

Basic Health (BH)

♿ 2009 MEMBER COST SHARING GRID ♿

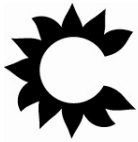
NOTE: ALL COST SHARING AMOUNTS ARE SUBJECT TO PLACE OF SERVICE AND BILLING METHODOLOGIES.

Service	BH Subsidized/ HCTC/ BH – S (Pregnant members that are not eligible for S-Med)	NOTES
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The following are Benefits and Services NOT Subject to the deductible and coinsurance

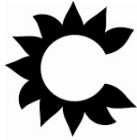
Preventive Care (office visits only)	NO member cost sharing	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office and Clinic Visit	\$15.00 co-pay per visit	Co-pay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries and follow-up visits. Co-pays do not apply to preventive care, laboratory, radiology services, radiation and chemotherapy. Some services will be subject to coinsurance.
Pharmacy – Retail (up to 30 day supply)	Tier 1: \$10 co-pay Tier 2: 50% co-insurance	Tier 1 is for formulary generic medications, or the actual cost of the drug if less than the co-pay. Tier 2 is for formulary brand name medications and non-formulary brand name medications.
Emergency Room	\$100.00 co-pay/visit	Co-pay is waived if member is admitted; Hospital coinsurance and deductible would apply.
Urgent Care	\$15.00 co-pay	Co-pay is for office visit only when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
Skilled Nursing, Hospice and Home Health Care	NO member cost sharing	Covered as an alternative to hospital care; requires a Prior Authorization.
Maternity*	NO member cost sharing for covered services	HCTC and BH-S only cover maternity related services.
Oxygen	NO member cost sharing	Includes equipment and supplies; requires a prior authorization.

* HCTC and BH-S only covered maternity related services



Basic Health (BH)

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<p>The following are benefits and services Subject to the deductible and coinsurance. A \$150 annual deductible must be met before CHP will pay 80% for the following benefits and services. The member’s coinsurance will apply toward \$1500 out-of-pocket maximum. Once the member has met the \$1500 out-of-pocket maximum CHP will pay 100% of the allowed charges.</p>		
Hospital, inpatient	20% coinsurance; deductible applies \$300 maximum facility charge per admittance	Facility charges may include, but are not limited to, room and board, prescription drugs provided while inpatient and other services received as inpatient. No charges for maternity care or when readmitted for the same condition within 90 days.
Hospital, outpatient	20% coinsurance; deductible applies	See “Other professional services” below.
Other professional services	20% coinsurance; deductible applies	Includes services received as an inpatient, surgeries, anesthesia, chemotherapy, radiation and other types of inpatient and outpatient services.
Mental Health	20% coinsurance; deductible applies to inpatient \$300 maximum facility charge per admittance	Limited to 10 inpatient days a year and 12 outpatient visits a year. Office visits to manage medication do not count toward the 12-visit maximum. Outpatient visits are subject to \$15 co-pay (see “Office visits”).
Laboratory and Pathology	NO member cost sharing for outpatient services 20% coinsurance for inpatient hospital-based laboratory services	Deductible applies to service with coinsurance.
Radiology (except x-rays, echo’s and ultrasounds)	20% coinsurance, except for outpatient x-ray and ultrasound	Deductible applies to services with coinsurance.
Ambulance (Air and Ground)	20% Co-insurance; deductible applies	Includes approved transfers from one facility to another. No coinsurance if transfer is at the plan’s request.
Chiropractic/Physical Therapy/Occupational Therapy	20% coinsurance; deductible applies	Up to a combined maximum of 12 visits per year (Only 6 can apply to Chiropractic care). Visits qualify only when used as post-operative treatment following reconstructive joint surgery.
Organ transplants	Deductible, coinsurance and co-pays apply by specific service	12-month waiting period, except for newborns or for a condition that is not preexisting.

