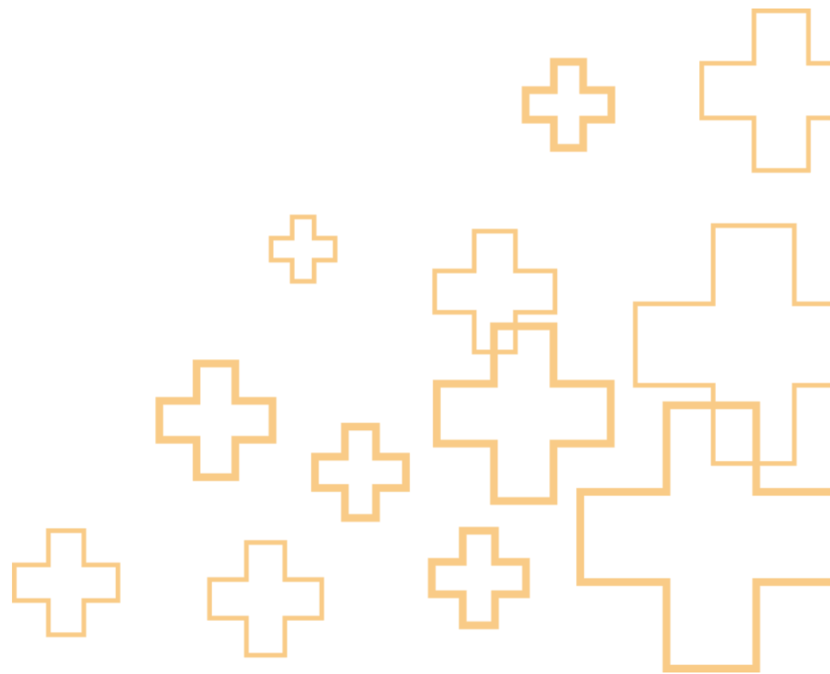
CONTRA COSTA
HEALTH

Contra Costa Health Plan Evidence of Coverage (EOC) and Disclosure Form

Effective January 1, 2026 (Plan Year 2026)

Plans Included

- IHSS Plan A2



Welcome to Contra Costa Health Plan!

We are pleased to welcome you as a member of Contra Costa Health Plan (CCHP). Your health matters to us. This handbook explains your benefits and shows you how to use your plan with confidence.

This handbook is your guide to getting started:

- Look at your Schedule of Benefits (SOB) at the back for details on your costs and copays.
- See Chapter 4, "How Your Plan Works," to learn how to pick a main doctor (Primary Care Provider or PCP), get referrals, and know when you need authorization.
- Keep contact information handy — the last page includes quick reference numbers for appointments, pharmacy, behavioral health, grievances, and more.
- Know your rights — Chapters 9 and 10 outline your rights, responsibilities, and steps to take if you need to file a grievance or appeal.

We encourage you to keep this handbook nearby and use it as a reference. If you have questions, Member Services is always available to support you.

About this Handbook

Welcome to Contra Costa Health Plan (CCHP). This handbook—called your Evidence of Coverage (EOC) and Disclosure Form—explains how your health plan works. It is both a guide for members and a legal document describing your coverage, rights, and responsibilities.

What this handbook includes

- It applies to all CCHP Commercial Plans: Plan A, Plan B, and Plan A2.
- Each plan has a separate Schedule of Benefits (SOB) included at the back. Refer to the SOB that matches your enrollment.
- The EOC explains how to access care, what services are covered, and what costs (if any) you may pay.
- Your rights and responsibilities as a member, as well as how to file a grievance or appeal, are described in later chapters.

Why this matters

- This document is required under the Knox-Keene Health Care Service Plan Act of 1975 and is regulated by the California Department of Managed Health Care (DMHC).
- Keep this handbook nearby. It can help anytime you have questions about your coverage or responsibilities.

Need help?

If you have questions about your plan, please contact:

- CCHP Member Services: 1-877-661-6230 (TTY 711)
- Online: cchealth.org/health-insurance/

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Chapter 1: Welcome to Contra Costa Health Plan

This chapter gives you an overview of Contra Costa Health Plan (CCHP), your coverage choices, and the tools that help you use your benefits. It explains your plan, your ID card, and the online options that help you stay in touch with your care team. Keep this section nearby as you get started.

About this Handbook

Welcome to Contra Costa Health Plan (CCHP). This handbook—called your Evidence of Coverage (EOC)—explain:

- What your plan covers
- How to get care and use your benefits
- Costs you may pay, like copays or deductibles
- Your rights and responsibilities
- How to file a complaint or appeal

This handbook is both a guide for members and the legal outline of what your plan covers. Please read it and keep it for reference. To learn how we protect your health information, see our Notice of Privacy Practices on our website at cchealth.org/policies/medical-privacy.php or ask Member Services for a copy.

About Contra Costa Health Plan

Contra Costa Health Plan (CCHP) is licensed and regulated by the California Department of Managed Health Care (DMHC) under the Knox-Keene Health Care Service Plan Act. We provide care through a network of doctors, hospitals, and clinics in Contra Costa County and nearby communities.

Our mission is to offer high-quality, affordable care—especially for people who need extra support.

Our Commercial Plans

CCHP offers several types of commercial coverage. Each plan works a little differently when you get care or pay for services.

- **Plan A** – Most care is provided through the Regional Medical Center (RMC) network. If specialty services are not available in RMC, referrals

may be made to the Community Provider Network (CPN). Members generally do not pay additional costs beyond the monthly premium.

- **Plan B** – Members may receive care in either the RMC or CPN networks. Services at RMC typically have no cost. Services in the CPN network may require copayments and deductibles but provide broader access.
- **Plan A2** – Available to temporary employees. Care is mainly provided through the RMC network, with most services covered at no additional cost beyond the premium. Referrals to the CPN network are allowed when services are not available at RMC.
- **IHSS Plan A2** – Available to In-Home Supportive Services (IHSS) providers; care is mainly provided through the RMC network, with certain copayments applying (for example, primary care, specialty, urgent care, prescription drugs, and children's vision exams). Referrals to the CPN network are allowed when services are not available at RMC.

For details about your costs and deductibles, see your Schedule of Benefits (SOB) at the back of this book.

Choosing Your Primary Care Provider (PCP) and Understanding Your Network

When your coverage starts, you choose your own main doctor (called a Primary Care Provider or PCP). Your PCP is your main contact for care and helps coordinate checkups, treatment, and referrals.

CCHP has two networks of providers that deliver care:

- Regional Medical Center (RMC) Network – The RMC Network includes Contra Costa Regional Medical Center and its affiliated health centers.
    - Plan A and IHSS Plan A2 members must select a PCP within the RMC Network.
    - Most services are provided through RMC; specialty care outside of RMC requires a referral or authorization.
    - Services received within RMC generally have no additional member cost. Please review your Schedule of Benefits (SOB) for plan-specific details.

- Community Provider Network (CPN) – The CPN consists of private and community-based providers administered directly by CCHP.
    - Plan B members may choose a PCP in either the RMC or CPN Network.
    - The CPN network gives you more choices, but you might have copays or deductibles for some services. Please review your SOB for cost-sharing details.
    - Care received through the RMC Network is typically available to Plan B members at no additional cost.

Your PCP's name and contact information are available in the MyChart web portal (mychart.cchealth.org) and the MyChart mobile app (Apple or Google). You may change your PCP after your coverage begins by logging in to MyChart or contacting Member Services for assistance.

For details about referrals and specialty care, see "Specialist Care and Referrals" in Chapter 4.

Using Your Member ID Card

Every member has access to a Contra Costa Health Plan ID card. You must be prepared to present your card whenever you receive care. Providers use this card to confirm your eligibility, plan type, and important contact information.

