2022 Contra Costa County Medical 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 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

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											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 Smart-Care HMO A	Health Net Smart-Care 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 health, chemical dependency or substance abuse disorders	$50 for medical urgent care services $20 for urgent care services related to health, chemical dependency or substance abuse disorders	$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 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 subsstance abuse disorders
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 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 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 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 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 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 days combined 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	No 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).