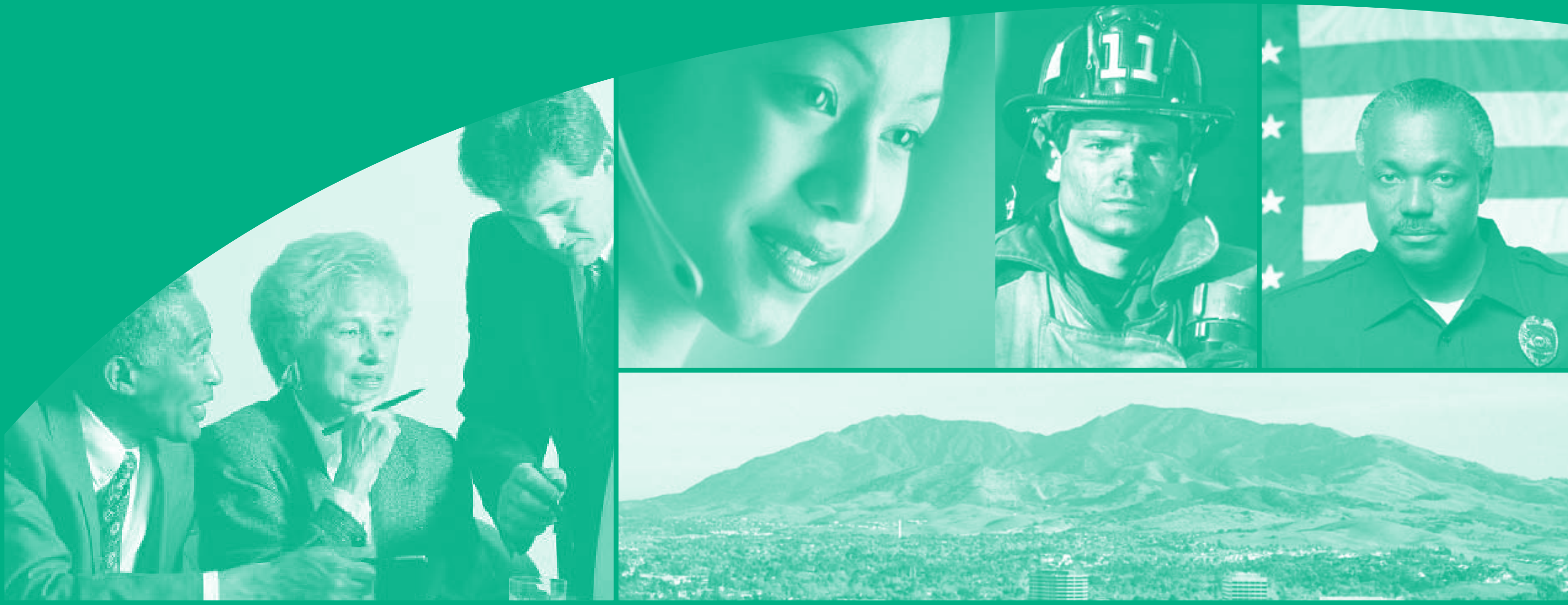


CONTRA COSTA COUNTY

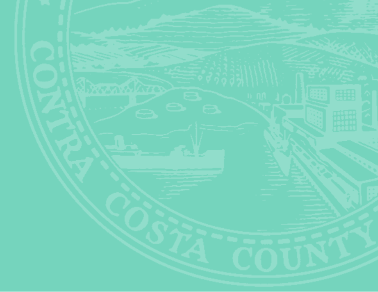
2013 Employee Benefits

Information and Open Enrollment Guide

Benefit Elections for Plan Year January 1, 2013 through December 31, 2013

Open Enrollment Period is September 10, 2012 through October 5, 2012

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



Dear Employees:

We are pleased to provide you with the 2013 Employee Benefits Information and Open Enrollment guide for eligible employees of Contra Costa County. Open Enrollment will begin at 8:00 AM on Monday September 10, 2012 and ends at 5:00 PM on Friday October 5, 2012. All original enrollment forms and required dependent documentation must be received by the Human Resources Department, Employee Benefits Services Unit during the Open Enrollment Period.

If adding a spouse, domestic partner or child you must bring the certified Marriage certificate, domestic partner certificate or certified birth certificate into the Employee Benefits office when enrolling.

Benefit Plan Changes effective January 1, 2013

- CA SB946 - Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Federal Guidelines on Women Preventive Services refer to your EOC or call your carrier for additional information
- Health Care Spending Account new Annual Limit of $2,500

Please refer to **page 12** of this guide to determine your eligibility for the plan options. It is very important that you compare all plan options and monthly premium costs to determine which plan best suits your personal and family needs.

Remember that each year you must re-enroll in the Health Care Spending Account (HCSA) and Dependent Care Assistance Program (DCAP).

The elections you make during this Open Enrollment period are effective for the Plan Year of January 1, 2013 through December 31, 2013. If you are not making any changes to your current plans or those who are covered by your current medical and dental plans, you do not need to complete any forms. If you are changing plans, adding or deleting dependents, or participating in the HCSA or DCAP, you do need to complete the appropriate forms and provide the required documentation.

If you have a qualified change in family status during the Plan Year, you must submit the change form and required documentation within sixty (60) days of the qualifying event date. Please see “Section 125 Compliance” on page 6 for additional information on qualifying events. Changes cannot be accepted outside the 60 day period following the actual qualifying event date.

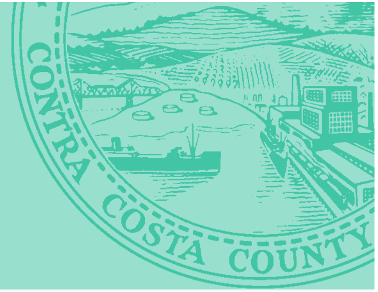
Finally, please make sure you review all information carefully. Refer to your 2012 Employee Benefits Statement that you received through the mail to confirm in which plans you currently participate and which family members are included in your plans. Be sure to complete and submit all enrollment forms and required documentation during the Open Enrollment period of September 10, 2012 through Friday October 5, 2012.

As always, should you have any questions, please contact the Human Resources Department, Employee Benefits Services Unit at (925) 335-1746 or send your questions to benefits@hrd.cccounty.us.

Best regards,

Your Human Resources Department
Employee Benefits Services Unit

Table of Contents



Open Enrollment Period 2
Eligibility 3
Dependent Eligibility Verification Process 4
Section 125 Compliance 6
Healthcare Options 6
Prescription Drug/Pharmacy Benefit Information 7
Dental Plan Options 8
Premium Conversion Plan (PCP) 8
Health Care Spending Account (HCSA) 9
Dependent Care Assistance Program (DCAP) 10
Enrollment Options 12
VDT Information 13
Contact List 14
Open Enrollment Procedures 15
Reviewing Other Benefit Programs 15
Medicare Eligible and Still Working 16
HMO Comparison Chart 18
PPO Comparison Chart 19
Dental Comparison Chart 22
Legislation 28
CoBRA 29
Notice of Creditable Coverage 31
IRS Regulations Regarding Domestic Partner Benefits 33
CHIP Notice 34

Open Enrollment Period

The open enrollment period begins at 8:00 AM on Monday September 10, 2012 and ends at 5:00 PM on Friday October 5, 2012.