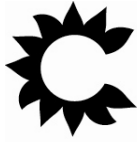


2009 Basic Health BENEFIT GRID

Benefit or Service	Prior Auth (PA)	REQUIRED: <input checked="" type="checkbox"/> Physician Orders (par) <input checked="" type="checkbox"/> Referral (non-par) <input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Hospital Notification <input checked="" type="checkbox"/> Prescription	BH Sub, HCTC & BH-S (pregnant women not eligible for BH S-Med) <u>Covered Service</u>	Member Responsibility <input checked="" type="checkbox"/> Co-pays (do <u>not</u> apply to deductible & OOP max) <input checked="" type="checkbox"/> Co-insurance (20%) <input checked="" type="checkbox"/> Annual Deductible (\$150/year) <input checked="" type="checkbox"/> Out-of-Pocket Maximum (OOP) (\$1,500/person)	Additional Information
Adult Developmental Programs			NO, not covered		
Alcohol Abuse			(SEE CHEMICAL DEPENDENCY)		
Allergy					
→ Injections	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	20% co-insurance	
→ Testing/Serum	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	20% co-insurance	
→ Office Visit	SOME¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	\$15 office visit co-pay	> 12 Specialty Provider visits require PA
Alopecia Treatment	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par) and/or Prescription	YES, treatment (e.g. topical medication) is covered when hair loss is a result of a medical, <u>not</u> genetic (e.g. male pattern baldness) condition. Hair transplants are considered cosmetic and therefore <u>not</u> covered.	Pharmacy co-pay	
Alternative Care					
→ Acupuncture	SOME¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 6 visits requires PA	20% co-insurance	> 6 visits requires PA
→ Biofeedback Therapy	SOME¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 6 visits requires PA	20% co-insurance	> 6 visits requires PA
→ Chiropractic Treatment (must be a chiropractor)	YES	Member may self refer to contracted providers; however chiropractic services are subject to medical necessity criteria (PA).	YES, covered up to 6 visits (PA).	20% co-insurance	12 combined (with physical and occupational therapy) visits, within 1 year of reconstructive joint surgery per calendar year (PA). NOTE: Only <u>6</u> visits of the 12 allowed can be chiropractic care visits.
→ Homeopathy			NO, not covered		
→ Hypnotherapy	SOME¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 6 visits requires PA	20% co-insurance	> 6 visits requires PA

¹ See additional information for PA requirements

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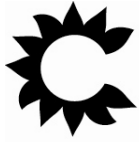


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Alternative Care, cont					
→ Massage Therapy	SOME²	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 6 visits requires PA	20% co-insurance	> 6 visits requires PA
→ Naturopathy	SOME²	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 6 visits requires PA	20% co-insurance	> 6 visits requires PA
→ Osteopathic Manipulative Therapy	SOME²	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered when performed by a Doctor of Osteopathy (DO). > 12 visits requires PA	20% co-insurance	See Chiropractic Treatment for additional information. > 12 visits requires PA
Ambulance					
→ Ground	NO	No Requirement (par/non-par)	YES, must meet the definition of an emergency and be considered the only appropriate method of transportation.	20% co-insurance	
→ Air	NO	No Requirement (par/non-par)	YES, must meet the definition of an emergency and be considered the only appropriate method of transportation.	20% co-insurance	
→ Facility-to-Facility Transfers	NO	No Requirement (par/non-par)	YES	20% co-insurance	If Community Health Plan approves a member's transfer from one facility to another, the ambulance transportation co-insurance will <u>not</u> apply.
Attention Deficit Disorder	(SEE MENTAL HEALTH)				
Audiology	(SEE HEARING EXAMS)				
Birth Control	(SEE FAMILY PLANNING)				
Birth Defects/ Congenital Anomalies					
→ Office Visits	SOME²	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	\$15 office visit co-pay	> 12 Specialty Provider visits require PA
→ Surgical Treatment	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	

² See additional information for PA requirements

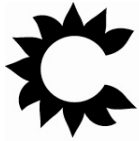
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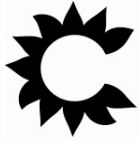
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Blood/Blood Components	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, including but not limited to, synthetic factors, plasma expanders, and their administration.	NO member cost sharing	
Cardiac Rehabilitation	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	
Chemical Dependency (alcohol and drug)					
→ Detoxification	NO	No requirement, if it is an ER visit (par/non-par) Hospital Notification, if admitted	YES, when the member is not yet enrolled in any other chemical dependency treatment program, medically necessary detoxification is covered as a medical emergency.	\$100 co-pay per emergency room visit If member is admitted from the emergency room, the co-pay will be waived and applicable co-insurance will apply.	Medical emergency treatment for detoxification is not included in the calculation of the \$5,000 per 24-month period, \$10,000 maximum. The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
→ Inpatient Treatment	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, \$5,000 (combined in/outpatient) in a 24 consecutive month period (includes <u>all</u> insurance coverage during that time) up to a lifetime benefit maximum of \$10,000 (combined in/outpatient) (only includes time on BH insurance).	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission. Includes diagnostic evaluation and education, organized individual and group counseling and covered prescription drugs.
→ Partial Hospitalization Programs	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, \$5,000 (combined in/outpatient) in a 24 consecutive month period (includes <u>all</u> insurance coverage during that time) up to a lifetime benefit maximum of \$10,000 (combined in/outpatient) (only includes time on BH insurance).	20% co-insurance	Also known as day programs or step therapy programs.
→ Outpatient (counseling sessions)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, \$5,000 (combined in/outpatient) in a 24 consecutive month period (includes <u>all</u> insurance coverage during that time) up to a lifetime benefit maximum of \$10,000 (combined in/outpatient) (only includes time on BH insurance).	\$15 office visit co-pay 20% co-insurance	See Methadone Treatment for additional information. Includes diagnostic evaluation and education, organized individual and group counseling, and covered prescription drugs.
→ Residential Treatment Programs/ Facilities			NO, not covered		This includes wilderness camps and programs.
Circumcision					
→ Routine			NO, not covered		
→ Medical Condition	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when necessary due to underlying medical condition.	\$15 office visit co-pay 20% co-insurance	Only covered when billed with the following diagnoses: 605, 607.1, and 607.81.