Your ID card is available in multiple formats:

- Digital card through the MyChart web portal (mychart.cchealth.org)
- Digital card in the MyChart mobile app (Apple or Google)
- Printed card – mailed to your home address

If your card is lost or damaged, log in to MyChart to print a new one or ask for a replacement card by mail.

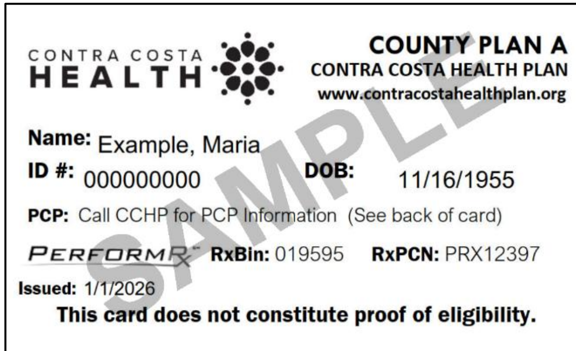
Example Member ID Card

Below is a sample Member ID card. Your card will display either one of Plan A, Plan B, IHSS Plan A2, or Plan A2 depending on your Primary Care Provider selection. Your Member ID card contains important details including:

- Your CCHP Member ID,
- Pharmacy Bin and PCN numbers, and

- Contact information on the back of the card including Member Services and the PerformRX Pharmacy Call Center.

Always bring your CCHP ID card when you get care so providers can confirm your coverage. Doing so helps providers verify your coverage and ensures claims are processed correctly.



Front of Card

Back of Card

MyChart Mobile App

For faster service and to manage your health online, we encourage you to use the MyChart web portal or mobile app (screenshot at right) whenever possible. If you are unable to access your card digitally, contact Member Services.

Accessing Your Health Information Online

As a CCHP member, you can see your health records online in MyChart (mychart.cchealth.org or the mobile app through Apple or Google), our secure member portal.

MyChart web portal and mobile app allows you to:

- View test results, medications, and upcoming appointments
- Send secure messages to your care team
- Request prescription refills
- Review your visit summaries and medical history
- Access your digital ID card

We encourage you to sign up and use the MyChart web portal and mobile app regularly. Engaging online keeps you informed, improves coordination with your providers, and gives you more control over your health care.

Using digital tools is optional. All services described in this handbook can be accessed without using MyChart or other online tools. If you prefer, you may receive information, schedule care, request materials, or contact us by phone, in writing, or in person.

Requesting Member Materials

Most forms and materials are available online anytime through the:

- Member web portal (mychart.cchealth.org)
- MyChart mobile app (Apple or Google)
- Contra Costa Health Plan website (cchealth.org/health-insurance)

You can ask for printed copies anytime. Member Services is here to help.

Choosing or Changing Your Primary Care Provider (PCP)

Every member selects a Primary Care Provider (PCP). You may change your PCP at any time. The fastest way is through the:

- MyChart web portal (mychart.cchealth.org)
- MyChart mobile app (Apple or Google)
- If you are unable to make the change online, Member Services can help you.

How to Contact Us

The quickest way to check your benefits or coverage is online in MyChart on the web or mobile app.

If you need help beyond what the online tools provide, contact Member Services:

- **Phone**: 1-877-661-6230
- **TTY**: 711
- **Website**: cchealth.org/health-insurance

- **Hours**: 8am to 5pm, Monday through Friday
- **Interpreter & disability assistance**: Free language assistance and materials in alternative formats (braille, large print, audio) are available. Call 1-877-661-6230 (TTY 711).

Our representatives are available to assist you with complex inquiries.

Your Schedule of Benefits

This handbook includes Schedules of Benefits (SOBs) at the back. These explain your specific coverage and costs, including:

- Copayments and deductibles
- Out-of-pocket maximums
- Service limits (such as physical therapy visits)

Be sure to review the SOB that applies to your plan. You can also view your plan's Summary of Benefits and Coverage (SBC) on the Contra Costa County Employee Benefits website at contracosta.ca.gov/1343/Employee-Benefits.

Chapter 2: Eligibility & Enrollment

This chapter explains who can enroll in Contra Costa Health Plan's commercial coverage, when coverage begins and ends, and how to make changes if your circumstances change. Understanding these rules will help you keep your coverage active and avoid gaps in care.

Who is Eligible

Eligibility for Contra Costa Health Plan commercial coverage depends on your employment or program status. You may be eligible if you are:

- An employee of a participating group
- A dependent of an eligible employee (spouse, domestic partner, or child as defined by state law)
- An In-Home Supportive Services (IHSS) provider covered under the County program
- A temporary employee eligible for the A2 Plan

Dependent coverage generally includes:

- Spouse or domestic partner
- Children up to age 26
- Disabled children over age 26 who remain dependent on the subscriber

Plan-Specific Eligibility

- **Plan A** – Employees and eligible dependents enrolled in employer-sponsored coverage, where most services are provided through the Regional Medical Center (RMC) network.
- **Plan B** – Employees and eligible dependents enrolled in employer-sponsored coverage, with access to both RMC and Community Provider Network (CPN) services.
- **Plan A2** – Temporary County employees.
- **IHSS Plan A2** – IHSS providers.

When Coverage Begins

Coverage begins on the effective date of enrollment, which may be:

- The first day of employment or program eligibility
- The first day of the month following your enrollment application
- A special enrollment period (for example, birth, adoption, marriage, or loss of other coverage)

You will receive an ID card and enrollment confirmation once coverage begins.

When Coverage Ends

Your coverage may end if:

- Employment or program eligibility ends
- Premiums are not paid (if applicable)
- Fraud or misrepresentation is committed in obtaining coverage

If your coverage ends, you may have rights to continue coverage under COBRA or Cal-COBRA. Details are provided later in this handbook.

Continuity of Care

If your Primary Care Provider, specialist, or medical group leaves Contra Costa Health Plan's (CCHP's) network while you are in the middle of treatment, you may be eligible to continue receiving care from that provider for a limited period of time. Continuity of care applies if you are:

- In the second or third trimester of pregnancy.
- Receiving care for a terminal illness.
- Under active treatment for a chronic or acute condition.
- Scheduled for surgery or another procedure that has already been authorized.

To request continuity of care, contact Member Services or have your provider submit a request; we will review eligibility and timeframes required by law and notify you in writing.

How to Make Changes

The fastest way to make changes to your coverage is through:

- MyChart web portal (mychart.cchealth.org)
- MyChart mobile app (Apple or Google)

You can use these tools to:

- Select a primary care provider (PCP)
- Find an in-network specialist or provider
- Request a new ID card
- Review your plan details
- Update your address or contact information

If you are unable to use the online tools, contact Member Services for assistance:

- **Phone**: 1-877-661-6230
- **TTY**: 711
- **Hours**: 8am to 5pm, Monday through Friday

Chapter 3: Termination and Continuation of Coverage

This chapter explains when coverage under Contra Costa Health Plan ends and what options may be available to continue coverage. Because continuation benefits such as COBRA and Cal-COBRA are generally administered by employers, members should always check directly with their benefits office for details.

When Coverage Ends

Your coverage may end if:

- **Employment or Program Eligibility Ends** – For example, if you are no longer employed by a participating group or no longer qualify for the IHSS program.
- **Premiums Are Not Paid** – If your group or you (when applicable) fail to pay required contributions.
- **Service Area Changes** – If you move outside the Contra Costa Health Plan service area.
- **Fraud or Misrepresentation** – If false information is provided to obtain coverage.
- **Plan Termination** – If your employer or group stops offering coverage through CCHP.

Coverage for dependents may also end when they no longer meet eligibility criteria, such as a child turning 26 or a dependent spouse no longer qualifying. If your provider or medical group's contract with CCHP ends, you may be reassigned to another in-network provider. You may also qualify for Continuity of Care (Chapter 2) if you are in an active course of treatment (for example, pregnancy, terminal illness, chronic or acute conditions, or scheduled procedures). Contact Member Services to request Continuity of Care and we will notify you in writing if you qualify.