The open enrollment period begins at 8:00 AM on Monday September 10, 2012 and ends at 5:00 PM on Friday October 5, 2012

During this period, eligible employees may:

- Enroll in a medical and dental plan, if you are eligible and you currently do not have medical or dental benefits
- Change your medical or dental plan
- Add or drop eligible dependent's medical or dental coverage
- Enroll in the 2013 Health Care Spending Account Plan
- Enroll in the 2013 Dependent Care Assistance Program
- Begin or end participation in the Premium Conversion Plan

Additionally, it is a good time to:

- Review or amend your life insurance beneficiary
- Add or increase supplemental life insurance, if eligible and subject to completion, submission and approval of Evidence of Insurability
- Review your deferred compensation plan deferrals, investment options and beneficiaries

When Enrolling In Plans, Remember:

- Premiums are deducted from your paycheck on the 10th of each month. If you do not have enough money in your paycheck for the full deduction, a partial deduction will not be taken. It is your responsibility to pay the full monthly premium due in the form of a check payable to Contra Costa County and received in the Contra Costa County Auditor Controller's Office by the 10th of the month, the same as if the amount was deducted from your paycheck.
- Medical, dental, health care spending account and dependent care assistance programs elected during open enrollment will be effective January 1, 2013 through December 31, 2013. If you do not make any changes during the open enrollment period, your current medical and dental plan elections as well as your current premium conversion plan election will remain in effect for calendar year 2013.
- The Health Care Spending Account and Dependent Care Assistance Program require re-enrollment every Plan Year.
- Employees who add their spouse, domestic partner and /or dependent child(ren) on their medical or dental plan must submit documentation verifying dependent eligibility.

Eligibility

Management, Exempt and Unrepresented Employees -

Employees regularly scheduled to work at least 20 hours per week are eligible to participate in the Medical, Dental and Life Insurance programs as well as Health Care Spending Account, Dependent Care Assistance Program, premium conversion plan and the deferred compensation plan. Employees regularly scheduled to work less than 20 hours per week, intermittently or on a provisional basis may participate in the medical, dental, life and premium conversion plans; however, these employees are required to pay the total monthly premium without a County contribution.

Represented Employees -

Eligibility to participate in the Employee Benefit Programs is defined in each Memorandum of Understanding (MOU). Generally speaking, employees regularly scheduled to work at least 20 hours per week are eligible to participate in the medical, dental and life insurance programs as well as health care spending account, dependent care assistance program, premium conversion plan and the deferred compensation plan. Employees regularly scheduled to work less than 20 hours per week, intermittently or on a provisional basis may participate in the medical, dental, life and premium conversion plans; however, these employees are required to pay the total monthly premium without a County contribution. Represented employees should review their specific MOU for further clarification of eligibility, as the hour requirement may vary based on the MOU.

Dependent Eligibility – Health Insurance Only

The following dependents of an enrolled employee are eligible for health insurance:

- Legal Spouse
- Qualified domestic partner (requires the completing and submitting of certification forms)
- 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 Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Act of 2010 requires that the County include as eligible dependents adult children until they reach age 26. The Act does not require the County to extend coverage to an employee's grandchildren or to the spouse of the employee's child.

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.

Note: It is against County Policy for an employee to enroll ineligible persons as dependents; to do so may subject the employee to disciplinary action as well as the obligation to reimburse the plan for all costs associated with the delivery of medical care services to an ineligible person.

Note: It is against County Policy for an employee to enroll ineligible persons as dependents; to do so may subject the employee to disciplinary action as well as the obligation to reimburse the plan for all costs associated with the delivery of medical or dental care services to an ineligible person.

Dependent Eligibility – Dental Insurance Only

The following dependents of an enrolled employee are eligible for health, dental and supplemental life coverage:

- Legal Spouse
- Qualified domestic partner (qualified domestic partner enrollment requires the completing and submitting certification forms that are available in the Employee Benefits Services Unit or online)
- Unmarried children who are dependent on you, your spouse or qualified domestic partner for support who are
  - ✓ Under age 19;
  - ✓ Age 19 to age 24, who are qualifying dependent children as defined by the Internal Revenue Service.
  - ✓ 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 qualified domestic partner and any child specified in a Qualified Medical Child Support Order (QMCSO) or similar court order.

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

Dependent Eligibility Verification Process

All employees adding dependents must submit documentation verifying eligibility of their covered dependents. Included on the Open Enrollment Change Form (this form was sent to you with your annual benefits statement) is a listing of required documents.

The following chart is an easy guide for which form and documents must be submitted. The chart does not include all possibilities and should be used in conjunction with the Dependent Eligibility Documentation listing on the Open Enrollment Change Form.

For further clarification, please contact the Employee Benefits Services Unit at (925) 335-1746.

Health Insurance Only	None	Marriage Certificate	Birth Certificate for each child **	State of California DP Registration	Contra Costa County Domestic Partner Registration*
Employee only	●				
Employee & Spouse		●			
Employee & Children under age 26			●		
Employee , Spouse & Children under age 26		●	●		
Employee & Domestic Partner				● OR	●
Employee/Domestic Partner & Children under age 26			●	● OR	●

Dental Insurance Only	None	Marriage Certificate	Birth Certificate for each child **	Dependent Verification	State of California DP Registration	Contra Costa County Domestic Partner*
Employee only	●					
Employee & Spouse		●				
Employee & Children under 19 yrs of age			●			
Employee & Children over 19 years of age			●	●		
Employee, Spouse & Children under 19 years of age		●	●			
Employee, Spouse & Children over 19 years of age		●	●	●		
Employee & Domestic Partner only					● OR	●
Employee, Domestic Partner & Children under 19 years of age			●		● OR	●
Employee, Domestic Partner & Children over 19 years of age			●	●	● OR	●

* Must provide Domestic Partner Picture ID, last 6 months of utility bills, bank statements and other such documentation showing a common address.

**Birth Certificates must include the employee's name or the spouse's name or the domestic partner's name. If you do not have a birth certificate with at least one of the aforementioned names included, you must provide a court document that shows you have/had medical care responsibility for the child prior to the child attaining age 19.

For other dependent verification requirements, please refer to the "Dependent Eligibility Documentation" chart on the Open Enrollment change form.

Section 125 Compliance

In compliance with Section 125 of the Internal Revenue Code (IRC), medical, dental or spending account 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;
- A change in the number of your tax dependents through birth, adoption, placement for adoption, or death;
- Your dependent's ability to satisfy dependent eligibility requirements;
- Termination or commencement of employment of a spouse, domestic partner or eligible dependent;
- A change in work schedule, such as a reduction or increase in hours by your spouse, domestic partner or eligible dependent.
- The taking of an unpaid leave of absence by either you or 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 in your dependent care provider that increases the cost of dependent care.

Medical, dental or spending account benefit elections may be changed during the plan year only if you have a qualified life status change event.

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

Healthcare Options

Healthcare Plans

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

- Which healthcare plan network includes the physician(s) that provide medical services to you and your family members?
- Which healthcare plan network includes the hospital and urgent care centers where your physician(s) have privileges?

- Is the cost or premium deduction amount affordable?
- How often do you expect to use services that include a co-payment? How much do you anticipate paying in co-payments for the calendar year?
- Are ancillary services such as on-line information, preventive care programs, on-line provider ratings or comparisons, and, on-line provider searches, etc. important to you?
- Do you and all eligible family members reside within the network service area?
- Do you or your family members always use physicians that are not in any of the healthcare provider networks?