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2009 BH Benefit Grid – Final_July



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Cochlear Implants (including BAHA)	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	\$15 office visit co-pay 20% co-insurance	Considered a prosthetic not a hearing aid.
Complications from Non-Covered Services			NO, not covered		
Cosmetic Services			NO, not covered		See Blepharoplasty for additional information.
Court-Ordered Services			NO, not covered		
Custodial/ Convalescent Care			NO, not covered		Care is considered custodial when it is for the purpose of helping you with activities of daily living or meeting personal needs and can be done safely and reasonably by people without professional skills or training.
Dental Anesthesia	YES	Prior Authorization [CMS NCD Guideline]	YES, when a dental procedure cannot be performed in a dental office due to underlying medical condition and/or clinical status (PA).		Both anesthesia and subsequent facility charges are included.
Dental Services					
→ Accidental	YES	Prior Authorization [CMS NCD Guideline]	YES, only for repair needed due to <u>accidental</u> injury to <u>sound natural teeth or jaw</u> , including replacement of teeth, provided that repair starts 90 days after injury, as determined medically necessary by the Plan (PA).	\$15 office visit co-pay 20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
→ Routine	NO		No, not covered		
→ Medically Necessary	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, dental extractions that become necessary because of medical procedures (for example: oncology, radiation, chemotherapy)	\$15 office visit co-pay 20% co-insurance	
Developmental Disabilities	(SEE NEURODEVELOPMENTAL THERAPY)				
Dialysis (hemodialysis, peritoneal, renal (kidney))	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	Monthly physician management services do not require PA.
Drugs	(SEE PRESCRIPTIONS, PHARMACY)				

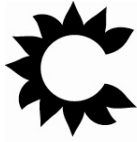


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Durable Medical Equipment (DME)/Supplies

→ Aerochamber	NO	Prescription	YES, must be obtained through the pharmacy benefit	Pharmacy co-pay	See 2009 CHP Drug Formulary for additional information.
→ Apnea Monitor			NO, not covered		
→ Bra's (post surgical)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, 2 covered initially with replacements thereafter due to normal wear and tear.	NO member cost sharing	
→ Breast Prosthesis (external)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, following a mastectomy benefit allows for replacement of external prostheses when necessitated by normal wear.	NO member cost sharing	
→ Breast Pumps			NO, not covered		
→ Communication Devices			NO, not covered		
→ C-PAP/Bi-Pap			NO, not covered		
→ CPM Machine (Continuous Passive Motion Machine)			NO, not covered		
→ Diabetic Supplies	NO	Prescription	YES, The following can be obtained with a prescription at a participating pharmacy: <ul style="list-style-type: none"> ▪ Insulin syringes ▪ Needles for insulin injections ▪ Lancets, autolancet devices ▪ Alcohol prep swabs ▪ Glucose test strips per formulary (limited to #204 in 30 days) ▪ Glucose monitors/test supplies per formulary. 	Pharmacy co-pay (Tier 1) or cost of supplies (whichever is less)	See Prescriptions, Pharmacy for information on general pharmacy & mail order prescription co-pays. See 2009 CHP Drug Formulary for additional information.
→ Diapers (disposable)			NO, not covered	Children and Adults	
→ Enteral Therapy Formula			NO, not covered		
→ Enteral Therapy Pump Rental			NO, not covered		
→ Fracture Frames			NO, not covered		

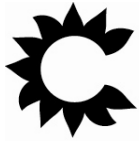


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Durable Medical Equipment (DME)/Supplies, cont

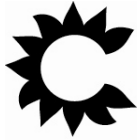
→ Hospital Beds			NO, not covered		
→ Humidifiers			NO, not covered		
→ Insulin Pump & Supplies			NO, not covered		
→ Lymphedema Sleeve	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered as part of cancer treatment, not DME	NO member cost sharing	
→ Nebulizer	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, purchase only	NO member cost sharing	Considered an exception to the DME exclusion.
→ Osteogenic (Bone) Stimulator			NO, not covered		
→ Oxygen & Related Equipment	YES	Prior Authorization [CMS NCD Guideline]	YES, must be determined medically necessary by the Plan (PA). NOTE: Oxygen delivery systems will be deemed purchased after 36 months of rental.	NO member cost sharing	Oxygen and related equipment are exempt from the PEC waiting period clause.
→ Parenteral Therapy and Supplies			NO, not covered		
→ Patient Lifts			NO, not covered		
→ Suction Pumps			NO, not covered		
→ TED Hose (support stockings)			NO, not covered		
→ TENS Unit			NO, not covered		
→ Trapeze Bars			NO, not covered		
→ Ventilators & Related Equipment			NO, not covered		
→ Wheelchairs			NO, not covered		Includes parts and repairs
Emergency Room Services	NO	No Requirement	YES	\$100 co-pay per emergency room visit	If member is admitted from the emergency room, the co-pay will be waived and applicable co-insurance will apply.



