Principal Benefits for
Contra Costa Health Plan (CCHP) Commercial Plan B COB (1/1/20 – 12/31/20)

Accumulation Period

The Accumulation Period for this plan is 1/1/20 through 12/31/20 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below

Amounts per Accumulated Period	**Self-Only Coverage** (Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	n/a	$3,000
Plan Deductible	0	0	0
Drug Deductible	0	0	0

Procedure	Benefit Description
Abortions	C
Acupuncture	10 visits / Year, $5/OV, (waived at CCRMC) (Does not apply toward Out of Pocket Max)
Alcohol	See Substance Use Disorder
Allergy Injection	C
Allergy Testing	C $5 OV, (copay waived at CCRMC)
Autism	C: Refer to Mental Health Nurse.
Biofeedback	NC
Blood & Blood Products	C
Blood Self Donation	NC
Cancer Clinical Trials: Routine Care Only	C
Chiropractic Care	C: 20 Visits / Year, $5 per OV, (copay waived at CCRMC) (Does not apply toward out of pocket Max)
Circumcision Medically Necessary Only	C
Contact lens (conventional)	C: One Pair/Year, up to $65 max
Contact or intraocular Lenses Medically Necessary	C: After first cataract surgery or for keratoconus
Contraceptives	C: No Copay
Custodial Care In skilled facility	NC
Dental Care	NC
Dental Anesthesia	Inpatient anesthesia for dental services if condition requires the dental procedure to be performed in a hospital setting, or surgical outpatient facility, or enrollees under seven (7) or developmentally disabled enrollees, regardless of age.
Diabetic Supplies	C
Durable Medical Equipment "DME"	C
Diagnostic Testing / Imaging	C
Dialysis-Acute	C
Dialysis-Chronic	C
Durable Medical Equipment	C: Confirm coverage for each item with Authorization
Emergency Medical / Mental Health Treatment	C: Worldwide
Eye Glasses (Conventional)	C: One Pair/Year, up to $65 Max
Eye glasses Medically Necessary	C: After first cataract surgery
Family Planning	C
Hearing Aid (batteries excluded except for initial Hearing Aid)	C: 1 Hearing Aid every 5 years
Hearing Tests (Audiology)	C: $5 OV, (copay waived at CCRMC)
Home Health Services (excluding: Housekeeping)	C

Procedure	Benefit Description
Hospice Care	C: When provided by Certified Hospice Program
Hospitalization and Maternity Care	C
Immunosuppressive Drug Therapy (After organ transplant)	C
Infertility Services	C: Diagnosis of infertility & medically necessary treatment of a medical condition causing infertility. NC: In-vitro fertilization, ovum transplants and other infertility services, other than artificial insemination.
Immunizations and Inoculations (travel)	C: Child and adult standard immunizations; travel inoculations as recommended by CDC
Laboratory	C
General Mental Health Outpatient Care	C: As medically necessary
Mental Health Acute Inpatient Care	C: As medically necessary
Mental Health Long Term Facility	Referred to CCHP Mental Health Coordinator
Midwife Services	NC
Newborn Coverage	C: for newborn to a subscriber or eligible spouse for month of birth and following Month C: for newborn to a subscriber's eligible dependent child for 48-96 hours only
Office visits (excludes: MH, SUD, Preventive exams; see Physicals)	C: $5 OV, No copay for children under age 23 months or for preventative services (copay waived at CCRMC
Optometry	C: $5 OV,(copay waived at CCRMC) Vision exams, Cataract spectacles and Cataract lenses and those glasses and lenses for treatment of Keratoconus only
Organ Transplant (Heart, Heart/Lung, Liver, Kidney, Bone Marrow, Corneal)	C
Orthotics	C: As Medically Necessary
Over-the-Counter Drugs	NC
Perinatal Exams (pre-Natal, post-Natal visit)	C
Phenyiketonuria (PKU)	C
Physical Examinations Including third Party Requests (except for insurance, court ordered licensure and travel)	C: $5 for non-preventative exams (copay waived at CCRMC)
Podiatry	C: $5 OV, (copay waived at CCRMC)
Prescription Drugs-Outpatient for prescriptions up to 3 months' supply or 100 pills	C: $3/prescription
Preventive Services	C:$0
Prosthetic Devices, Corrective Appliances and Artificial aides	C: Confirm coverage for each item with CCHP
Reconstructive Surgery	C
Refraction	C: $5 OV, (copay waived at CCRMC)
Rehabilitation- Acute Inpatient	For acute medical conditions only.
Respite Care with Hospice	C
Second Opinion	C
Skilled Nursing Sub Acute Facility Stay (limited to services for recovery from illness or injury)	C: 100 days/ benefit period for skilled nursing needs
Sterilization	C
Sub-Acute Care	Refer to CCHP for information
Detox for Substance Use Disorder: ER, Inpatient, Outpatient Visit	C: As medically necessary
Substance Use Disorder treatment- Inpatient for Addiction	C: As medically necessary
Substance Use Disorder Counseling - Outpatient	C
Medical Supplies-Disposable non-renewable	C: Confirm coverage for each item with CCHP
Therapy-Outpatient: Physical, Speech-language pathology and Occupational	C: $5 per OV (copay waived at CCRMC) , Medically Necessary up to 2 months; Additional as appropriate to medical condition
TMJ Treatment (Medical Treatment Only)	C: $5 OV, (copay waived at CCRMC)
Transgender Services	C: Refer to CCHP Authorizations for Specifics

Procedure	Benefit Description
Transportation, Emergency or Medically Necessary	C
Urgent Care	C: $5 (copay waived at CCRMC)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetics testing supplies).