Differences Between The Healthcare Plans

- Health Maintenance Organizations (HMO) plans (Contra Costa Health Plans, Kaiser Permanente, and Health Net) offer members a range of health benefits, including preventive care. The HMO will give you a list of doctors from which you select a primary care provider (PCP). Your PCP coordinates your care including referrals to specialists.
- Preferred Provider Organization (PPO) plans (Health Net) allow 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.

In accordance with 2010 Health Care Reform legislation, the following provision apply to all Non-Medicare health plans:

- Coverage of preventive health services
- No lifetime or annual benefit limits on essential benefits
- No pre-existing conditions on dependents below age 19
- Extension of dependent coverage for adult children to age 26
- Requirement of certain choice of providers for pediatric and obstetrical or gynecological (ob/gyn) care
- Requirement of in-network coverage for emergency room visits to non-network providers
- Effective January 1, 2013 Expanded women's preventive care services

Prescription Drug/Pharmacy Benefit Information

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

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

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

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 personal 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?

The PCP allows eligible employees to authorize a pre-tax salary reduction to pay monthly medical and dental plan premiums.

Differences Between Dental Plans

- The Delta Dental Plan offers the freedom to choose any licensed dentist; however, maximum out-of-pocket savings is available by choosing a Delta Dentist. Approximately 92% of California dentists are also Delta dentists whose fees are pre-negotiated to keep down costs.
- The DeltaCare USA (PMI) Plan includes a more select number of private and group dental offices. There are minimal out of pocket costs when using PMI 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.

Premium Conversion Plan (PCP)

The PCP allows eligible employees to authorize a pre-tax salary reduction to pay monthly medical and dental plan premiums. This benefit does not defer taxes to a later date, it exempts your medical and dental plan contributions from taxes altogether. You may participate in the PCP if you enroll in either the medical or dental plan. Once you enroll, you will continue to participate in this plan until the next open enrollment period when you may choose to revoke your election. If you elect to continue participating in the Premium Conversion Plan, no action is necessary during the open enrollment period.

To enroll or cancel your participation in the PCP, please complete the Premium Conversion Plan Enrollment/Change Form and return the form to the Employee Benefits Services Unit on or before 5 PM on October 5, 2012. This form is available on the Employee Benefits website.

Health Care Spending Account (HCSA)

The HCSA provides an opportunity for employees to authorize a salary reduction on a pre-tax basis to pay for eligible medical, dental and vision expenses that are not covered by medical, dental or vision insurance plans. For Plan Year 2013, the maximum HCSA salary reduction amount is $2,500 per year. Again, this amount is not subject to Federal or State Withholding or FICA taxes. Eligible dependents are the same as for medical and dental, except, eligible dependents do not include domestic partners or dependents of domestic partners or same-sex spouses or dependents of the same-sex spouse.

Effective January 1, 2011 over-the-counter (OTC) drugs other than insulin are no longer qualified medial expenses for the purpose of the Health Care Spending Account.

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Affordability Act of 2010 provides that effective January 1, 2011 most over-the-counter (OTC) drugs other than insulin are no longer qualified medical expenses for the purpose of the Health Care Spending Account. Exception:

- OTC items other than drugs are still qualified expenses.
- OTC drugs prescribed by a physician will also continue to be allowed.

You must enroll in the Health Care Spending Account each Plan Year.

In order to enroll in the HCSA during this Open Enrollment Period, your employment date must be prior to July 1, 2012. If you were hired on or after July 1, 2012, you will be given the opportunity to enroll in the Plan upon meeting eligibility requirements which include six months continuous permanent employment.

Effective January 1, 2013 the maximum HCSA salary reduction amount will be $2,500 per year.

To be reimbursed through the HCSA, expenses must be for health care, dental care or vision care received primarily for the prevention or treatment of a physical or mental defect or illness. Out-of-pocket expenses are generally eligible if they are not reimbursed by insurance. Regardless of whether the expenses are incurred by you or your eligible dependents, they must be incurred during the Plan Year or during the period of coverage if you enroll after the Plan Year begins. An expense is incurred when you or one of your dependents receives the services, not when you are billed, charged for, or pay for the services. To be eligible for reimbursement, a health care expense must be:

- For you, your spouse or qualifying dependent child(ren) as defined in the IRC
- Permitted under the Internal Revenue Code
- Medically necessary; and
- Not reimbursed by your health/dental/vision insurance or any other benefit plan, nor will you seek reimbursement from such plans.

An extensive list of medical expenses that can be deducted on Schedule A of Form 1040 appears in IRS Publication 502 (Medical and Dental Expenses), although Publication 502 should not be solely relied upon to determine your eligible expenses under the HCSA. For example, expenses such as insurance premiums are deductible on Schedule A, but are not eligible for reimbursement through the HCSA. In addition, the IRS allows you to deduct an expense if it is paid during the tax year, while the HCSA claims are reimbursed only if an expense is incurred during the Plan Year. Expenses reimbursed through your HCSA may not also be deducted on Schedule A.

Keep in mind:

- Some health care treatments or services, including those deemed cosmetic in nature, require proof of medical necessity from your health care provider with your initial reimbursement request and for each subsequent Plan Year that you participate.
- Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement. Prescription drugs that are solely for cosmetic purposes are not eligible for reimbursement.
- The effective date that expenses are incurred for eyeglasses, prosthetic devices and such is the day the item is available to be picked up, not the date ordered.
- Unused funds designated for the HCSA cannot be refunded to you. Please verify with your health care provider (prior to enrolling for the upcoming Plan Year) that you are a suitable candidate for any surgical procedure (i.e. laser eye surgery) before committing the money to your HCSA.
- Expenses incurred for weight loss programs may only be reimbursable if a physician prescribes the treatment as medically necessary to prevent, treat or alleviate a specific diagnosed medical illness such as hypertension, diabetes or obesity.

To enroll in the HCSA, please complete the Health Care Spending Account Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5 PM on October 5, 2012.

Dependent Care Assistance Program (DCAP)

To participate, you must enroll each year in the Health Care Spending Account and Dependent Care Assistance Program.

The DCAP provides an opportunity for employees to authorize a salary reduction on a pre-tax basis to pay for eligible dependent care expenses. For Plan Year 2012, the maximum DCAP salary reduction amount is $5,000 per year ($2,500 if married, filing separately), and, is not subject to Federal or State Withholding or FICA taxes.

Under DCAP, the definition of qualifying person includes:

- A dependent child who is 12 years old or younger, for whom the employee is entitled to a deduction under Internal Revenue Code (IRC) Section 151(c);
- A dependent or spouse of an employee, regardless of age (including elder care), who is mentally or physically incapable of self-care; or
- A child of a divorced or separated employee who is 12 years old or younger, if the employee has custody of the child, even if the employee has released an exemption under IRC Section 152(e)(2).

Eligible expenses include charges for care of a qualifying person inside or outside your home. This includes feeding, administration of medicine, general supervision and nursery school. The main purpose must be the person's well-being and protection.

Expenses for care do not include amounts you pay for food, clothing and entertainment. However, if these amounts cannot be separated from the cost of caring for the qualifying person(s), you can include the total cost.