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Experimental or Investigational Procedures/Treatment			NO, not covered		To determine if CHP considers a service to be experimental and investigational submit a PA with chart notes requesting medical review.
Eye Ball Polishing			NO, not covered		
Eye Exams					
→ Routine			NO, not covered		
→ Medical Condition (Diagnose and treat disease/conditions of the eye.)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered for medical diagnosis such as but not limited to diabetes, glaucoma, & retinal detachment.	\$15 office visit co-pay	
Eye Glasses, Contact Lenses, Fitting and Dispensing			NO, not covered (See Additional Information column)		Intraocular lenses inserted during cataract surgery <u>are covered</u> .
Family Planning					
→ Contraception (emergency)	NO	Prescription	YES	Pharmacy co-pay	
→ Contraceptive Devices, Supplies or Medications					
• Prescriptions	NO	Prescription	YES, see Prescriptions, Pharmacy	Medroxy progesterone injection may be subject to pharmacy co-pay in addition to the \$15 office co-pay. Birth control pills are subject to the pharmacy co-pay.	See 2009 CHP Drug Formulary for additional information.
• Over-The-Counter (OTC) Products	NO	Prescription	YES, <u>some</u> OTC products are covered. Condoms and spermicide are not covered.	Pharmacy co-pay	See 2009 CHP Drug Formulary for additional information.
→ Maternity Services					
• Birthing Classes			NO, not covered		
• Inpatient	NO	Hospital Notification	BH: YES, covered for 30 days after pregnancy diagnosis by provider. HCTC/BH-S: YES	NO member cost sharing for maternity related services	Member must contact BH @ 1.800.660. 9840 to apply for coverage. If member is denied coverage (S-Med), then maternity care will be covered under BH-S

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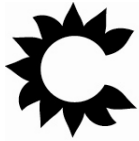
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Family Planning, cont

• Outpatient (includes observation & short stay)	NO	Women may self refer to contracted WHC providers	BH: YES, covered for <u>30</u> days after pregnancy diagnosis by provider. HCTC/BH-S: YES	NO member cost sharing for maternity related services	
• Office Visits	NO	Women may self refer to contracted WHC providers	BH: YES, covered for <u>30</u> days after pregnancy diagnosis by provider. HCTC/BH-S: YES	NO member cost sharing for maternity related services	
• Home Delivery	NO	Women may self refer to contracted WHC providers	BH: YES, covered for <u>30</u> days after pregnancy diagnosis by provider. HCTC/BH-S: YES	NO member cost sharing for maternity related services	
• Doula Services			NO, not covered		
→ Newborn Care	NO	5 days or less is covered under mom's Hospital Notification.	BH: YES, covered for <u>30</u> days after pregnancy diagnosis by provider. HCTC/BH-S: YES, however coverage is limited to <u>normal</u> newborn care such as nursery services and routine pediatric care while inpatient, after delivery. Sick newborns that are re-admitted are NOT covered (beyond 5 days).	NO member cost sharing for maternity related services, <u>including</u> routine newborn care.	
→ Sterilization for Women (includes tubal ligation)	NO	Member may self refer to contracted Women's Health Care Providers	YES	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
Forensic Exam			NO, not covered		Medical exam for legal purpose only.

Genetic Counseling

→ Prenatal	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	HCTC/BH-S: YES, covered during pregnancy and through the end of the month containing the 60 th day the pregnancy ends. Must be medically necessary (<i>meaning a change in delivery of care will occur</i>). BH: YES, covered for <u>30</u> days after pregnancy diagnosis by provider.	NO member cost sharing for maternity-related services	Not covered if requested for diagnostic purposes only.
→ Non-Prenatal			NO, not covered		



2009 Basic Health BENEFIT GRID

Benefit or Service	Prior Auth (PA)	REQUIRED: <input checked="" type="checkbox"/> Physician Orders (par) <input checked="" type="checkbox"/> Referral (non-par) <input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Hospital Notification <input checked="" type="checkbox"/> Prescription	BH Sub, HCTC & BH-S (pregnant women not eligible for BH S-Med) <u>Covered Service</u>	Member Responsibility <input checked="" type="checkbox"/> Co-pays (do <u>not</u> apply to deductible & OOP max) <input checked="" type="checkbox"/> Co-insurance (20%) <input checked="" type="checkbox"/> Annual Deductible (\$150/year) <input checked="" type="checkbox"/> Out-of-Pocket Maximum (OOP) (\$1,500/person)	Additional Information
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Genetic Testing

