , HDHP & Health Net SmartCare A & B

2021 Contra Costa County Medical Plan Comparison Guide
Non-Medicare Enrolled Retirees

	HMO PLANS										PPO PLANS	
	Contra Costa Health Plan (CCHP) HMOs		Kaiser Permanente				Health Net HMOs				Health Net PPOs*	
											Health Net PPO Plan A	
	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 SmartCare HMO A	Health Net SmartCare HMO B	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 combined PPO/OON	$250 combined PPO/OON
Family	None	None	None	$500/Member $1,000/Family	$2,800/Member $3,000/Family	None	None	None	None	None	$750 combined PPO/OON	$750 combined PPO/OON
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

2021 Contra Costa County Medical Plan Comparison Guide
Non-Medicare Enrolled Retirees - Continued

	HMO PLANS										PPO PLANS	
	Contra Costa Health Plan (CCHP) HMOs		Kaiser Permanente				Health Net HMOs		Health Net SmartCare		Health Net PPOs	
											Health Net PPO Plan A	
	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 SmartCare HMO A	Health Net SmartCare HMO B	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	$10	$20	10% after deductible	$15	$15 for medical urgent care services $10 for urgent care services related to vehaviorol health, chemical dependency or substonce abuse disorders	$50 for medical urgent care services $20 for urgent care services related to vehaviorol health, chemical dependency or substonce abuse disorders	$25 for medical urgent care services $15 for urgent care services related to vehaviorol health, chemical dependency or substonce abuse disorders	$50 for medical urgent care services $30 for urgent care services related to vehaviorol health, chemical dependency or substonce abuse disorders	If admitted: 10% Not admitted: $50 plus 10% for medical urgent care services $10 (deductible waived) for urgent care servic es related to behavioral health, chemical dependency or substonce abuse disorders	If admitted: 10% Not admitted: $50 plus 10% for medical urgent care services $10 (deductible waived) for urgent care services related to behavioral health, chemical dependency or substonce abuse disorders
Allergy Injections	$0	$0	$3	$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 up to 100 day supply $20 brand up to 100 day supply	$10 generic up to 30 day supply $30 brand up to 30 day supply	$10 generic up to 30 day after deducible $30 brand up to 30 day after deducible	$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 after deductible $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 allow-ance 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 – diag-nosis and artificial insemination 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 calendaryear and lifetime maximumbenefit of $10,000)	50% after $500 Infertility deductible; (maximum benefit of $2500 per calendaryear and lifetime maximumbenefit 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 combined 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 visits combined PPO/OON	20%; up to 100 visits 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 self refferal*	Not self refferal*	Not self refferal*	$15	Discounts available	Discounts available	$10 up to 20 visits (Combined with chiropractic)	$10 up to 20 visits (Combined 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 (Combined with chiropractic)	$10 up to 20 visits (Combined with chiropractic)	Not covered; Discounts available	Not covered; Discounts available

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

* Kaiser accupuncture available only with refferal, at Kaiser facilities

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).

2021 Contra Costa County Medical Plan Comparison Guide
Retiree Plans that Coordinate with Medicare

	HMO PLANS								PPO PLANS	
	Contra Costa Health Plan (CCHP) HMOs		Kaiser Permanente Senior Advantage		Health Net Seniority		Health Net HMO COB		Health Net PPO COB	
									Health Net PPO COB Plan A	
	CCHP Plan A	CCHP Plan B	KPSA – Plan A	KPSA – Plan B	Health Net Seniority Plus Plan A	Health Net Seniority Plus Plan B	Health Net HMO COB Plan A	Health Net HMO COB Plan B	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 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 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	None	None	None	None	None	$250	
Family	None	None	None	None	None	None	None	None	$750	
When does the Deductible apply?	N/A	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.	
Max Calendar Year Out of Pocket (OOP) Expense										
Individual	N/A	$1,500	$1,500	$1,500	$3,400	$3,400	$1,500	$2,000	$1,500	$5,000
Family	N/A	$3,000	$3,000	$3,000	N/A	N/A	$4,500	$6,000	$3,000	$10,000
What counts towards the OOP Max?	N/A	All Copays/Coinsurance apply to OOP except those for: Chiropractic, Acupuncture	All Copays/Coinsurance apply to OOP except those for: Chiropractic	All Copays/Coinsurance apply to OOP except those for: 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	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	$0	$0	$250	$0	$0	$0	$1,000	10%	30%
Outpatient Surgery (at a Facility)	$0	$0	$10	$25	$0	$20	$0	$500	10%	30%
Emergency Services										
Emergency Department Visits	$0	$0	$10	$50	$20 (waived if admitted)	$50 (waived if admitted)	$25	$100	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 10% Not admitted: $50 plus 10%
Ambulance	$0	$0	$0	$50	$0	$0	$0	$0	10%	10%