Federal tax laws specify that to qualify as an eligible expense:

- Out-of-home care must comply with all federal requirements if the facility provides care for more than six non-resident individuals. (State and some local laws require licensing where care is provided to fewer persons.) Out-of-home care for a qualifying person age 13 or older will qualify, provided that person is physically or mentally incapable of self-care and regularly spends at least eight hours each day in your household.
- Children's schooling may be included if your child is not in kindergarten or a higher grade.
- Registration fees for day care are included

DCAP provides an opportunity for employees to authorize a salary deduction on a pre-tax basis to pay for eligible dependent care expenses.

You can include only the cost of care in determining your eligible expense. The services must occur during the calendar year for which you are enrolled and on days you work. If you are married, they must also occur on days your spouse works (or if spouse is a full-time student, on days you work and your spouse attends school).

Eligible expenses for this Open Enrollment period begin January 1, 2013. If you become eligible to enroll at a later date, eligible expenses will begin on the first day of the month after your enrollment form has been received and approved by the Employee Benefits Services Unit.

Expenses that are not eligible include:

- The cost of schooling for a child in kindergarten or above;
- Summer camp expenses when the child stays overnight;
- Payments to a person for whom you can claim a dependency exemption for federal income tax purposes;
- Payments to your non-dependent child (for eligible dependent care services) unless he or she will be age 19 or older by December 31, 2013;
- Expenses incurred before January 1, 2013 (or other effective date of enrollment);
- Food, clothing, diapers and entertainment separated from the cost of caring for a qualified person; and,
- Membership fees.

You must carefully estimate the amount of eligible child care and/or dependent care expenses you expect to incur during 2013. Be sure to consider the possibility of declining expenses as your child gets older. Your salary reduction amount is fixed annually during this open enrollment period. The salary reduction you decide on should not exceed your estimate of dependent care expenses as federal tax regulations require forfeiture of any amount not used for expenses incurred within the calendar year.

To enroll in the DCAP, please complete the Dependent Care Assistance Program Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5 PM on October 5, 2012.

Enrollment Options

FOR PERMANENT FULL-TIME EMPLOYEES OR PART TIME EMPLOYEE WORKING AT LEAST 20 HOURS PER WEEK IF YOU ARE A MEMBER OF:	CCHP A+B KAISER A HN HMO A HN PPO A	KAISER B HN HMO B HN PPO B	DENTAL PLAN	PCP	HCSA	DCAP
AFSCME LOCAL 2700 - UNITED CLERICAL, TECHNICAL & SPECIALIZED EMPLOYEES	●		●	●	●	●
AFSCME LOCAL 512 - PROFESSIONAL & TECHNICAL EMPLOYEES	●	●	●	●	●	●
SEIU, LOCAL 1021 - SOCIAL SERVICES UNION	●		●	●	●	●
PUBLIC EMPLOYEES UNION, LOCAL 1	●		●	●	●	●
CALIFORNIA NURSES ASSOCIATION - WORKING AT LEAST 16 HRS/WK.	●		●	●	●	●
PHYSICIANS' & DENTISTS' ORGANIZATION OF CONTRA COSTA COUNTY	●		●	●	●	●
WESTERN COUNCIL OF ENGINEERS	●		●	●	●	●
UNREPRESENTED EMPLOYEES	●	●	●	●	●	●
UNREPRESENTED MANAGEMENT EMPLOYEES	●	●	●	●	●	●
DEPUTY SHERIFFS' ASSOCIATION			●	●	●	●
DISTRICT ATTORNEY INVESTIGATORS' ASSOCIATION			●	●	●	●
IAFF LOCAL 1230			●	●	●	●
UNITED CHIEF OFFICERS ASSOCIATION			●	●	●	●
UNREPRESENTED UNIFORMED FIRE MANAGEMENT			●	●	●	●
UNREPRESENTED EXEC. SHERIFF MANAGEMENT			●	●	●	●
PUBLIC DEFENDERS ATTORNEY AND INVESTIGATORS	●	●	●	●	●	●
DEPUTY DISTRICT ATTORNEYS ASSOCIATION	●	●	●	●	●	●
PROBATION PEACE OFFICERS ASSOCIATION	●	●	●	●	●	●
IPTFE LOCAL 21	●	●	●	●	●	●
PERMANENT INTERMITTENT EMPLOYEES(PIE), PROVISIONAL EMPLOYEES, PERMANENT PART-TIME EMPLOYEES WORKING LESS THAN 20 HOURS PER WEEK AND SPECIAL DISTRICT EMPLOYEES *	●	●	●	●		
COBRA PARTICIPANTS **	●	●	●		●	

* PIE are eligible for these plan if noted above for Permanent F/T or P/T employees

* * COBRA Participants are eligible for these benefits if noted above for Permanent F/T or P/T employees

VDT Program Information

Who is eligible?

The Management Resolution or your Collective Bargaining Unit (MOU) will advise if you are eligible for this benefit. If this benefit is included in your MOU, the benefit covers:

- Permanent full-time and part-time employees whose job requires use of a video display terminal (VDT) for at least two (2) hours a day or more, as certified by their supervisor.

What are the benefits?

The benefits of the VDT plan include the following every 12 months:

- An annual VDT vision exam
- Single, bifocal or trifocal lenses
- Frames that are covered under the plan frame allowance
- Up to two total hours of County time to have your exam and to obtain your glasses

Who is the carrier?

Your benefits are provided through Vision Service Plan (VSP).

How do I make arrangement for the VDT exam Approval?

1. Approval forms & Instructions are available on the Benefits Website @ www.cccounty.us
2. **Caution**: Do not make an appointment for vision services until you receive an authorization letter from VSP. **Any services obtained before receiving your VSP authorization may result in you being fiscally liable for those services rendered by your provider. The VDT approval letter is valid only for 60 days.**

Upgrades

You may select frames or materials above the plan allowance, however, you will be responsible for paying the difference in the cost between the plan allowance and your upgrade.

For example, if you select any of the following, there will be an extra charge:

1. Blended lenses.
2. Oversize lenses.
3. Progressive multi focal lenses.
4. Edge treatments and anti-reflective coatings.
5. Solid and gradient plastic dyes.
6. A frame that costs more than the plan allowance.
7. Cosmetic lenses.
8. Optional cosmetic processes.
9. UV (ultraviolet) protected lenses.
10. Tinted lenses other than pink #1 or #2.

Limitations and Exclusions

Not Covered – There is no benefit for professional services or materials connected with:

1. Subnormal vision aids.
2. Orthoptics or vision training and any associated supplementary testing not specifically related to working with a VDT; Plano lenses; or two pair of glasses in lieu of bifocals.
3. Contact lenses.
4. Photochromic or tints greater than 20%
5. Laminated lenses
6. Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
7. Medical or surgical treatment of eyes.
8. Services provided by a non-member doctor.
9. Any eye examination or any corrective eye wear required by an employer as a condition of employment.

This is only a partial list of exclusions and limitations to the Vision Service Plan VDT benefit. If you have questions regarding items not listed above, please call Vision Service Plan at 800-877-7195.