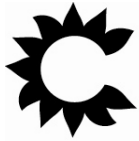
→ Prenatal	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	HCTC/BH-S: YES, covered during pregnancy and through the end of the month containing the 60 th day the pregnancy ends. Must be medically necessary (<i>meaning a change in delivery of care will occur</i>). BH: YES, covered for <u>30</u> days after pregnancy diagnosis by provider.	NO member cost sharing for maternity-related services	Not covered if requested for diagnostic purposes only.
→ Non-Prenatal (Diagnostic)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered for children to rule out underlying genetic disorder or for the purposes of diagnosis.	NO member cost sharing for laboratory services	
→ Non-prenatal (Investigational)			NO, not covered		

Health Education/Wellness Program

→ Asthma Education	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to <u>6</u> visits per calendar year.	20% co-insurance	Group and/or individual sessions count toward visit maximum.
→ Diabetic Education	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, limited to <u>6</u> visits per calendar year.	20% co-insurance	Must include nutrition, exercise, prevention of acute & chronic complications and monitoring & medication.
→ Diabetic Self Mgmt. Training	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, limited to <u>6</u> visits per calendar year.	20% co-insurance	Group and/or individual sessions count towards the visit maximum.
→ Nutritional Counseling					
• Obesity Dx.	SOME ³	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered for children (0-18) > 12 visits requires PA	20% co-insurance	Covered for Obesity Diagnosis only > 12 visits requires PA
• Other Medical Dx.	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to 2 visits per calendar year.	20% co-insurance	
Hearing Aids			NO, not covered		
Hearing Exams (audiology)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, examinations to determine hearing loss.	\$15 office visit co-pay 20% co-insurance (pro fee's)	

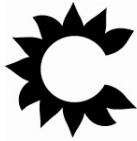
³ See additional information for PA requirements

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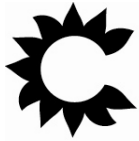
2009 Basic Health BENEFIT GRID

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HIV/AIDS Testing	NO	No requirement (par/non-par)	YES	NO co-pay for laboratory services	
Home Health Care	YES	Prior Authorization	YES, when considered an alternative to hospitalization in an acute care facility, to be determined by the Plan (PA) .	NO member cost sharing for home health care services, if approved by the Plan 20% co-insurance for any drugs/medications	If member is being discharged from hospital, refer case to the CHP Utilization Mgmt. department to assess coverage.
Home Infusion Therapy	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary or palliative. (PA) .	NO member cost sharing, if approved by the Plan	
Home Intrauterine Activity Monitoring			NO, not covered		Considered to be experimental and investigational.
Home Phototherapy for Hyperbilirubinemia (Jaundice)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, however the equipment is not covered.	NO member cost sharing	
Hospice Care	YES	Prior Authorization + CHP CM Referral [CHP Guideline]	YES, must be determined medically necessary or palliative. (PA) .	NO member cost sharing	
Hospital Care					
→ Inpatient	SOME	Prior Authorization Or Hospital Notification	YES, PA is required for elective inpatient stays. Hospital Notification is required for all non-elective inpatient stays.	20% co-insurance <u>WAIVED</u> if admission is maternity related	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission. Hospitals are required to notify CHP of all inpatient admissions within one business day of admission by calling 1-800-440-1561.
→ Outpatient Surgery	SOME	PCP/Physician Orders (par) Plan Approved Referral (non-par) Or Prior Authorization	YES, PA is required on select elective surgeries. See specific surgery for information.	20% co-insurance	
→ Outpatient Services	SOME	PCP/Physician Orders (par) Plan Approved Referral (non-par) Or Prior Authorization	YES, PA is required on select elective surgeries. See specific surgery for information.	20% co-insurance	Co-insurance applies to both facility and professional charges.
HPV (Human Papilloma Virus) Test	NO	Women may self refer to contracted WHC providers	YES, covered as part of a Pap Test	NO member cost sharing for laboratory services	



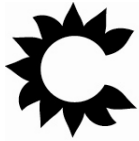
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Hyperbaric Oxygen Pressurization	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	
Immunizations	NO	No requirement when done by the PCP	YES	NO member cost sharing for preventive health care	NOTE: international travel or work-related immunizations are not covered. See individual Immunization for more information.
→ Flu Vaccinations	NO	No requirement when administered by the PCP	YES, including FluMist™ FluMist™ is covered for members ages 2-49 only.	NO member cost sharing	CHP will reimburse members up to \$20 when a receipt is provided.
→ HPV (Human Papilloma Virus)			NO, not covered		Also known as Gardasil™
→ Menactra™ (meningococcal vaccine)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, in the following circumstances: <ul style="list-style-type: none"> ▪ Children ages 11-12 ▪ Teenagers age 15 ▪ Teenagers age 18-19, if entering college as a freshman <u>and</u> living in a dorm ▪ Patients with functional or anatomic asplenia ▪ Patients with terminal complement component deficiencies ▪ Patients with HIV/AIDS 	NO member cost sharing for preventive health services	
→ Rotavirus Vaccine (Rotateq™)			NO, not covered		
→ Zostavax™ (Varicella vaccine)			NO, not covered		Vaccine for shingles
Impotence Treatment			NO, not covered		
Incarcerated Care			NO, not covered		
Infertility/Sterility Testing and Treatment			NO, including but not limited to testing and treatment of infertility, sterility, artificial insemination, sterilization reversal and in vitro fertilization.		
Injections					
→ Botox™ Injections	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	20% co-insurance	Cosmetic Botox is not covered.



