

# 2023 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*	
	CCHP Plan A	CCHP Plan B	Kaiser HMO Plan A	Kaiser HMO Plan B	HDHP	Teamsters 856 Trust Fund KP	Health Net SmartCare HMO A	Health Net SmartCare HMO B	Health Net PPO Plan A	
									In Network	Out of Network
<b>Network Eligibility</b>	You must reside near and have worked for Contra Costa County.	You must reside near and 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 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.
<b>Calendar Year Deductible</b>										
Individual	None	None	None	\$500	\$1,500	None	None	None	\$250 combined PPO/OON	\$250 combined PPO/OON
Family	None	None	None	\$500/Member \$1,000/Family	\$3,000/Member; \$3,000/ Family	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	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.
<b>Max Calendar Year Out of Pocket (OOP) Expense</b>										
Individual	N/A	\$1,500	\$1,500	\$3,000	\$3,000	\$1,500	\$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	\$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 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
<b>Hospital Services</b>										
Inpatient	\$0	\$0	\$0	10% after deductible	10% after deductible	\$0	\$0	\$1,500	10%	30%
Outpatient Surgery (at a Facility)	\$0	\$0	\$10	10% after deductible	10% after deductible	\$10 per procedure	\$0	\$250 hospital; \$100 surgical center	10%	30%
<b>Emergency Services</b>										
Emergency Department Visits	\$0	\$0	\$10	10% after deductible	10% after deductible	\$35 per visit (Waived if admitted)	\$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	\$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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## Non-Medicare Enrolled Retirees - Continued

HMO PLANS								PPO PLANS		
	Contra Costa Health Plan (CCHP) HMOs		Kaiser Permanente				Health Net SmartCare		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 SmartCare HMO A	Health Net SmartCare HMO B	Health Net PPO Plan A	
									In Network	Out of Network
<b>Physician Services</b>										
Office Visits	\$0	\$5	\$10	\$20	10% after deductible	\$10	\$15	\$30	\$10	30%
Preventive Exams	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	Not Covered
Urgent Care Visits	\$0	\$5	\$10	\$20	10% after deductible	\$10	\$25 for medical urgent care services, \$15 for urgent care services related to health, chemical dependency or substance abuse disorders	\$50 for medical urgent care services \$30 for urgent care services related to health, chemical dependency or substance 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 substance 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 substance abuse disorders
Allergy Injections	\$0	\$0	\$3	\$0	10% after deductible	\$0	\$0	\$0	10%	30%
Physical, Occupational, Speech Therapy	\$0	\$5	\$10	\$20	10% after deductible	\$10	\$15	\$30	10%	30%
Diagnostic X-Ray & Lab	\$0	\$0	\$0	\$10	10% after deductible	\$0	\$0	\$0 copay; \$100 copay for complex radiology (CT, SPECT, MRI MUGA and PET)	10%	30%
<b>Prescription Drugs</b>										
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 deductible; \$30 brand up to 30 day after deductible	\$10 generic (up to 100 day supply); \$20 brand (up to 100 day supply)	\$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, \$75 brand; \$125 non-formulary	\$10	\$10
<b>Additional Services</b>										
Durable Medical Equipment	\$0	\$0	\$0	20% (no deductible)	10% after deductible	\$0	\$0	\$0	10%	30%
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	\$15	\$30	\$0 newborn until age 2; \$10 child age 2 through 16; Not covered adult 17 and older	Not Covered
Hearing Exams	\$0 *	\$5 *	\$0	\$0	\$0	\$0	\$15	\$30	\$10**	Not Covered
Infertility - diagnosis and treatment only	\$0 Infertility — diagnosis and artificial insemination only	\$5 Infertility — diagnosis and artificial insemination only	\$10	50% (no deductible)	Not Covered	Subject to applicable copays	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 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 up to 100 visits	\$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 up to 100 days per benefits period	\$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	20%	20%
Acupuncture	\$0 up to 10 visits	\$5 up to 10 visits	Not self referral*	Not self referral*	Not self referral*	\$15 up to 20 visits (combined with Chiropractic)	\$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 up to 20 visits (combined with acupuncture)	\$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 acupuncture available only with referral, 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).