Continuation of Coverage

If your coverage ends, you may have rights to continue coverage under state or federal law, including COBRA or Cal-COBRA. These benefits are administered directly by your employer's benefits department.

For information about whether you qualify for continuation coverage, and how to enroll, please contact your employer's benefits office.

Conversion Coverage

If continuation coverage is not available through your employer, you may have the option to apply for an individual conversion plan directly with Contra Costa Health Plan. Contact Member Services if you need more information.

Special Enrollment Rights

If you lose coverage, you may qualify for lower-cost coverage through Covered California or free coverage through Medi-Cal.

You can also get a special enrollment period through Covered California or another group plan if:

- You lose job-based coverage
- You get married, have a baby, adopt, or place a child for adoption
- You lose Medi-Cal or another public program

These options help you stay covered without a break.

If your coverage ends, Contra Costa Health Plan may share your name, address, and contact information with Covered California to help you find new coverage.

If you do not want us to share your information, call Member Services at 1-877-661-6230 (TTY 711) to opt out.

Chapter 4: How Your Plan Works

This chapter explains how to use your Contra Costa Health Plan coverage. You will learn about choosing and working with a Primary Care Provider (PCP), how referrals work, what to do in an emergency, and how to get care when you are away from home.

Primary Care Provider (PCP)

Your PCP is your main point of contact for most health care services.

- Choose your PCP through the MyChart web portal (mychart.cchealth.org) or MyChart mobile app (Apple or Google).
- You may change your PCP at any time online.
- Your PCP coordinates your care, provides preventive services, and makes referrals when needed.

If you cannot make the change online, Member Services can assist you. You may request the education, training, and board certification status of network practitioners. Call Member Services at 1-877-661-6230 (TTY 711) and we will provide this information.

Specialist Care and Referrals

- **Plan A** – Most specialty care is provided through the RMC network. If the service is not available at RMC, your PCP may refer you to the CPN network. There is generally no additional cost beyond your premium.
- **Plan B** – You may see specialists in either the RMC or CPN networks. Care at RMC usually has no cost. Care in the CPN network may require copayments and deductibles. A PCP referral is usually required for CPN specialists.
- **Plan A2** – Most specialty care is provided through the RMC network. If the service is not available at RMC, your PCP may refer you to the CPN network. Most services are covered at no additional cost beyond the premium.
- **IHSS Plan A2** – Most specialty care is provided through the RMC network, with a copay for each visit. If the service is not available at RMC, your PCP may refer you to the CPN network. Copays apply, and prior authorization may be required depending on the service.

Referrals can be requested and tracked in the MyChart web portal or MyChart mobile app. For a side-by-side comparison of specialty care rules and costs by plan, see the Specialty Care by Plan table later in this section.

Authorizations and Utilization Management

Some services require **prior authorization**. These may include hospital admissions, certain outpatient procedures, advanced imaging (e.g., MRI/CT), some specialty drugs, and selected durable medical equipment.

- **How to request:** Your provider submits requests to CCHP. You can track status in the **Member Portal/MyChart**.
- **Decision timeframes:** For **urgent** requests, CCHP makes a determination as quickly as your condition requires and generally **within 72 hours**. For **non-urgent** requests, decisions are generally made **within 5 business days** (or sooner where required).
- You will receive a written notice of approval or denial. If denied, your notice explains appeal options (see Chapter 9).
- You or your provider can obtain the prior authorization criteria used in decision-making at no cost by calling Member Services or by visiting the Plan website.

Specialty Care by Plan

Different plans have different rules for how you may access specialty care. The table below summarizes the basic differences between each commercial plan. Be sure to check your Schedule of Benefits for details on any costs that may apply to you.

Plan	Specialty Care Rules	Costs
Plan A	Most specialty care is provided through the Regional Medical Center (RMC) network. If the service is not available in RMC, your Primary Care Provider (PCP) may refer you to the Community Provider Network (CPN). Prior authorization may be required for certain services (e.g., advanced imaging, hospital admissions, some specialty procedures).	$0 (no cost to member)
Plan B	Members may see specialists in either the RMC or CPN networks. A PCP referral is usually needed for CPN specialists. Prior authorization may be required for certain services.	RMC services: $0. CPN services: copays and/or deductibles apply.

Plan	Specialty Care Rules	Costs
Plan A2	Most specialty care is provided through the RMC network. If the service is not available at RMC, your PCP may refer you to the CPN network. Prior authorization may be required for certain services.	$5 per visit (waived at CCRMC). See Schedule of Benefits for details.
IHSS Plan A2	Most specialty care is provided through the RMC network, with a $10 copay (waived at CCRMC). OOPM applies to medical cost share; see SOB. If the service is not available in RMC, your PCP may refer you to the CPN network. Prior authorization may be required for certain services.	$10 per visit (waived at CCRMC). See Schedule of Benefits for details.

Timely Access Standards

CCHP ensures members can access care within the timeframes required by the Department of Managed Health Care (DMHC). These standards include:

Type of Appointment	Maximum Wait Time
Urgent care that does not require prior authorization	48 hours
Urgent care that does require prior authorization	96 hours
Routine primary care visit	10 business days
Routine specialist visit	15 business days
Non-urgent mental health visit	10 business days
Non-urgent follow-up mental health visit	10 business days
Non-urgent ancillary services (lab, imaging, therapy)	15 business days

If you need help scheduling care:

1) Use the MyChart web portal,
2) MyChart mobile app,
3) CPN members call their assigned PCP, or
4) Call CCHP Member Services.

Timely Access to Mental Health and Substance Use Disorder (MH/SUD) Services

We cover the full range of mental health and substance use disorder services, including all levels of care. These services are not limited to short-term or acute treatment. Coverage is provided based on your medical needs, consistent with state law (Health and Safety Code section 1374.72).

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If CCHP cannot provide you with an appropriate in-network MH/SUD provider,

we will arrange services for you with an out-of-network provider at no additional cost to you. You will pay only your normal in-network copayments or coinsurance.

If your need is not urgent, we must offer you an appointment within 10 business days of your request.

If you urgently need services, we must offer you an appointment:

- Within 48 hours if prior authorization is not required, or
- Within 96 hours if prior authorization is required.

If we cannot meet these timely-access or geographic-access standards, you may obtain services from any licensed provider, even if they are not in our network. To be covered, your first appointment with that provider must be within 90 calendar days of the date you first asked us for MH/SUD services.

If you need help getting MH/SUD services or are having trouble finding an appointment, you can:

1. Call CCHP at the number listed at the bottom of this page.
2. Call the California Department of Managed Health Care's Help Center at 1-888-466-2219.
3. Visit www.healthhelp.ca.gov for assistance.

Second Opinions

You have the right to request a second medical opinion if you are unsure about a diagnosis or recommended treatment. The second opinion must be provided by an appropriately qualified health care provider within CCHP's network, or outside the network if one is not available in-network. CCHP will respond to your request within five business days (sooner if your condition is urgent).

Emergency and Urgent Care

You are always covered for emergency care anywhere in the United States and worldwide.

- **Emergency care** is for sudden, serious conditions that could put your health at risk if not treated right away.
- **Urgent care** is for conditions that need attention soon but are not life-threatening.

In an emergency, call 911 or go to the nearest emergency room. Show your CCHP ID card when possible.

You can find urgent care locations and after-hours instructions in the MyChart web portal or MyChart mobile app.

Emergency Care

Emergency services are covered anywhere in the U.S. and worldwide, 24 hours a day, without prior authorization. Coverage is based on the **prudent layperson standard**: if an average person with an average knowledge of health and medicine could reasonably believe that not receiving immediate medical attention would place their health in serious jeopardy, then it is an emergency.