2009 Basic Health BENEFIT GRID

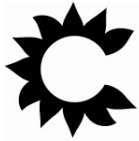
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Injections, cont					
→ Enbrel™	YES	Prescription + ESI PA (<i>if self administered</i>) Prior Authorization (ONLY if member is unable to self-administer)	YES, when determined to be medically necessary by the Plan (PA).	If administered by a physician 20% co-insurance (subject to deductible and OOP maximum) If provided by a pharmacy 50% pharmacy co-insurance	PA Requirement applies to all FDA approved injections. [CMS NCD Guideline]
→ Euflexxa™	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	
→ Growth Hormone Therapy	YES	Prescription + ESI PA (<i>if self administered</i>) Prior Authorization (ONLY if member is unable to self-administer)	YES, must be determined medically necessary by the Plan (PA). NOT covered through a home health agency.	If administered by a physician 20% co-insurance (subject to deductible and OOP maximum) If provided by a pharmacy 50% pharmacy co-insurance	PA is required for all provider types, including PCP. NOTE: The actual drug requires PA, not just administration.
→ Orencia™	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA).	20% co-insurance	Medication used to treat rheumatoid arthritis.
→ Orthovisc™	YES	Prior Authorization [CHP Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	
→ Remicade™ Infusion	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA).	20% co-insurance	
→ Synagis™/RespiGam™ Injections	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	Up to 5 injections will be authorized during RSV season (November 15 - April 15).
→ Synvisc™/Hyalgan™ Injections	YES	Prior Authorization [CMS Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	
→ Tysabri™ (natalizumab)	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	Medication used to treat multiple sclerosis.
→ Xolair™	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	Medication to treat asthma



2009 Basic Health BENEFIT GRID

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Interpreter Services			NO, except for administrative issues only, e.g. handling member grievances. Not covered by CHP for medical encounters (including office visits). See Additional Information column.		NOTE: The Title VI, Civil Rights Act of 1964 prohibits exclusion from health care services and discrimination on the grounds of race, color or national origin, including non-English or Limited English Proficiency (LEP), if the provider receives any reimbursement from federal programs, including Basic Health, they are required to provide interpretation services.
IV Therapy					
→ Outpatient	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, must be determined medically necessary by the Plan (PA).	20% co-insurance	
→ Home	YES	Prior Authorization (when covered) [Milliman™ Guideline]	NO, <u>except</u> when deemed the most appropriate vehicle for administration of a medically necessary covered injectable, to be determined by the Plan (PA).	NO member cost sharing for home health care services, if approved by the Plan 20% co-insurance for any drugs/medications	See Home Health Care and Home Infusion Therapy for additional information.
Learning Disabilities			NO, not covered		
Lymphedema Treatment	NO	PCP/Physician's Orders (par) Referral (non-par)	YES > 12 visits requires PA	\$15 office visit co-pay	This treatment, commonly done by a physical therapist, is separate from the PT benefit after reconstructive joint surgery.
Mammogram (routine and diagnostic)	NO	Women may self refer to contracted facilities	YES	NO member cost sharing	
Manipulation of Spine & Extremities (SEE CHIROPRACTIC CARE AND OSTEOPATHIC MANIPULATION)					
Medical Nutritional Therapy			NO, not covered		Including oral supplements
Mental Health Care					
→ Inpatient	NO	Hospital Notification	YES, covered up to 10 inpatient days per calendar year	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission. Involuntary admissions do not require written or verbal authorization for payment per RCW 48.44.343.

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2009 BH Benefit Grid – Final_July



2009 Basic Health BENEFIT GRID

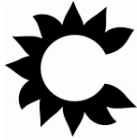
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Mental Health Care, cont