2021 Contra Costa County Medical Plan Comparison Guide

Retiree Plans that Coordinate with Medicare (Continued)

	HMO PLANS								PPO PLANS	
	Contra Costa Health Plan (CCHP) HMOs		Kaiser Permanente Senior Advantage		Health Net Seniority		Health Net HMO COB		Health Net PPO COB	
									Health Net PPO COB Plan A	
	CCHP Plan A	CCHP Plan B	KPSA — Plan A	KPSA — Plan B	Health Net Seniority Plus Plan A	Health Net Seniority Plus Plan B	Health Net HMO COB Plan A	Health Net HMO COB Plan B	In Network	Out of Network
Office Visits	$0	$5	$10	$25	$5	$20	$10	$20	$10	30%
Preventive Exams	$0	$0	$0	$0	$0	$0	$0	$0	$0	Not Covered
Urgent Care Visits	$0	$5	$10	$25	$20 (waived if admitted)	$20 (waived if admitted)	$15 for medical urgent care services $10 for urgent care services related to behavioral health, chemical dependency or substance abuse disorders	$50 for medical urgent care services $20 for urgent care services related to behavioral health, chemical dependency or substance abuse disorders	If admitted: 10% Not admitted: $50 plus 10%	If admitted: 10% Not admitted: $50 plus 10%
Allergy Injections	$0	$0	$3	$0	$0	$0	$0	$0	10%	30%
Physical, Occupational, Speech Therapy	$0	$5	$10	$25	$0	$0	$10	$0	10%	30%
Diagnostic X-Ray & Lab	$0	$0	$0	$0	$0	$0	$0	$0	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 $20 brand	$5 generic $5 brand	$10 generic $20 brand $35 non-formulary	$10 generic$20 brand$35 non-formulary	$10 generic$20 brand$35 non-formulary	$5	$5
Mail —Order Pharmacy — 100 day supply (Kaiser) or 90 (Health Net or CCHP) day supply	Covered	$3 up to 90 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	$20 generic $40 brand $70 non-formulary	$10	$10
Additional Services										
Durable Medical Equipment	$0	$0	$0	20%	$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	$10	$25	$5	$20	$10	$20	$10 through age 16	Not Covered
Hearing Exams	$0 *	$5 *	$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	$10	$20	Discounts available	Discounts available
Infertility - diagnosis and treatment only	$0 Infertility — diagnosis and artificial insemination only	$5 Infertility — diagnosis and artificial insemination only	$10	$25	$5	$20	$10	$25	$10 through age 16	Not Covered
Home Health Services	$0	$0	$0 up to 100 visits	$0 up to 100 visits	$0	$0	$0	$20 copay starts on 31st calendar day after the first visit	20%; up to 100 visits combined 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	$0 up to 100 days	$0 up to 100 days	$0 up to 100 days	$0 up to 100 days	$1,000 up to 100 days	20%; up to 100 days combined PPO/OON	20%; up to 100 days combined PPO/OON
Hospice	$0	$0	$0	$0	Through Medicare	Through Medicare	$0	$0	20%	20%
Acupuncture	$0 up to 10 visits	$5 up to 10 visits	Not self refferal*	Not self refferal*	Discounts available	Discounts available	Discounts available	Discounts available	20%	20%
Chiropractic	$0 up to 10 visits	$5 up to 20 visits	$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	$10 up to 20 visits	Not covered; Discounts available	Not covered; Discounts available

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

* Kaiser accupuncture available only with refferal, at Kaiser facilities

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).