After your Emergency Medical Condition is stabilized, ongoing hospital services may require authorization. If authorization is not obtained due to circumstances beyond your control, CCHP will work with the facility and providers to arrange transfer or authorize continued care as appropriate. You will not be balance billed for covered emergency or post-stabilization services.

Emergency Care vs. Urgent Care

It is important to understand the difference between emergency care and urgent care so you know where to go when you need treatment. The table below provides examples of when to seek emergency services versus urgent care services.

Type of Care	When to Use	Examples	Where to Go	Coverage
Emergency Care	For sudden, serious conditions that could put your health at risk if not treated right away.	Chest pain, severe shortness of breath, major injury, possible stroke, loss of consciousness.	Call 911 or go to the nearest emergency room.	Covered anywhere in the U.S. and worldwide.
Urgent Care	For conditions that need attention soon but are not life-threatening.	Sprains, ear infections, urinary tract infections, minor cuts requiring stitches.	Visit an urgent care center or after-hours clinic. Locations are listed in the MyChart web portal and	Covered in-network. Copayments may apply depending on your plan.

Type of Care	When to Use	Examples	Where to Go	Coverage
			MyChart mobile app.	

If you paid for emergency care: If you paid out-of-pocket for covered emergency services, you can find reimbursement information and instructions on our website at cchealth.org/home/showpublisheddocument/30808/638913797234070000. Be sure to keep copies of all documents.

Out-of-Area Coverage: Emergency services are covered worldwide. Non-emergency care outside Contra Costa Health Plan's service area is not covered unless prior authorized. If you are traveling and need urgent or emergency care, show your CCHP ID card when possible and notify CCHP as soon as reasonably possible.

After Business Hours

Call your Primary Care Provider (PCP) or the CCHP Nurse Advice Line (1-877-661-6230, Option 1; TTY 711) for guidance on how to obtain care and where to go.

Nurse Advice Line

If you are not sure whether you need emergency care or urgent care, you can call our 24/7 Nurse Advice Line. A registered nurse will listen to your symptoms, answer your questions, and help you decide the right level of care.

- Available 24 hours a day, 7 days a week
- No cost to you
- Languages available through interpreter services
- **Phone**: 1-877-661-6230, Option 1
- **TTY**: 711

This service is a good first step when you are uncertain, and it may help you avoid unnecessary emergency room visits.

Continuity of Care

See **Chapter 2: Continuity of Care** for eligibility, timeframes, and how to request.

If CCHP cannot meet timely access or geographic access standards for any mental health or substance use disorder service listed in Chapter 5, we will arrange out-of-network care for you at the same cost you would pay for in-network services.

Chapter 5: Covered Benefits

This chapter describes the health care services covered under your Contra Costa Health Plan commercial plan. Covered benefits are available when services are medically necessary, provided by in-network providers (unless otherwise noted), and consistent with the terms of your plan.

The Schedules of Benefits (SOBs) at the back of this handbook provide details about copayments, deductibles, and service limits that may apply.

Preventive and Routine Care

Preventive care helps you stay healthy and detect problems early. Preventive services are covered when received in-network. Some plans require a copay for these services. Please see your Schedule of Benefits (SOB) for details.

Examples include:

- Annual physical exams and well-child visits
- Immunizations and flu shots
- Cancer screenings (mammograms, colonoscopies, Pap smears)
- Blood pressure, cholesterol, and diabetes screenings

Preventive Care at a Glance

Service	Coverage
Annual physical	Covered in full, see SOB for copays
Well-child visits	Covered in full, see SOB for copays
Recommended immunizations	Covered in full, see SOB for copays
Screening (blood pressure, cholesterol, diabetes, cancer)	Covered in full, see SOB for copays

Hospital and Inpatient Services

Hospital services are covered when medically necessary and authorized. Coverage includes:

- Room and board in a semi-private room
- Nursing care
- Operating room, intensive care unit, and recovery room
- Medications, supplies, and diagnostic tests while hospitalized
- Physician and specialist services provided during admission

Outpatient Services and Surgery

Outpatient services are covered when performed in a hospital, ambulatory surgery center, or clinic. Examples include:

- Outpatient surgeries and procedures
- Endoscopy and colonoscopy
- Diagnostic imaging (X-ray, ultrasound, MRI, CT scan)
- Laboratory tests

Clinical Trials

If you participate in an **approved clinical trial**, CCHP covers **routine patient care costs** related to the trial. These are services you would receive even if you were not in the trial (e.g., office visits, lab tests, hospital services).

CCHP does **not** cover the investigational item or service itself, items provided solely for data collection, or costs paid by the trial sponsor. See Chapter 6 for details.

Pharmacy Benefits

Prescription medications are covered through the CCHP pharmacy network. Coverage includes:

- Generic, preferred brand, and non-preferred brand drugs
- Certain specialty drugs with prior authorization
- Preventive drugs at no cost (as required by the ACA)

You can review the current **drug formulary** and any prior authorization requirements online. Exceptions and continuity: If your medication is not on the formulary, requires step therapy, or has quantity limits, your prescriber may request an exception. To request a formulary exception, step-therapy exception, or quantity limit override, your prescriber should contact PerformRx. Members may also call PerformRx (1-855-287-9128, TTY 711) for assistance. If you are new to CCHP and are taking a medication for an ongoing condition, you may qualify for a limited transition fill while your prescriber requests authorization for continued coverage. Transition fills are time-limited; see your adverse decision letter or call PerformRx for details.

You can check your covered drug list (formulary) and request refills online through the:

- CCHP website (cchealth.org/health-insurance/)
- MyChart web portal (mychart.cchealth.org)
- MyChart mobile app (Apple or Google)

Pharmacy Tiers at a Glance

Tier	Coverage
Generic drugs	Lowest cost option; same active ingredients as brand drugs
Preferred brand drugs	Brand drugs preferred by CCHP's formulary
Non-preferred brand drugs	Higher cost alternatives when other drugs are available
Specialty drugs	High-cost or complex medications, often requiring prior authorization

Mental Health and Substance Use Disorder Services

CCHP covers medically necessary services to prevent, diagnose, and treat mental health conditions and substance use disorders. Services must follow generally accepted standards of mental health and substance use disorder care and be provided by licensed or certified behavioral health professionals acting within their scope of practice.

Covered Services Include

Your plan covers the following mental health and substance use disorder (MH/SUD) services when medically necessary:

- Outpatient therapy (individual, group, family)
- Inpatient mental health care
- Partial hospitalization and intensive outpatient programs
- Substance use disorder treatment, including detoxification and rehab
- Services must be medically necessary and provided by licensed behavioral health professionals.

Additional Covered MH/SUD Services (Required Under California Law)

In addition to the services listed above, your plan also covers the following medically necessary MH/SUD services, as required by California Health and Safety Code sections 1367.005, 1374.72, 1374.721, 1374.73, and Title 28, California Code of Regulations section 1300.74.72.01:

- Emergency services for MH/SUD conditions, both inside and outside the service area
- Urgent care services for MH/SUD conditions
- Physician services, including consultation, referral, and medications given in a provider's office or facility
- Hospital inpatient services, including acute psychiatric and chemical dependency recovery hospitals
- Ambulatory care services, including physical, occupational, and speech therapy when related to MH/SUD
- Diagnostic services (lab tests, imaging, and therapeutic services)
- Home health care services related to MH/SUD treatment
- Preventive MH/SUD care, including screenings, early interventions, and crisis stabilization
- Hospice services consistent with Medicare standards for MH/SUD needs
- Behavioral health treatment for autism spectrum disorder
- Coordinated specialty care for first-episode psychosis
- Day treatment programs
- Drug testing (presumptive and definitive) used for MH/SUD evaluation or treatment
- Electroconvulsive therapy (ECT)
- Services for gender dysphoria following the most current WPATH Standards of Care
- Medically monitored and medically managed inpatient ASAM levels of care (3.7 and 4)
- High-intensity and medically managed residential care (LOCUS/CALOCUS-CASII Level 6A and 6B)
- Intensive community-based services, including assertive community treatment (ACT) and intensive case management
- Intensive home-based treatment
- Medication management

- Narcotic (opioid) treatment programs
- Outpatient prescription drugs for MH/SUD treatment, including office-based opioid treatment
- Psychological and neuropsychological testing
- Psychiatric health facility services, including structured outpatient services
- Reconstructive surgery for gender dysphoria, consistent with state law
- Additional residential levels of care, including:
- LOCUS/CALOCUS levels 5A, 5B, and 5C
- ASAM levels 3.1, 3.3, and 3.5
- School-based MH/SUD services as allowed under state law
- Transcranial magnetic stimulation (TMS)
- Withdrawal management (detox) across all ASAM levels (1-WM through 4-WM)

Home Health Care for Mental Health and Substance Use Disorders

Your plan covers home health care services when they are medically necessary to treat a mental health condition or substance use disorder. Home health care is covered when:

You are confined to your home except for short absences or absences needed for medical treatment.