→ Outpatient	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to 12 visits per calendar year, including medically necessary diagnosis and treatment of eating disorders	\$15 office visit co-pay	NOTE: medication management does <u>not</u> count against the 12-visit benefit limit maximum (CPT 90862).
→ Partial Hospitalization Programs	NO	PCP/Physician's Orders (par) Referral (non-par)	YES, partial hospitalization days may be used in lieu of covered inpatient days at an exchange rate of 2 partial hospitalization days for 1 inpatient day.	\$15 office visit co-pay	Also known as day programs or step therapy programs.
→ Psychological Evaluations	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered once every 12 months for adults and unlimited for children.	\$15 office visit co-pay	
→ Residential Mental Health Treatment Programs/ Facilities			NO, not covered		
Methadone Treatment	NO	PCP/Physician Orders (par/non-par)	Covered under the chemical dependency benefit with a maximum of \$5,000 during a 24-month consecutive calendar month period/ \$10,000 lifetime maximum.	NO member cost sharing	NOTE: Methadone may be covered through the pharmacy benefit for non-chemical dependency diagnoses.
Neurodevelopmental Therapy			NO, not covered for children ages six and under.		
Neuropsychological Testing	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to 12 -combined visits per member per lifetime.	20% co-insurance	Neuropsychological testing does <u>not</u> count against the 12 outpatient mental health visit maximum.
Obesity Services			NO, not covered		See Nutrition Counseling for additional information
Occupational Injuries			NO, not covered		
Office Visit	SOME ⁴	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	\$15 office visit co-pay	Evaluation and Management > 12 Specialty Provider visits require PA
Orthopedic Shoes (Orthotic)			NO, not covered		
Orthoptic Therapy			NO, not covered		Aka eye training

⁴ See additional information for PA requirements

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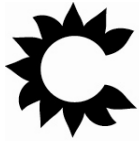


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Out of Area Coverage	(in/out of state or worldwide)				
→ Routine			NO, not covered		
→ Urgent Care (urgently needed care)	NO	Referral (non-par)	YES	\$15 office visit co-pay	
→ Inpatient	NO	Hospital Notification	YES, only if related to an urgent or emergent condition	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
→ ER	NO	No Requirement (par/non-par)	YES	\$100 emergency room visit co-pay	
Outpatient Diagnostic Services					
→ Procedures/Test	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	20% co-insurance; deductible applies	
→ Laboratory Services	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	No co-pay or co-insurance for outpatient services 20% co-insurance for inpatient hospital-based laboratory services	
→ Therapeutic Radiological Services	SOME⁵	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, PET Scans, some MRI/MRA, CT-head, and CT Angiography require a PA .	20% co-insurance, except for outpatient x-ray and ultrasound	See 2009 Prior Authorizations list
Over the counter medications			NO, not covered		
Pain Clinic					
→ Office Visits	SOME⁵	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	\$15 office visit co-pay	Referrals to a pain clinic should be written for a specific service recommended in a treatment plan from the pain clinic. > 12 Specialty Provider visits require PA
→ Outpatient Rehabilitation			NO, not covered		
→ Alternative Care	YES	Prior Authorization [CHP Guideline]	YES, may include biofeedback and/or acupuncture (PA).	20% co-insurance	

⁵ See additional information for PA requirements

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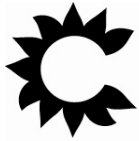


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Pain Clinic, cont					
→ Treatment (e.g. nerve block, epidural steroid injection)	SOME⁶	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 visits requires PA	20% co-insurance	> 12 visits requires PA
Pain Management	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par) Hospital Notification (inpatient care)	YES	\$15 office visit co-pay 20% co-insurance	See Pain Clinic for additional information. The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
Palliative Care	YES	Prior Authorization + CHP CM Referral [CHP Guideline]	YES, covered in conjunction with hospice and must be determined medically necessary by the Plan (PA).	NO member cost sharing	See Hospice for additional information
Pathology Services	NO	No Requirement (par/non-par)	YES	NO member cost sharing	
Penile Prosthesis			NO, not covered		
Physical Exams	NO	No requirement when done by the PCP	YES	NO member cost sharing for preventive care	NOTE: Physicals for program eligibility, insurance, employment or immigration are not covered.
PKU (Phenylketonuria)					
→ Formula	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, Phenylketonuria (PKU) supplements are covered in full for treatment of this disorder.	NO member cost sharing	
→ Screening	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO member cost sharing	
Podiatry (including diabetic foot care)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	\$15 office visit co-pay	Routine foot care is <u>not</u> covered.
Prescriptions, Pharmacy					
→ Inpatient Drugs	NO	Hospital Notification	YES, covered under authorized hospital notification.	NO member cost sharing for inpatient drugs Inpatient prescription drugs are paid in full with authorized inpatient stay.	
→ Out of Area Drugs	SOME⁷	Prescription	YES, members can obtain prescriptions when out of the service area when filled at a participating pharmacy.	See co-payments under Outpatient Drugs below.	See 2009 Formulary for additional information.