Contact List

	Phone Number	Web Site
Health Net HMO	1-800-522-0088	www.healthnet.com
Health Net PPO	1-800-676-6976	www.healthnet.com
CCHP Plans A & B	1-877-661-6230	www.contracostahealthplan.org
Kaiser	1-800-464-4000	www.kp.org
Delta Dental	1-800-765-6003	www.deltadentalins.com
DeltaCare USA (PMI)	1-800-422-4234	www.deltadentalins.com
Hartford	1-888-435-9670	www.retire.hartfordlife.com
VSP	1-800-877-7195	www.vsp.com
EAP - DSA & IAFF & UCOA	1-800-227-1060	
EAP for all others	1-925-930-3661	www.cccounty.us
CalPERS Long Term Care		
- General	1-800-266-1050	www.calpers.ca.gov
- Enrolled member	1-800-982-1775	www.calpers.ca.gov

Open Enrollment Procedures

Before completing enrollment forms, consider the following:

1) Review your personalized 2012 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; and,
   c) 2012 elections for Health Care Spending Account (HCSA) and Dependent Care Assistance Program (DCAP).
2) Confirm that all dependents listed satisfy and will continue to satisfy the definition of "eligible dependent" as defined earlier in this Guide.
3) Review the 2013 Employee Benefits Information and Open Enrollment Guide.
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 not making a plan change nor are you adding or deleting a dependent, you do not need to complete the 2013 Benefits Open Enrollment Medical & Dental Change Form that was enclosed with your benefit statement.
   b) If you are changing a health care plan or dental care plan or are adding or deleting family members, then you will need to complete the 2013 Benefits Open Enrollment Medical & Dental Change Form and return the form to the Employee Benefits Services Unit on or before 5 PM on October 5, 2012.
5) Decide whether or not you are going to change your Premium Conversion Plan Election.
   a) If you are going to continue the election as in the past, no action is necessary.
   b) If you elect to either begin participating or cease participation, you will need to complete the Premium Plan Conversion Enrollment and Change Form and return the form to the Employee Benefits Services Unit on or before 5 PM on October 5, 2012. The PCP enrollment/change form can be located on the County website at http://www.cccounty.us.
6) Complete the Health Care Spending Account Expense Worksheet to determine if you should consider participating in the HCSA. To enroll in the HCSA, please complete the 2013 Flexible Spending Account Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5 PM on October 5, 2012. This worksheet and enrollment form are available on the Employee Benefits website.
7) Complete the Dependent Care Assistance Program Worksheet to determine if you should consider participating in the DCAP. To enroll in the DCAP, complete the Flexible Spending Account Enrollment Form and return the form to the Employee Benefits Services Unit on or before 5 PM on October 5, 2012. This worksheet and enrollment form are available on the Employee Benefits website.
8) The 2013 monthly medical and dental premium rate sheet was included in the mailing you received. This information is also available on the Employee Benefits website.

The Following Options Are Not Included In The Open Enrollment Process, But Should Be Reviewed Annually.

1) Supplemental Life Insurance amounts for you or family members may be increased or decreased in accordance with the Plan provisions by requesting, completing and submitting the required application forms to ING Benefits. Forms and directions are available on the County website at http://www.cccounty.us.
2) It's a good time to update your life insurance beneficiary information. Remember, you may designate beneficiaries for your Basic Life Insurance, Supplemental Life Insurance and Management Life Insurance. Please read the instructions, complete the form and return it to the Employee Benefits Services Unit.
3) Designation of Beneficiary Form can be located on the County website at http://www.cccounty.us under Employee Benefits Open Enrollment.
4) It is also a good time to review your Deferred Compensation Account. To review your account with our Hartford Representative or to change your deferral amount, investment allocation or beneficiary for the Contra Costa County Deferred Compensation Plan, please contact the Hartford at 1-888-435-9670 ext. 62401.

MEDICARE ELIGIBLE AND STILL WORKING

If you are an active employee approaching age 65 or have attained the age of 65, the following information is to help you understand Medicare and how it coordinates with the health care benefits provided by Contra Costa County.

Medicare Part A Insurance – Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities (Not custodial or long-term care). It also helps cover hospice care and some home health care. Medicare beneficiaries must meet certain conditions to get these benefits.

Medicare Part B Insurance – Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

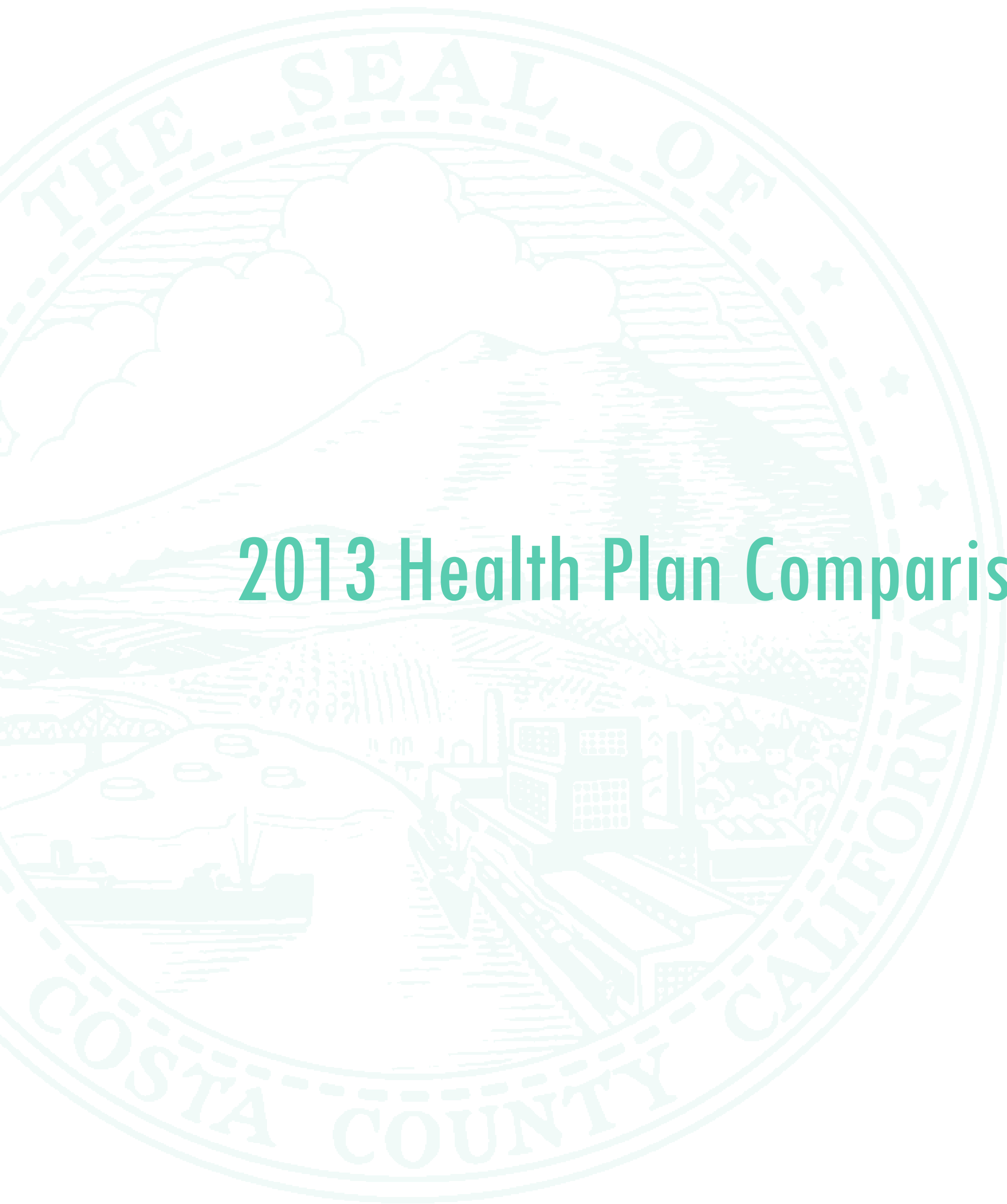
It is not necessary for you or your spouse to enroll in Medicare Part B while you are an active employee and include your spouse on your medical plan with Contra Costa County. You may postpone your enrollment in Medicare Part B, without penalty, until the time you retire.