Skilled services (such as nursing, physical therapy, occupational therapy, or speech therapy) are medically necessary to evaluate or treat your condition, or to maintain your current level of health.

A physician, physician assistant, nurse practitioner, or clinical nurse specialist creates and reviews your plan of care at least every 60 days.

Covered home health services for MH/SUD include:

- Part-time skilled nursing
- Part-time home health aide services
- Physical therapy
- Occupational therapy

- Speech-language pathology
- Medical social services
- Medical supplies from a home health agency
- Durable medical equipment, if your plan covers DME

If your plan covers more home health hours for other medical conditions, the same (or more) hours must be covered for MH/SUD conditions. Any limits must be consistent with Medicare and cannot be more restrictive for MH/SUD care.

Preventive Mental Health and Substance Use Disorder Services

Your plan covers preventive services that help identify mental health conditions and substance use disorders early, even if you have not been diagnosed with a condition. Preventive MH/SUD services include:

- Screening, brief intervention, and referral to treatment (SBIRT)
- Primary care–based services for people who use alcohol or drugs in risky or harmful ways
- Early intervention services consistent with ASAM Level 0.5
- Screening for mental health conditions, developmental disorders, and adverse childhood experiences (ACEs)
- Crisis intervention and stabilization
- Community-based prevention and outreach programs
- Mental health first aid and support after trauma or a disaster

These services are covered without requiring a diagnosis and must follow generally accepted standards of mental health and substance use disorder care.

Maternity and Newborn Care

Maternity care is covered, exclusive to:

- Care for the month of birth
- Care for the month following birth

Pediatric Services

Children are covered for a wide range of services, including:

- Preventive well-child visits and immunizations
- Vision exams and corrective lenses (as applicable by plan)
- Hearing screenings

Rehabilitation and Therapy Services

Services include:

- Physical therapy
- Occupational therapy
- Speech therapy
- Cardiac and pulmonary rehabilitation
- Limits on the number of visits may apply (see Schedule of Benefits).

Laboratory and Radiology Services

Laboratory and imaging services are covered when medically necessary and ordered by your provider. This includes:

- Blood work
- Pathology tests
- X-rays and diagnostic imaging

Durable Medical Equipment (DME) and Supplies

Coverage includes medically necessary equipment and supplies prescribed by your provider, such as:

- Wheelchairs, walkers, and crutches
- Oxygen equipment
- Diabetes supplies
- Prosthetics and orthotics
- Some items may require prior authorization.

Other Covered Services

Your plan also covers:

- Home health care

- Hospice care
- Skilled nursing facility care
- Telehealth visits are covered on the same basis and to the same extent as in-person visits when clinically appropriate and provided by participating providers.
- Emergency coverage during natural disasters or other declared emergencies
- Preventive dental and vision (if included in your specific plan — see Schedule of Benefits)

Chapter 6: Exclusions and Limitations

The Contra Costa Health Plan (CCHP) does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

Exclusions and limitations do not apply to medically necessary mental health or substance use disorder services listed in Chapter 5 if applying those limits would be more restrictive than what is allowed under California law. Mental health and substance use disorder benefits must follow California Health and Safety Code sections 1367.005, 1374.72, 1374.721, 1374.73, and Title 28, California Code of Regulations section 1300.74.72.01.

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by Contra Costa Health Plan (CCHP) or required by law.

1. **Acupuncture Services**
   Contra Costa Health Plan (CCHP) does not cover acupuncture services, except as described in this EOC in Chapter 5 or as required by law.
2. **Chiropractic Services**
   Contra Costa Health Plan (CCHP) does not cover chiropractic services, except as described in this EOC in Chapter 5 or as required by law.
3. **Clinical Trials**
   Contra Costa Health Plan (CCHP) does not cover clinical trials, except Approved Clinical Trials as described in this EOC in Chapter 5 or as required by law.

   Coverage of Approved Clinical Trials does not include the following:

   - The investigational drug, item, or service itself.
   - Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.

- Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in Chapter 6, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in Chapter 9.

4. **Cosmetic Services, Supplies, or Surgeries**
   Contra Costa Health Plan (CCHP) does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in Chapter 5, or as required by law. Contra Costa Health Plan (CCHP) does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in Chapter 5, or as required by law.

   This exclusion does not apply to the following:

   - Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
   - Reconstructive surgery as described in this EOC in Chapter 5.
   - For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in Chapter 5.

5. **Custodial or Domiciliary Care**
   Contra Costa Health Plan (CCHP) does not cover custodial care, which

involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this EOC in Chapter 5 or as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
- Custodial care provided in a healthcare facility.

6. **Dental Services**
   Contra Costa Health Plan (CCHP) does not cover dental services or supplies, except as described in this EOC in Chapter 5 or as required by law.
7. **Dietary or Nutritional Supplements**
   Contra Costa Health Plan (CCHP) does not cover dietary or nutritional supplements, except as described in this EOC in Chapter 5 or as required by law.
8. **Disposable Supplies for Home Use**
   Contra Costa Health Plan (CCHP) does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in Chapter 5 or as required by law.
9. **Experimental Services or Investigational Services**
   Contra Costa Health Plan (CCHP) does not cover Experimental Services or Investigational Services, except as described in this EOC in Chapter 6 or as required by law.

   Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or

animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and
(2) The efficacy and safety of such services in human subjects are not yet established; and
(3) The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

(1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
(2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
(3) Reference to current medical literature.

However, if Contra Costa Health Plan (CCHP) denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, Contra Costa Health Plan (CCHP) must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to Contra Costa Health Plan (CCHP) that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by Contra Costa Health Plan (CCHP).

3. Either (a) your Health Care Provider, who has a contract with or is employed by Contra Costa Health Plan (CCHP), has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by Contra Costa Health Plan (CCHP) for the recommended or requested service.
5. If not for Contra Costa Health Plan (CCHP)'s determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If Contra Costa Health Plan (CCHP) denies coverage of the recommended or requested therapy and you meet all of the qualifications, Contra Costa Health Plan (CCHP) will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that Contra Costa Health Plan (CCHP) cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in Chapter 9. In certain circumstances, you do not have to participate in Contra Costa

Health Plan (CCHP)'s grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See Chapter 9.

10. **Vision Care**
    Contra Costa Health Plan (CCHP) does not cover vision services, except as described in this EOC in Chapter 5 or as required by law.
11. **Hearing Aids**
    Contra Costa Health Plan (CCHP) does not cover hearing aids, except as described in this EOC in Chapter 5 or as required by law.
12. **Immunizations**
    Contra Costa Health Plan (CCHP) does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as described in this EOC in Chapter 5 or as required by law.
13. **Non-licensed or Non-certified Providers**
    Contra Costa Health Plan (CCHP) does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as described in this EOC in Chapter 6 or as required by law.

