

**BASIC HEALTH CARE**  
 Covered Benefits, Limitations and Exclusions

SERVICE	COVERAGE
Abortions	Not Covered (Pregnancy is covered by Medi-Cal)
Acupuncture	Not Covered
Advice Nurse	Covered
Allergy Injections and Allergy Testing	Covered
Alcohol Abuse	Not Covered (Covered by other programs administered by the Health Services Department)
Biofeedback	Not Covered
Blood	Covered, except self-donation is not covered
Chiropractic Care	Not Covered
Contact Lenses	Not Covered, except for implants following cataract surgery for Aphakia or Keratocomas
Cosmetic Surgery	Not Covered
Custodial Care	Not Covered

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SERVICE	COVERAGE
Dental Care	<p>Not covered except for emergency dental services limited to dental x- rays, dental examinations, and extractions only.</p> <p>Children, ages 5 through 14 inclusive, are limited to the following covered services:</p> <ol style="list-style-type: none"> <li>1. Emergency dental services</li> <li>2. Dental examinations</li> <li>3. Dental x-rays</li> <li>4. Dental fillings</li> <li>5. Extractions</li> <li>6. Preventive dental care that includes teeth cleaning, sealants, and fluoride applications</li> </ol>
Diabetic Supplies	Covered
Diabetic Testing	Covered
Drug Abuse	Not Covered (Covered by other programs administered by the Health Services Department)
Durable Medical Equipment	Covered
Emergency and Urgent Care	Covered
Eye Glasses	Not Covered
Experimental Treatment	Not Covered
Family Planning	Covered

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SERVICE	COVERAGE
Hearing Aids and Batteries	Not Covered
Hearing Tests (Audiology)	Covered
Hemodialysis – Acute	Covered
Hemodialysis – Chronic	Not Covered
Home Health Services	Not Covered
Hospitalization	Covered
Hospice	Not Covered
Immunizations and Inoculations	Covered, except travel inoculations and medications are not covered
Infertility Services	Not Covered
Long Term Care and Skilled Nursing Facility	Not Covered
Maternity Care	Not Covered (Covered by Medi-Cal)
Mental Health and Substance Use Disorder Services	Not Covered (Covered by other programs administered by the Health Services Department)
Newborn Coverage	Not Covered (Covered by Medi-Cal)
Organ Transplant	Not Covered

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SERVICE	COVERAGE
Orthoptic (Eye Training)	Not Covered
Outpatient Visits	Covered, but some visits require prior authorization
Over the Counter Medications	Only those medications listed on the Preferred Drug List; periodically amended by the Pharmaceuticals and Therapeutics Committee, are covered.
Personal and Comfort Items	Not Covered
Physical Examinations	Not covered, except back-to-work programs are covered
Prescription Medications, Outpatient (Legally requires a prescription)	Only those medications listed on the Preferred Drug List; periodically amended by the Pharmaceuticals and Therapeutics Committee, are covered.
Prosthetic Devices, Corrective Appliances and Artificial Aids	Not Covered
Radial Keratotomy	Not Covered
Refraction	Covered
Skilled Nursing Facility	Not Covered
Sterilization	Covered
Supplies, Disposable	Covered



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SERVICE	COVERAGE
Therapy: Outpatient, Physical, and Occupational	Covered only in cases of expected short-term improvements (2 month maximum)
TMJ Treatment	Not Covered
Transportation	Not Covered

NOTE: All Covered Services are provided only at Contra Costa County facilities unless referred and preauthorized by Contra Costa County.