Once you retire, you and your Medicare eligible spouse must enroll in Medicare Part B in a very timely manner. Failure to enroll in the prescribed time will subject you to a penalty of 10% per year for each year you delay enrollment. This penalty continues the entire time you are enrolled in Medicare.

At the time of your retirement, contact Social Security who will provide you with a form for the County to complete to verify your group medical coverage through the County. Bring this form to the Employee Benefits Services Unit.

Medicare Part D or Prescription Drug Coverage – Most people will pay a monthly premium for this coverage. Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Medicare Beneficiaries get to choose the drug plan and pay a monthly premium. Like other insurance, if a Medicare beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

It is not necessary for you or your spouse to enroll in Medicare Part D Prescription Drug Coverage while you are an active employee and include your spouse on your medical plan with Contra Costa County. Additionally, at the present time, it is not necessary for you and your spouse to enroll in Medicare Part D Prescription Drug Coverage once you are retired and continue to participate in the retiree medical plans. See the section entitled Notice of Creditable Coverage for additional information.



2013 Health Plan Comparison Guide

2013 Contra Costa County Health Plan Comparison Guide

	HMO PLANS						PPO PLANS			
	Kaiser Permanente		Health Net HMOs		Contra Costa Health Plan (CCHP) HMOs		Health Net PPOs*			
	Kaiser HMO Plan A	Kaiser HMO Plan B	Health Net HMO Plan A	Health Net HMO Plan B	CCHP Plan A	CCHP Plan B	Health Net PPO Plan A		Health Net PPO Plan B	
							In Network	Out of Network	In Network	Out of Network
Network Eligibility	You must live or work in a Kaiser service area at the time of enrollment.	You must live or work in a Kaiser service area at the time of enrollment.	You must reside in a Health Net service area.	You must reside in a Health Net service area.	You must reside in or work for Contra Costa County.	You must reside in or work for Contra Costa County.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.	You may receive care from any Preferred Provider in the Health Net PPO network for covered services.	You may receive care from any licensed provider in the USA for covered services.
Calendar Year Deductible										
Individual	None	$500	None	None	None	None	$250		$500	
Family	None	$1,000	None	None	None	None	$750		$1,500	
When does the Deductible apply?	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	N/A	N/A	N/A	N/A	Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.		Deductible applies to all services requiring a coinsurance % unless otherwise noted below. Dollar copays are not subject to the deductible.	
Max Calendar Year Out of Pocket (OOP) Expense										
Individual	$1,500	$3,000	$1,500	$2,000	N/A	N/A	$1,500	$5,000	$3,000	$9,000
Family	$3,000	$6,000	$4,500	$6,000	N/A	$1,500	N/A	N/A	N/A	N/A
What counts towards the OOP Max?	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic, Infertility services	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic, Acupuncture, Infertility services	All Copays/Coinsurance apply to OOP except those for: Prescription Drugs, Chiropractic, Acupuncture, Infertility services	N/A	All Copays apply to OOP except those for: Prescriptions Drugs, Chiropractic, Acupuncture	All Copays/ Coinsurance apply to the OOP except those for: Expenses used to meet the deductible, Services not certified as required, Prescription Drugs	All Copays/ Coinsurance apply to the OOP except those for: Expenses used to meet the deductible, Services not certified as required, Prescription Drugs	All Copays/ Coinsurance apply to the OOP except those for: Expenses used to meet the deductible, Services not certified as required, Prescription Drugs	All Copays/ Coinsurance apply to the OOP except those for: Expenses used to meet the deductible, Services not certified as required, Prescription Drugs
Hospital Services										
Inpatient	$0	10% after deductible	$0	$1,000	$0	$0	10%	30%	20%	40%; $600 max payable per day
Outpatient Surgery (at a Facility)	$10	10% after deductible	$0	$500	$0	$0	10%	30%	20%	40%; max allowable amount is 50% of billed charges
Emergency Services										
Emergency Department Visits	$10	10% after deductible	$25	$100	$0	$20	If admitted: 10% (no deductible) Not admitted: $50	If admitted: 30% (no deductible) Not admitted: $50	If admitted: 20% (no deductible) Not admitted: $100	If admitted: 40% (no deductible) Not admitted: $100
Ambulance	$0	$150	$0	$0	$0	$0	10%	10%	20%	40%

2013 Contra Costa County Health Plan Comparison Guide (Continued)

	HMO PLANS						PPO PLANS			
	Kaiser Permanente		Health Net HMOs		Contra Costa Health Plan (CCHP) HMOs		Health Net PPOs*			
	Kaiser HMO Plan A	Kaiser HMO Plan B	Health Net HMO Plan A	Health Net HMO Plan B	CCHP Plan A	CCHP Plan B	Health Net PPO Plan A		Health Net PPO Plan B	
							In Network	Out of Network	In Network	Out of Network
Physician Services										
Office Visits	$10	$20	$10	$20	$0	$5	$10	30%	$20	40%
Preventive Exams	$0	$0	$0	$0	$0	$0	$0	Not Covered	$0	Not Covered
Urgent Care Visits	$10	$20	$15	$50	$0	$5	If admitted: 10% (no deductible) Not admitted: $50	If admitted: 30% (no deductible) Not admitted: $50	If admitted: 20% (no deductible) Not admitted: $100	If admitted: 40% (no deductible) Not admitted: $100
Allergy Injections	$3	$0	$0	$0	$0	$0	10%	30%	$20	40%
Physical, Occupational, Speech Therapy	$10	$20	$10	$0	$0	$5	10%	30%	20%; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
Diagnostic X-Ray & Lab	$0	$10	$0	$0	$0	$0	10%	30%	20%	40%
Prescription Drugs										
Retail Pharmacy - 30 day supply	$10 generic $20 brand	$10 generic $30 brand	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary	$0	$3 up to 90 day supply	$5	$5	$10 generic $20 brand $35 non-formulary	$10 generic $20 brand $35 non-formulary
Mail-Order Pharmacy - 100 (Kaiser) or 90 (HN) day supply	$10 generic $20 brand	$20 generic $60 brand	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary	Covered	$3 up to 90 day supply	$10	$10	$20 generic $40 brand $70 non-formulary	$20 generic $40 brand $70 non-formulary
Additional Services										
Durable Medical Equipment	$0	20% (no deductible)	$0	$0	$0	$0	50%	50%	20% combined (PPO/OON) limit $2,000	40% combined (PPO/OON) limit $2,000
Vision Exams (Routine exam only, materials not covered)	$0	$0	$10	$20	$0; up to $65 allowance for glasses or contacts	$5; up to $65 allowance for glasses or contacts	$10 through age 16	Not Covered	$20 through age 16	Not Covered
Hearing Exams	$0	$0	$10	$20	$0	$5	$10 through age 16	Not Covered	$20 through age 16	Not Covered
Infertility - diagnosis and treatment only	$10	50% (no deductible)	50%	50%	$0	$5	50% after $500 Infertility deductible; up to $2500/yr & $10,000/lifetime	50% after $500 Infertility deductible; up to $2500/yr & $10,000/lifetime	20%; after $500 Infertility deductible; up to a combined $2,000/lifetime max	40%; after $500 Infertility deductible; up to a combined $2,000/lifetime max
Home Health Services	$0 up to 100 visits	$0 up to 100 visits	$0	$20 starting w/ 31st day	$0	$0	20% combined (PPO/OON); up to 100 visits	20% combined (PPO/OON); up to 100 visits	20%; $110 max payable per day	40%; $110 max payable per day
Skilled Nursing Care	$0 up to 100 days	10% (no deductible) up to 100 days	$0 up to 100 days	$1,000 up to 100 days	$0 up to 100 days for benefit period	$0 up to 100 days for benefit period	20% combined (PPO/OON); up to 100 days	20% combined (PPO/OON); up to 100 days	20%	40%; $250 max payable per day
Hospice	$0	$0	$0	$0	$0	$0	20%	20%	20%	40%
Acupuncture	Not Covered	Not Covered	Discounts available	Discounts available	$0 up to 10 visits	$5 up to 10 visits	20% to max of $25 per visit	20% to max of $25 per visit	$20; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined)
Chiropractic	$15 up to 20 visits	$15 up to 20 visits	$10 up to 20 visits	$10 up to 20 visits	$0 up to 10 visits	$5 up to 20 visits	Not covered; Discounts available	Not covered; Discounts available	$20; limited to 20 visits (in and out of network combined)	40%; limited to 20 visits (in and out of network combined) $25 max payable per visit