    This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.
14. **Prescription Drugs / Outpatient Prescription Drugs**
    Contra Costa Health Plan (CCHP) does not cover the following Prescription Drugs, except as described in this EOC in Chapter 5 or as required by law:

    - When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.

- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of severe obesity. Enrollment in a comprehensive weight loss program, if covered by Contra Costa Health Plan (CCHP), may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
    - Insulin,
    - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs,
    - Over-the-counter drugs for reversal of an opioid overdose, or
    - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by Contra Costa Health Plan (CCHP) or a CCHP provider, except when coverage is otherwise required in the context of Emergency Services and Care.

15. **Private Duty Nursing**

Contra Costa Health Plan (CCHP) does not cover private duty nursing

in the home, hospital, or long-term care facility, except as described in this EOC in Chapter 5 or as required by law.

16. **Personal or Comfort Items**
Contra Costa Health Plan (CCHP) does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

17. **Reversal of Voluntary Sterilization**
Contra Costa Health Plan (CCHP) does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as described in this EOC in Chapter 5 or as required by law.

18. **Surrogate Pregnancy**
Contra Costa Health Plan (CCHP) does not cover testing, services, or supplies for a person who is not covered under Contra Costa Health Plan (CCHP) for a surrogate pregnancy, except as described in this EOC in Chapter 5 or as required by law.

19. **Therapies**
Contra Costa Health Plan (CCHP) does not cover the following physical and occupational therapies, except as described in this EOC in Chapter 5 or as required by law:
    - Massage therapy, unless it is a component of a treatment plan;
    - Training or therapy for the treatment of learning disabilities or behavioral problems;
    - Social skills training or therapy; and
    - Vocational, educational, recreational, art, dance, music, or reading therapy.

20. **Routine Physical Examination**
Contra Costa Health Plan (CCHP) does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as described under this EOC in Chapter 5 or as required by law.

21. **Travel and Lodging**
    Contra Costa Health Plan (CCHP) does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in Chapter 5, as otherwise described in this EOC in Chapter 5, or as required by law.
22. **Weight Control Programs and Exercise Programs**
    Contra Costa Health Plan (CCHP) does not cover weight control programs and exercise programs, except as described in this EOC in Chapter 5 or as required by law.

Chapter 7: Costs You May Pay

As a member of Contra Costa Health Plan (CCHP), you may be responsible for certain costs when you receive covered health care services. These costs depend on your plan and the type of service you receive. This chapter explains the different kinds of member costs. The exact amounts you will pay are listed in the **Schedule of Benefits (SOB)** at the back of this handbook.

Costs at a Glance

Cost Term	What It Means	Where You'll See It
Premium	The amount you or your employer pay each month to keep your coverage active.	Deducted from your paycheck or billed directly.
Copayment (Copay)	A fixed dollar amount you pay when you get a service or prescription.	Doctor visits, urgent care, prescriptions.
Deductible	The amount you pay each year before CCHP begins to share the cost of covered services.	Applied to some services.
Out-of-Pocket Maximum (OOPM)	The most you will pay in a year for covered services. Once you reach it, the plan pays 100%.	Tracks across copays and deductibles.

Premiums

A **premium** is the monthly amount you (or your employer) pay to maintain your health coverage. Premiums are usually deducted directly from your paycheck if you are an employee or billed to you if you are enrolled through another arrangement.

Copayments

A **copayment (copay)** is a fixed dollar amount you pay at the time you receive certain covered services. Examples include:

- A flat fee for a doctor's office visit.
- A flat fee for a prescription medication.

Your copay amounts are listed in your Schedule of Benefits.

Deductibles

A **deductible** is the amount you must pay each year before CCHP begins to share the cost of certain covered services. Some services, such as preventive care, are not subject to the deductible.

The deductible amounts and which services apply are listed in your Schedule of Benefits.

Out-of-Pocket Maximum

The **out-of-pocket maximum (OOPM)** is the most you will pay in a year for covered services, including copayments, and deductibles. Once you reach this amount, CCHP pays 100% of the cost of covered services for the rest of the year.

Your OOPM is listed in your Schedule of Benefits.

Balance Billing

You will not be balance billed for covered emergency services, even if the services are provided by an out-of-network facility or clinician. CCHP covers emergency care at the in-network cost share, which may be $0 depending on your plan.

You also will not be balance billed for covered non-emergency services received at an in-network facility, even if some clinicians involved in your care (for example, anesthesiologists, pathologists, or radiologists) are out of network.

If you receive a bill you believe is incorrect or higher than your in-network cost share, contact Member Services and we will help review it.

Using Online Tools

You can track your costs and benefits at any time:

- **MyChart web portal** (mychart.cchealth.org) shows your claims, deductible status, and out-of-pocket maximum.
- **MyChart mobile app** (Apple or Google) gives you mobile access to the same information.

Using these tools helps you stay informed and avoid surprises.

Chapter 8: Coordination of Benefits

Sometimes members are covered by more than one health plan at the same time. This is called **Coordination of Benefits (COB)**. COB rules determine which plan pays first (the "primary" plan) and which plan pays second (the "secondary" plan). The goal is to make sure your claims are processed correctly and to avoid duplicate payments for the same service.

How COB Works

- The **primary plan** pays benefits first.
- The **secondary plan** may pay some or all of the remaining costs, depending on its rules.
- Together, the two plans will not pay more than 100% of the covered cost.

Primary vs. Secondary Coverage

The rules for determining which plan is primary include:

- **Employer vs. Employer Plans**: If you are covered by two employer-sponsored plans, the plan covering you as an employee is usually primary over the plan covering you as a dependent.
- **Medicare**: If you are enrolled in Medicare and CCHP and are an active employee, CCHP is usually primary and Medicare is secondary. If you are retired, Medicare is primary.
- **Medi-Cal**: If you have Medi-Cal and CCHP, Medi-Cal is generally the payer of last resort and will pay after all other available coverage.
- **Children with Dual Coverage**: If a child is covered under both parents' plans, the **birthday rule** usually applies — the plan of the parent whose birthday falls earlier in the year is primary.
- **Workers' Compensation**: Services related to a work injury or illness are generally covered by Workers' Compensation. CCHP is not the primary payer for those services.
- **Other Situations**: Additional COB rules may apply based on state or federal law.

Coordination of Benefits at a Glance

Situation	Primary Plan	Secondary Plan
You are covered by your own employer plan and also by your spouse's employer plan	Your employer plan	Your spouse's plan
You have Medicare and CCHP	Active employee: CCHP Retired: Medicare	Active employee: Medicare Retired: CCHP
You have Medi-Cal and CCHP	CCHP	Medi-Cal
Your child is covered under both parents' plans	The plan of the parent with the earlier birthday in the year	The other parent's plan
You are covered by two employer-sponsored plans and one is COBRA	The active employee plan	The COBRA plan

What You Need to Do

- Always tell your providers if you have more than one health plan.
- Show all of your health insurance ID cards at the time of service.
- Providers will bill the primary plan first and then bill the secondary plan.

Online Access

You can check how your claims were processed by logging into the:

- **Member web portal** (mychart.cchealth.org)
- **MyChart mobile app** (Apple or Google)

Emergency and urgent care are covered at the in-network cost share, even if provided out of network. You cannot be balance billed for these services.

Chapter 9: Grievances & Appeals

As a member of Contra Costa Health Plan (CCHP), you have the right to let us know if you are unhappy with your care or services. You also have the right to ask us to review a decision if we deny or modify coverage. This chapter explains the difference between a grievance and an appeal, how to file one, and the timelines that apply.

Grievances vs. Appeals at a Glance

Type	What It Is	When to Use	Filing Deadline	Decision Timeline
Grievance	Any written or verbal complaint about CCHP, providers, or services.	When you are dissatisfied with care, service, or how something was handled.	180 days from the incident.	Acknowledgment within 5 days. Resolution within 30 days.
Appeal	A formal request to review a denial, delay, or modification of a covered service or payment.	When CCHP denies or modifies coverage you believe should be provided.	180 days from the denial notice.	Resolution within 30 days (or 72 hours if expedited).