# 2023 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 Plus		Health Net HMO COB		Health Net PPO COB	
	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	Health Net PPO COB Plan A	
									In Network	Out of Network
<b>Network Eligibility</b>	You must reside near and have worked for Contra Costa County.	You must reside near and 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.
<b>Calendar Year Deductible</b>										
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.	
<b>Max Calendar Year Out of Pocket (OOP) Expense</b>										
Individual	N/A	\$1,500	\$1,000	\$1,000	\$3,400	\$3,400	\$1,500	\$2,000	\$1,500	\$5,000
Family	N/A	\$3,000	N/A	N/A	N/A	N/A	\$3,000	\$4,000	\$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	All Copays/Coinsurance apply to OOP	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
<b>Hospital Services</b>										
Inpatient	\$0	\$0	\$0	\$250	\$0	\$0	\$0	\$1,500	10%	30%
Outpatient Surgery (at a Facility)	\$0	\$0	\$10	\$25	\$0	\$20	\$0	\$250 hospital; \$100 surgical center	10%	30%
<b>Emergency Services</b>										
Emergency Department Visits	\$0	\$0	\$10	\$50	\$20 (waived if admitted)	\$50 (waived if admitted)	\$50	\$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	\$100	10%	10%

# 2023 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 Plus		Health Net HMO COB		Health Net PPO COB	
	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	Health Net PPO COB Plan A	
									In Network	Out of Network
Office Visits	\$0	\$5	\$10	\$25	\$5	\$20	\$15	\$30	\$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)	\$25 for medical urgent care services, \$15 for urgent care services related to behavioral health, or substance abuse disorders	\$50 for medical urgent care services, \$30 for urgent care services related to behavioral health, 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	\$15	\$30	10%	30%
Diagnostic X-Ray & Lab	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0 copay; \$100 copay for complex radiology (CT, SPECT, MRI, MUGA and PET)	10%	30%
<b>Prescription Drugs</b>										
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; 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 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 \$75 brand, \$125 non-formulary	\$10	\$10
<b>Additional Services</b>										
Durable Medical Equipment	\$0	\$0	\$0	20%	\$0	\$0	\$0	\$0	10%	30%
Vision (Routine exam only, materials not covered except as noted)	\$0; up to \$65 allowance annually for glasses or contacts	\$0; up to \$65 allowance annually for glasses or contacts	\$10	\$25	\$100 frame allowance every 24 months	\$100 frame allowance every 24 months	\$15	\$30	\$0 newborn to age 2; \$10 child age 2 through 16; Not covered adult 17 and older	Not Covered
Hearing Exams	\$0*	\$5*	\$150 allowance (including contacts) every 24 months	\$150 allowance (including contacts) every 24 months	\$5	\$20	\$15	\$30	\$10**	Not Covered
Infertility - diagnosis and treatment only	\$0 Infertility — diagnosis and artificial insemination only	\$5 Infertility — diagnosis and artificial insemination only	\$10	\$25	Not Covered	Not Covered	50%	50%	50% after \$500 infertility ded (max ben of \$2500 per cal year and lifetime max ben of \$10,000)	50% after \$500 infertility ded (max ben of \$2500 per cal year and lifetime max ben of \$10,000)
Home Health Services	\$0	\$0	\$0 up to 100 visits	\$0 up to 100 visits	\$0	\$0	\$15 starting w/31st days up to 100 days	\$30 starting w/31st days 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	\$0 up to 100 days	\$0 up to 100 days	\$0 up to 100 days	\$500 up to 100 days	\$1,500 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 referral*	Not self referral*	\$5 up to 20 visits	\$20 up to 20 visits	\$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	\$5 up to 20 visits	\$5 up to 20 visits	\$10 up to 20 visits (combined with Acupuncture)	\$10 up to 20 visits (combined with Acupuncture)	Not covered; Discounts available	Not covered; Discounts available

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

\* Kaiser acupuncture available only with referral, 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).

\*\* Hearing exams, coverage is the same as Vision