Notes:

*The PPO benefits available to non-California residents slightly differ from the above.
For non-California PPO plan design details, please refer to the Evidence of Coverage (EOC).

2013 Dental Plan Comparison Guide

PLAN NAME	DELTA DENTAL		DELTACARE USA- PLAN CA AA16
ELIGIBILITY	You may receive services from any licensed dentist. The amount paid is determined on whether the dentist is a participating or a non-participating dentist.		You must visit a dentist from the current list of DeltaCare USA network dentists. If a dentist who is NOT on the list provides treatment, it will not be covered by your DeltaCare USA program. DeltaCare USA is offered and administered by PMI Dental Health Plan, Delta Dental's HMO affiliate.
HOW TO FIND OR CONFIRM IF A DENTIST IS A MEMBER	800-765-6003		Refer to the DeltaCare USA Evidence of Coverage (EOC) or contact PMI at 800-422-4234
SPECIALTY REFERRALS	Free choice by member		Specialist Services must be referred by an assigned DeltaCare USA dentist.
DEDUCTIBLE	One time $50 per family		None
MEMBER SERVICES	Participating Dentist PLAN PAYS:	Non-Participating Dentist Plan pays up to 70% of maximum plan allowance:	FEE
DIAGNOSTICS:			
ORAL EXAMINATION AND DIAGNOSIS	70%	Up to 70%	No Cost
OFFICE VISITS	70%	Up to 70%	No Cost
FULL MOUTH X-RAYS:	70%	Up to 70%	No Cost
SINGLE FILM	70%	Up to 70%	No Cost
EACH ADDITIONAL FILM	70%	Up to 70%	No Cost
TEETH CLEANING (PROPHYLAXIS-TREATMENT TO INCLUDE SCALING AND POLISHING)	70% (1)	Up to 70% (1)	No Cost (2)
SEALANTS PER TOOTH (3)	70%	Up to 70%	No Cost
ORAL HYGIENE INSTRUCTION	Not Covered	Not Covered	No Cost
TOPICAL FLUORIDE	70%	Up to 70%	No Cost
SPACE MAINTAINERS	70%	Up to 70%	No Cost
SPECIALIST CONSULTATION	70%	Up to 70%	No Cost
BIOPSY OF ORAL TISSUE (SOFT)	70%	Up to 70%	No Cost
EMERGENCY TREATMENT	70%	Up to 70%	No Cost
EMERGENCY TREATMENT (AFTER NORMAL WORKING HOURS)	70%	Up to 70%	No Cost
BROKEN APPOINTMENT CHARGE (LESS THAN 24 HOUR NOTICE)	Determined by Dentist	Determined by Dentist	$10 per 15 minutes of appointment time
PERIODONTICS:			
SUBGINGIVAL CURETTAGE - PER QUADRANT	70%	Up to 70%	No Cost
GINGIVECTOMY - PER QUADRANT	70%	Up to 70%	No Cost
OSSEOUS SURGERY - PER QUADRANT	70%	Up to 70%	No Cost
ENDODONTICS:			
PULP CAPPING	70%	Up to 70%	No Cost
PULPOTOMY	70%	Up to 70%	No Cost
ROOT CANAL THERAPY - PER CANAL:			
EXCLUDING SECOND OR THIRD MOLARS	70%	Up to 70%	No Cost
SECOND OR THIRD MOLARS	70%	Up to 70%	No Cost
APICOECTOMY AND FILLING CANAL	70%	Up to 70%	No Cost
APICOECTOMY ON SEPARATE APPOINTMENT	70%	Up to 70%	No Cost
RESTORATIVE:			
PIN BUILD UP UNDER FILLING	70%	Up to 70%	No Cost
ALL FILLINGS OF PERMANENT AND PRIMARY TEETH	70%	Up to 70%	No Cost

(1) Teeth Cleaning is limited to twice per calendar year. One additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant if pregnant.
(2) Teeth Cleaning is limited to one procedure each six month period
(3) Sealants limited on first molars up to age 9 and second molars up to age 16

2013 Dental Plan Comparison Guide (Continued)

PLAN NAME	DELTA DENTAL		DELTACARE - PLAN CA AA16
MEMBER SERVICES	Participating Dentist PLAN PAYS:	Non-Participating Dentist Plan pays up to 70% of maximum plan allowance:	FEE
CROWNS AND BRIDGES: (4):			
CROWNS - PER UNIT	70%	Up to 70%	No Cost
BRIDGES - PER UNIT	50%	Up to 50%	No Cost
STAINLESS STEEL CROWNS	70%	Up to 70%	No Cost
DOWEL PIN (SUBJECT TO DENTIST CONSULTANT REVIEW)	70%	Up to 70%	No Cost
PIN BUILD UP	70%	Up to 70%	No Cost
POST AND CORE (SUBJECT TO DENTIST CONSULTANT REVIEW)	70%	Up to 70%	No Cost
RECEMENTATION:			
INLAY	70%	Up to 70%	No Cost
CROWN	70%	Up to 70%	No Cost
BRIDGE	70%	Up to 70%	No Cost
PROSTHETICS: (5)			
DENTURES:			
COMPLETE UPPER OR LOWER DENTURE - PER DENTURE	50%	Up to 50%	No Cost
PARTIAL UPPER OR LOWER DENTURE - PER DENTURE	50%	Up to 50%	No Cost
STAYPLATE	50%	Up to 50%	No Cost
DENTURE ADJUSTMENTS	50%	Up to 50%	No Cost
DENTURE RELINE	50%	Up to 50%	
DENTURE AND PARTIAL REPAIRS	50%	Up to 50%	No Cost
DENTURE DUPLICATION (REBASE)	50%	Up to 50%	No Cost
ADDING TEETH OR CLASPS TO PARTIAL DENTURE - PER UNIT	50%	Up to 50%	No Cost
IMPLANTS	50%	Up to 50%	
ORAL SURGERY:			
EXTRACTIONS; LOCAL ANESTHESIA (SIMPLE)	70%	Up to 70%	No Cost
SURGICAL EXTRACTION	70%	Up to 70%	No Cost
IMPACTIONS:			
SOFT TISSUE	70%	Up to 70%	No Cost
PARTIAL BONY	70%	Up to 70%	No Cost
FULL BONY	70%	Up to 70%	No Cost
FRENECTOMY	70%	Up to 70%	No Cost
ALVEOLECTOMY - PER QUADRANT	70%	Up to 70%	No Cost
GENERAL ANESTHESIA WITH ORAL SURGERY	70%	Up to 70%	Not Covered
ORTHODONTIA:			
FULL BANDED CASE	Not Covered	Not Covered	$350.00 Start up fee
			$1,250/children
ORTHODONTIA: For Deputy Sheriff's Assoc. (DSA) and District Attorney Investigators Assoc. (DAIA)			$1,450/adults
FULL BANDED CASE	50%/ Up to 50%	$ 2,000 lifetime maximum per person	
MAXIMUM BENEFIT PAYMENTS PER CALENDAR YEAR Bargaining Unit DSA, DAIA, IAFF, UCOA & PDOC Unrepresented and All Other Bargaining Units	$1,600.00 Per Member $1,800.00 for certain bargaining units (refer to MOU)		NO MAXIMUM