Step 1: Try to Resolve with Member Services

Many concerns can be resolved quickly by contacting **Member Services**.

- **By Phone:** Call **1-877-661-6230 (press 2)**. California Relay users may call **711**.
- **Online** via the **MyChart web portal** (mychart.cchealth.org) or **MyChart mobile app** (Apple or Google).

If your issue is not resolved, you may file a formal grievance.

Step 2: File a Grievance

A **grievance** is any written or verbal expression of dissatisfaction.

- **How to File:** Online through the Contra Costa Health Plan web at cchealth.org/health-insurance/my-contra-costa-health-plan/file-a-

complaint, by phone, in writing, or using forms available in provider offices.

In Person or by Mail:
Contra Costa Health Plan
595 Center Avenue, Suite 100
Martinez, CA 94553

- **Confidentiality:** All grievances are confidential and handled according to state and federal privacy rules.
- **Acknowledgment:** You will receive a written acknowledgment **within 5 days**. The notice will include information on how to contact the Plan if you have additional questions or information to provide.
- **Resolution:** CCHP will resolve your grievance within **30 days** of receipt.
- **Time Limit to File:** You must file within **180 days** of the incident.
- **Behavioral Health Access Issues:** If you believe you cannot get timely mental health or substance use disorder care, you may file a grievance at any time. You may also contact the DMHC Help Center immediately for assistance with access issues, including delays in appointments or inability to find a provider.
- **Authorized Representatives:** You may appoint another person—such as a family member, caregiver, provider, or legal representative—to file a grievance or appeal on your behalf. A signed consent form is required. CCHP will provide the necessary form upon request.
- **Behavioral Health (Mental Health / Substance Use Disorder) Grievances**: You may file a grievance at any time if you are unable to get timely mental health or substance use disorder services, including delays in appointments or difficulty locating a provider. Behavioral health grievances may be filed with CCHP or directly with CCHP's behavioral health administrator. Filing with either entity satisfies the Plan's grievance requirements.

Step 3: Appeal a Denial

If you believe CCHP has wrongly denied, delayed, or modified a covered service or payment, you may file an **appeal**.

- **How to Appeal:** Submit a written request to Member Services within **180 days** of the denial.
- **Resolution:** CCHP will provide a written response within **30 days** of receiving your request.
- **What to Expect:** The response will explain whether the denial is upheld, overturned, or modified.

Step 4: Expedited Review

If you believe waiting 30 days could seriously harm your health, you may request an **expedited review**.

- **Examples:** You need urgent services, or you are already receiving care and believe stopping would cause serious harm.
- **Decision Timeline:** Within **72 hours (3 days)** of your request.
- **If Denied Expedited Review:** We will notify you within **3 days** and process your case under the regular grievance timeline.

Step 5: Independent Options

If you are not satisfied with the outcome, or if your grievance is not resolved within 30 days, you may contact the **California Department of Managed Health Care (DMHC)**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at Contra Costa Health Plan **1-877-661-6230 Press 2** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The

department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

Using CCHP's grievance and appeal process does not take away your legal rights or your ability to contact the DMHC at any time.

Chapter 10: Members' Rights & Responsibilities

As a member of Contra Costa Health Plan (CCHP), you are entitled to important rights and you also share certain responsibilities. These rights and responsibilities are designed to help you receive quality care and to ensure that you and your providers work together effectively.

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.

- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services
- Keep eligible dependents on your Plan, as allowed by law.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.

- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Chapter 11: Definitions

This chapter explains important terms used throughout this Evidence of Coverage (EOC). These definitions are provided to ensure that you clearly understand the meaning of certain words or phrases when they appear in your benefits and coverage information. Unless otherwise noted, all terms are used as defined below.

Definitions

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health.
  - The federal Centers for Disease Control and Prevention.
  - The Agency for Healthcare Research and Quality.
  - The federal Centers for Medicare and Medicaid Services.
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.

    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        - The United States Department of Veterans Affairs.
        - The United States Department of Defense.
        - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in this Evidence of Coverage or under California health plan law.

Emergency Medical Condition means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within

the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Independent Medical Review (IMR) means a review of Contra Costa Health Plan (CCHP)'s denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by Contra Costa Health Plan (CCHP) related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Contra Costa Health Plan (CCHP) must pay for the services if an IMR decides you need it.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and

(2) The efficacy and safety of such services in human subjects are not yet established; and
(3) The service is not in wide usage.

Life-Threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in Contra Costa Health Plan (CCHP) and for whom coverage is active or live.

Mental Health or Substance Use Disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Prescription Drug or "drug" means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug" or "prescription drug" includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by Contra Costa Health Plan (CCHP) within which the plan shall provide health care services.

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Conclusion

These definitions are intended to support your understanding of this Evidence of Coverage. If you have any questions about these terms or others used in this handbook, you may contact Member Services or review additional resources on the MyChart web portal or MyChart mobile app.

Chapter 12: Schedule of Benefits

This chapter shows your financial responsibility when using health care services under each CCHP commercial product. Please review the table that matches your plan. For the most current details, you can also review your plan's Summary of Benefits and Coverage (SBC), available on our website at contracosta.ca.gov/10526/2026-Plan-Highlights-and-Summary-of-Bene or by request.

CONTINUE TO NEXT PAGE

IHSS Plan A2 Schedule of Benefits

Service Category	Member Cost	Notes
Primary Care Visit	$10	Waived at CCRMC.
Specialist Visit	$10	Waived at CCRMC. Referral required within RMC. Prior authorization required for CPN specialty.
Preventive Care	$0	Includes USPSTF A/B services, immunizations, preventive care.
Urgent Care Visit	$10	Waived at CCRMC. $0 for urgent mental health or substance use disorder care.
Emergency Room Visit	$0	No cost to member.
Inpatient Hospitalization	$0	Semi-private room/board, physician services, nursing care. Prior authorization required except in emergencies.
Outpatient Surgery / Facility Services	$0	Includes outpatient hospital and surgery center services. Prior authorization required.
Maternity Care	$0	Includes care for the month of birth and care for the month following birth. Prior authorization required for hospital admission.
Mental Health & Substance Use Disorder – Outpatient	$0	Therapy, counseling, medication management. Prior authorization required for some services. For information about your rights to timely and geographically accessible Mental Health and Substance Use Disorder (MH/SUD) services, including access to out-of-network providers when timely access standards cannot be met, see the Timely Access to MH/SUD Services section
Mental Health & Substance Use Disorder – Inpatient	$0	Includes detoxification and rehabilitation. Prior authorization required. For information about your rights to timely and geographically accessible Mental Health and Substance Use Disorder (MH/SUD) services, including access to out-of-network providers when timely access standards cannot be met, see the Timely Access to MH/SUD Services section
Prescription Drugs	$10 generic / $10 brand	Retail or mail order. Quantity limits, step therapy, and/or prior authorization may