2021 Dental Plan Comparison Guide - All Retirees

PLAN NAME	DELTA DENTAL PLAN (PPO & PREMIER)		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	888-335-8227		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 Dentists PLAN PAYS: based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees	FEE
DIAGNOSTICS:			
ORAL EXAMINATION AND DIAGNOSIS	70%	Up to 70%	No Cost
OFFICE VISITS	70%	Up to 70%	No Cost (regularly scheduled hours); $20 after hours
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

2021 Dental Plan Comparison Guide - All Retirees- Continued

PLAN NAME	DELTA DENTAL PLAN (PPO & PREMIER)		DELTACARE - PLAN (HMO)
MEMBER SERVICES	Participating Dentist PLAN PAYS:	Non-Participating Dentists PLAN PAYS: based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees	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
ORTHODONTIA: For Deputy Sheriff's Assoc. (DSA) and District Attorney Investigators Assoc. (DAIA)			
FULL BANDED CASE	50% up to $2,000 Lifetime Maximum Per Member		
MAXIMUM BENEFIT PAYMENTS PER CALENDAR YEAR Bargaining Unit DSA, DAIA, IAFF, UCOA & PDOC Unrepresented and All Other Bargaining Units	$1,600.00 Lifetime Maximum Per Member $1,800.00 Lifetime Maximum Per Member 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 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. leave start date
3. expected end date
4. physician's name and address
5. physician's signature and date signed

Contra Costa County

Human Resources Department

Administration Building
1025 Escobar Street, 2nd Floor
Martinez, CA 94553

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage which 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 of one of the following qualifying events happens:

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

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

(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 lose coverage under the Plan because any of the following qualifying events:

(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."

Filing a proceeding in bankruptcy under title 11 of the United States Code can sometimes be considered a qualifying event. If a 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 30 days of the qualifying event.

Human Resources Department
Employee Benefits Service Unit
1025 Escobar Street, 2nd Floor, Martinez, CA 94553
Phone Number 925-655-2100

Other coverage options besides COBRA Continuation Coverage.

Instead of enrolling in COBRA continuation coverage, there may be more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through "Special Enrollment Period(SEP)." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, If you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

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 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 925-655-2100 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
1025 Escobar Street, 2nd Floor
Martinez, CA 94553

DATE: For Plan Year January 1, 2021 - December 31, 2021

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

FROM: Ann Elliott, Human Resources 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. Youcan get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare AdvantagePlan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide atleast a standard level of coverage set by Medicare. Some plans may also offer more coverage for ahigher monthly premium.

2.Contra Costa County has determined that the prescription drug coverage offered by the ContraCosta County Employee/Retiree health plan is, on average for all plan participants, expected to payout as much as standard Medicare prescription drug coverage pays and is therefore consideredCreditable Coverage. Because your existing coverage is Creditable Coverage, you can keep thiscoverage 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, 2021 – DECEMBER 31, 2021

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan and drop your current Contra Costa County medical plan coverage, be aware that you and your dependents will not be able to get this coverage back.

However, please be aware Contra Costa County Medicare participants do not need to enroll in Medicare Part D because our medical plans already include creditable prescription drug coverage.

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) 655-2100.

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).

Centers for Medicare and Medicaid (CMS) Notice Form 10182-CC

Contra Costa County

Human Resources Department

Administration Building
1025 Escobar Street, 2nd Floor
Martinez, CA 94553

DATE: For Plan Year January 1, 2021 - December 31, 2021

NOTICE TO: Participants in Contra Costa County Employee/Retiree Health Plans

FROM: Ann Elliott, Human Resources 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're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at **www.askebsa.dol.gov** or call **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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**LOUISIANA** – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
ALASKA – Medicaid	**MAINE** – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
ARKANSAS – Medicaid	**MASSACHUSETTS** – Medicaid and CHIP
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MINNESOTA** – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
FLORIDA – Medicaid	**MISSOURI** – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 678-564-1162 Ext.2131	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
IOWA – Medicaid	**NEVADA** – Medicaid
Website: http://dhs.iowa.gov/hawk Phone: 1-800-257-8563	Medicaid Website: https://dhofp.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medical Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov Phone: 1-800-635-2570	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

NEW YORK – Medicaid	**TEXAS** – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH** – Medicaid and CHIP
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA– Medicaid	**VERMONT** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON** – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid	**WISCONSIN** – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING** – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
SOUTH DAKOTA – Medicaid	
Website: http://dss.sd.gov Phone: 1-888-828-0059	

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

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 2021 Open Enrollment Guide and the 2021 Evidence of Coverage from the carriers, the Evidence of Coverage will prevail.

Design and Layout by:
Contra Costa County
Print & Mail Services
(925) 646-5521
graphics@pw.cccounty.us