(4) Gold, if used, will be an additional charge to the member.

(5) Benefits are subject to a maximum allowance and there is a six month waiting period on these services for new enrollees.

FOR YOUR NOTES

LEGISLATION

LEGISLATION

MICHELLE'S LAW

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

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

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

MEDICARE, MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) EXTENSION ACT (MMSEA)

The MMSEA imposes a new reporting requirement on group health plans that cover Medicare-eligible individuals. The legislation requires the reporting of Social Security Numbers (SSNs) for affected members.

SSNs are required for all dependents enrolled in a group health plan with Contra Costa County. Employees/Retirees/Survivors without this information on file will be contacted to update the required records.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

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

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

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

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

Contra
Costa
County

Human Resources
Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA Continuation Coverage

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

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:
(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:
(1) Your spouse dies;
(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:
(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the plan as a "dependent child."

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

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

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

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

Duration of COBRA Coverage

<u>18-month period</u> 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.

<u>36-month period</u>. 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.

<u>29-month period for disabled qualified beneficiaries</u>. 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.

<u>Early Termination of COBRA Coverage</u>

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

<u>Second qualifying event extension of 18-month period of continuation coverage</u>

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.

<u>If You Have Questions</u>

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

Contra
Costa
County

Human Resources
Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

DATE: For Plan Year January 1, 2013 – December 31, 2013

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

FROM: Christine J. Penkala, Employee Benefits Manager

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

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

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

When Can You Join A Medicare Drug Plan?

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

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

NOTICE OF CREDITABLE COVERAGE FOR PLAN YEAR JANUARY 1, 2013 — DECEMBER 31, 2013

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

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

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 [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Call Employee Benefits Service Unit at (925) 335-1746.

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

For More Information About This Notice Or Your Current 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).

IRS REGULATIONS - DOMESTIC PARTNER BENEFITS

Implementation of IRS regulations impacting imputation of income for health benefits for domestic partner medical/dental plan participants

Contra Costa County complies with Internal Revenue Service regulation revisions and official guidance that affects imputation of income to certain employees in regard to health benefits. The County imputes income for state and federal income tax purposes for employees who receive County paid health benefits for domestic partners, same sex spouses and their dependents. This results in imputation of less income, and lowered FICA payments, for certain affected employees and in imputation of larger amounts of income, and increased FICA payments, for other affected employees.

Employees that have Domestic Partner coverage only will have income imputed based on the County's subsidy for the single rate.

Example: If the County's subsidy for single coverage for the plan is $509.92 the income imputed to the employee will be equal to the County's subsidy for the single rate, or $509.92.
Employees that have family coverage that includes either a Domestic Partner or a Domestic Partner and the Domestic Partner's child(ren) will have imputed income based on the value of the benefit received for the Domestic Partner and his or her child(ren).

Example: If the County's subsidy for family coverage for the plan is $1,214.90 per month and an employee has family coverage for his or her child plus a Domestic Partner, income will be imputed to the employee equal to the County subsidy for the single rate, or $509.92 per month, for the Domestic Partner's coverage. If an employee has family coverage for a Domestic Partner and a domestic partner's child then the imputed income would be equal to the County's subsidy for two single rates or $1,019.81 per month. If an employee has family coverage for a Domestic partner and two or more of the domestic partner's children, the imputed income would be the full County subsidy for the family rate, or $1,214.90 per month.

If you have any questions regarding the imputation of income or other tax issues, please consult your tax advisor. If you have any questions regarding your domestic partner premium deductions, please contact the Human Resources Department Employee Benefits Services Unit at 925-335-1746.

IRS CODE 152

In limited circumstances, your domestic partner and the dependent children of your domestic partner may qualify as a "federal tax dependent" under Internal Revenue Code (IRC) Section 152 (as modified by section 105(b)) for health coverage purposes, provided certain qualifying conditions are met. Employer-provided health insurance coverage for a federal tax dependent is not subject to federal income tax and will not be included in your gross income. Additionally, such coverage can be provided on a pre-tax basis and eligible medical expense claims for that dependent can be reimbursed on a pre-tax basis through a health care flexible spending account.

You must complete a Declaration of Tax Dependent Status form each calendar year. You can find the form at www.cccounty.us.

To qualify as a federal tax dependent during a given tax year, a person must meet all of the following qualifications:

1. Is a dependent who shares your principal residence for the full tax year (January 1 through December 31), except for temporary absences such as vacation, military service or education; and
2. Is a dependent who receives more than half of their support from you; and,
3. is a dependent who is a citizen or resident of the United States or a country contiguous to the United States.

The rules are complicated and this provides only a brief summary of the requirements for qualifying as a federal tax dependent. You are encouraged to consult with an individual tax advisor to determine whether your domestic partner and/or children of your domestic partner satisfy these requirements.

You must complete a Declaration of Tax Dependent Status form each calendar year. You can find the form at www.cccounty.us.

Contra
Costa
County

Human Resources
Department

Administration Building
651 Pine Street
Martinez, CA 94553-1292

DATE: For Plan year January 1, 2013 – December 31, 2013

NOTICE TO: Participants in Contra Costa County Employee Health Plans

FROM: Christine J. Penkala, Employee Benefits Manager

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

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

ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268 **GEORGIA** – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562 **KANSAS** – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447 **MAINE – Medicaid** Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid and CHIP
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

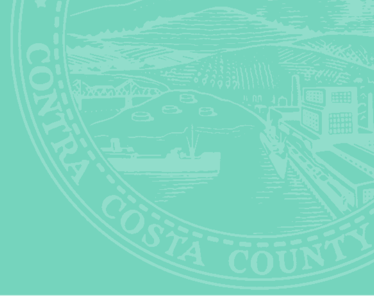
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

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

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

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



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 2013 Open Enrollment Guide and the 2013 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@gsd.cccounty.us

CONTRA COSTA COUNTY