Service Category	Member Cost	Notes
		apply. Diabetes medications apply toward OOPM.
Durable Medical Equipment (DME) & Rehabilitation Services	$0–$10	DME: $0 if medically necessary. Rehabilitation (PT/OT/ST): $10 per visit, medically necessary up to 2 months per condition. Copay waived at CCRMC. Prior authorization required.
Skilled Nursing Facility (SNF)	$0	Limited to 100 days per year. Prior authorization required.
Home Health Care	$10	Skilled services only. Copay waived at CCRMC. Prior authorization required.
Hospice Care	$0	In-home and inpatient hospice covered. Prior authorization required.
Infertility Services	$10	Waived at CCRMC. Diagnosis and artificial insemination; up to 3 complete oocyte retrievals, unlimited embryo transfers. Prior authorization required.
Fertility Preservation	$0	Standard fertility preservation services (e.g., for cancer treatment) as medically necessary. Prior authorization required.
Organ & Tissue Transplants	$0	Medically necessary, non-experimental. Prior authorization required.
Reconstructive Surgery	$0	Medically necessary (e.g., post-mastectomy, congenital anomaly repair). Prior authorization required.
TMJ (Temporomandibular Joint) Treatment	Not covered	Not a covered benefit.
Vision Exam (Adult)	$10	Waived at CCRMC. One annual routine exam covered. Self-referral allowed.
Vision Eyewear (Adult)	Not covered	Except for cataract lenses/spectacles or lenses for keratoconus (1 per eye/year at scheduled rate).
Pediatric Vision	$0	One routine eye exam and one pair of glasses per year for children.
Hearing Tests / Hearing Aids	$10 hearing test; hearing aids not covered	Waived at CCRMC.
Dental Services (Adult)	$10 per visit	Limited basic dental benefits at Martinez, Pittsburg, and Richmond Health Centers. Up to $188 for removable appliances (dentures). Referral required. Copay waived at CCRMC.
Pediatric Dental	Not covered	Preventive and medically necessary dental care for children. Prior authorization may be required.

Service Category	Member Cost	Notes
Chiropractic Services	Not covered	Not a covered benefit.
Acupuncture Services	Not covered	Not a covered benefit.
Other Services (Labs, X-ray, Imaging)	$0	Includes lab tests, X-ray, diagnostic and advanced imaging. Some advanced imaging may require prior authorization.
Ambulance / Medically Necessary Transportation	$0	Emergency ambulance covered. Non-emergency transport requires prior authorization.
Out-of-Area Non-Emergent Care	Not covered.	Emergency and urgent care only outside service area.
Deductible	$0	None.
Out-of-Pocket Maximum (OOPM)	$1,500 individual	Premiums, non-covered services, and most pharmacy copays do not count toward OOPM (except diabetes medications).

Notices

Nondiscrimination Notice

Discrimination is against the law. Contra Costa Health Plan (CCHP) follows State and Federal civil rights laws. CCHP does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

CCHP provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
    Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If you need these services, contact CCHP between 8 AM - 5 PM by calling **1-877-661-6230**. If you cannot hear or speak well, please call **TTY 711**. Upon request, this document can be made available to you in braille, large print, audio cassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Contra Costa Health Plan
595 Center Ave Ste 100, Martinez, CA 94553
1-877-661-6230 (TTY 711)

HOW TO FILE A GRIEVANCE

If you believe that CCHP has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with

CCHP's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Call 1-877-661-6230 (TTY 711)
- **In writing:** Send to CCHP Civil Rights Coordinator, Member Grievance Unit, 595 Center Avenue, Suite 100, Martinez, CA 94553; Fax: 1-925-313-6047
- **In person:** Visit your doctor's office or CCHP and say you want to file a grievance
- **Electronically:** Visit CCHP's website at www.contracostahealthplan.org

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil rights by phone, in writing, or electronically:

- By Phone: 1-800-368-1019 (TTY 1-800-537-7697)
- In writing: Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  Complaint forms are available at:
  https://www.hhs.gov/ocr/complaints/index.html
- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Notice of Privacy Practices

Read how we use and protect your health information: cchealth.org/about-contra-costa-health/our-vision-and-mission/policies/your-medical-privacy. To request a paper copy, call Member Services.

Interpreter Services

ATTENTION: If you need help in your language call 1-877-661-6230 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-877-661-6230 (TTY: 711). These services are free of charge.

الشعار بالعربية(Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-877-661-6230 (TTY 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ 1-877-661-6230 (TTY 711). هذه الخدمات مجانية.

Հայերեն պիտակ **(Armenian)**

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-877-661-6230 (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-877-661-6230 (TTY: 711): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ ប ើអ្នក ត្រូវ ការជំនួយ ជាភាសា រ ស់អ្នក សូម ទូរស័ព្ទទៅបេខ 1-877-661-6230 (TTY: 711)។ ជំនួយ និង បសវាកមម សត្ា ់ ជនព្ិការ ដូចជាឯកសារសរបសរជាអ្កសរផុស សត្ា ់ជនព្ិការភ្នកក ឬឯកសារសរបសរជាអ្កសរព្ុមពធំ ក៏អាចរកបានផងភ្ដរ។ ទូរស័ព្ទមកបេខ 1-877-661-6230 (TTY: 711)។ បសវាកមមទំងបនេះមិនគិរថ្លៃប ើយ។

简体中文 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-877-661-6230 (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-877-661-6230 (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-877-661-6230 (TTY 711) تماس بگیرید.
کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است.
با 1-877-661-6230 (TTY 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

ह िंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-877-661-6230 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगोों के ललए सहायता और सेवाऐं, जैसे ब्रेल और बडे लरोंट में भी दस्तावेज़ उपलब्ध हैं। 1-877-661-6230 (TTY: 711) पर कॉल करें। ये सेवाऐं लन: शुल्क हैं।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-877-661-6230 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-877-661-6230 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)

注意日本語での対応が必要な場合は 1-877-661-6230 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-877-661-6230 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-877-661-6230 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-877-661-6230 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແຫກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-877-661-6230 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-877-661-6230 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-877-661-6230 (TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-877-661-6230 (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-877-661-6230 (TTY 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-877-661-6230 (TTY 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-877-661-6230 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-877-661-6230 (линия TTY:711). Такие услуги предоставляются бесплатно.

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-877-661-6230 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-877-661-6230 (TTY: 711). Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-877-661-6230 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-877-661-6230 (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-877-661-6230 (TTY: 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-877-661-6230 (TTY: 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-877-661-6230(TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-877-661-6230 (TTY: 711). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-877-661-6230 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-877-661-6230 (TTY: 711). Các dịch vụ này đều miễn phí.

Important Contact Information to Know

When you need help with your benefits, services, or care, use the numbers and websites below. Keep this page handy for quick reference.

Service	Contact Information	Hours/Notes
Emergency Services	Call 911	Available anywhere in the U.S. and worldwide, 24/7.
Member Services	1-877-661-6230, Option 2 (TTY 711)	Mon–Fri, 8 AM–5 PM. For benefits and general questions.
Nurse Advice Line	1-877-661-6230, Option 1 (TTY 711) 24/7 availability, free	24/7. Speak with a registered nurse about symptoms or urgent questions.
Appointment Scheduling (RMC Network)	Phone: 1-800-495-8885 (TTY 711) Portal: mychart.cchealth.org App: Apple or Google	Schedule, change, or cancel appointments with RMC network providers. CPN members should schedule directly through their assigned CPN PCP.
Behavioral Health Services	1-877-661-6230, Option 4 (TTY 711)	For mental health and substance use disorder services.
PerformRx (Pharmacy Benefits Manager)	1-855-287-9128 (TTY 711) www.PerformRX.com	24/7. For pharmacy benefits, drug coverage, prior authorization, and mail-order refills.
Interpreter & Disability Assistance	1-877-661-6230, Option 7 (TTY 711)	Free language assistance and alternate formats (braille, large print, audio).
Grievances & Appeals	Online: cchealth.org/health-insurance/my-contra-costa-health-plan/file-a-complaint Phone: 1-877-661-6230 (TTY 711)	Submit a complaint, appeal, or request Independent Medical Review.
Manage Your Health Online (MyChart mobile app, MyChart web portal, CCHP website)	Web: cchealth.org/health-insurance/ Portal: mychart.cchealth.org App: Apple or Google	Access ID cards, benefits, claims, secure messaging, and plan documents.
Department of Managed Health Care (DMHC) Help Center	1-888-466-2219 (TTY 1-877-688-9891) www.dmhc.ca.gov	For help if you have a problem that your plan has not resolved.