⁶ See additional information for PA requirements

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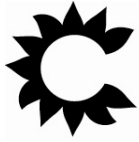
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Prescriptions, Pharmacy, cont

→ Outpatient Drugs (obtained from pharmacy)	SOME ⁷	Prescription	YES, must be purchased at a participating pharmacy. Generic drugs will be dispensed unless the generic equivalent is not available. NOTE: CHP Formulary applies to all prescription drugs.	Up to a 30-day supply or refill of retail outpatient prescriptions. Tier 1: \$10 co-pay for formulary generic medications, or the actual cost of the drug if less than the co-pay. Tier 2: 50% co-insurance for formulary brand name medications and non-formulary brand name medications or the actual cost of the drug if less than the co-pay.	For all Prior Authorization drug requests call Express Scripts PA Service Specialist at 1.888.256.6132. This number is available 24 hours a day, 7 days a week. For non-formulary drug requests, provider can call Express Scripts @ 1.888.256.6132 See 2009 CHP Drug Formulary for additional information. See 2009 Formulary for additional information.
→ Mail Order Prescriptions /Extended Day Supply			NO, not available		
→ Take Home Drugs (dispensed upon discharge from the hospital)			NO, must be obtained with a prescription at a participating pharmacy.		
Preventive Care	NO	No requirement when done by the PCP	YES, including but not limited to immunizations, well-child checks, screening colonoscopies, mammograms, bone density testing.	NO member cost sharing for preventive care	See Screening Exams for additional information. Preventive health services are covered and paid without restriction regarding frequency.
Prostheses (arm or leg)			NO, not covered		
Psychiatric Treatment			(SEE MENTAL HEALTH)		
Pulmonary Rehabilitation			NO, not covered		
Radiation & Chemotherapy					
→ Radiation Treatment	SOME ⁷	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, some agents require PA.	\$15 office visit co-pay 20% co-insurance	See 2009 Prior Authorization list > 12 Specialty Provider office visits require PA
→ Oral Chemotherapy	SOME ⁷	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, some agents require PA.	\$15 office visit co-pay 20% co-insurance	See 2009 Prior Authorization list > 12 Specialty Provider office visits require PA
→ Injectable/Infused Chemotherapy	SOME ⁷	Prior Authorization [CMS NCD Guideline]	YES, some agents require PA. See 2009 PA list for specifics.	\$15 office visit co-pay 20% co-insurance	PA requests should include a treatment plan and protocol they will be using.

⁷ See additional information for PA requirement

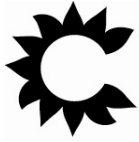
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2009 Basic Health BENEFIT GRID

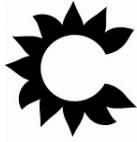
Benefit or Service	Prior Auth (PA)	REQUIRED: <input checked="" type="checkbox"/> Physician Orders (par) <input checked="" type="checkbox"/> Referral (non-par) <input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Hospital Notification <input checked="" type="checkbox"/> Prescription	BH Sub, HCTC & BH-S (pregnant women not eligible for BH S-Med) <u>Covered Service</u>	Member Responsibility <input checked="" type="checkbox"/> Co-pays (do <u>not</u> apply to deductible & OOP max) <input checked="" type="checkbox"/> Co-insurance (20%) <input checked="" type="checkbox"/> Annual Deductible (\$150/year) <input checked="" type="checkbox"/> Out-of-Pocket Maximum (OOP) (\$1,500/person)	Additional Information
Rehabilitation (Inpatient)	YES	Prior Authorization	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
Rehabilitation (outpatient)					
→ Physical Therapy	YES	Prior Authorization [Milliman™ Guideline]	YES, covered up to <u>12 combined</u> (with occupational therapy and chiropractic care) visits per calendar year, within 1 year of reconstructive joint surgery (PA) .	\$15 office visit co-pay 20% co-insurance	Spine is considered to be a covered joint. NOTE: Only <u>6</u> of the 12 visits allowed can be chiropractic care visits.
→ Occupational Therapy	YES	Prior Authorization [Milliman™ Guideline]	YES, covered up to <u>12 combined</u> (with physical therapy and chiropractic care) visits per calendar year, within 1 year of reconstructive joint surgery (PA) .	20% co-insurance	Spine is considered to be a covered joint. NOTE: Only <u>6</u> of the 12 visits allowed can be chiropractic care visits.
→ Speech Therapy			NO, not covered		
Respite Care (hospice)			NO, except when billed in conjunction with hospice.		
Reversal of Sterilization			NO, not covered		
Rituxan™ (rituximab)	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	PA requirement applies to both rheumatoid arthritis and cancer diagnoses.
Saliva Testing			NO, not covered		Considered to be experimental and investigational at this time.
School Nurse Services			NO, not covered		
Screening Exams (preventive)					
→ Colorectal (colonoscopy)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, screening and diagnostic colonoscopies are covered	NO member cost sharing for screening colonoscopies 20% co-insurance	Only G0105, G0121 and 45378 are considered screening colonoscopies.
→ Diabetes	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO member cost sharing	
→ Mammography	NO	No Requirement (par/non-par)	YES	NO member cost sharing	

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2009 BH Benefit Grid – Final_July



2009 Basic Health BENEFIT GRID

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Sexual Reassignment (Surgery, Services and Supplies)			NO, not covered		
Skilled Nursing Facility	YES	Prior Authorization + CHP CM case referral [CHP Guideline]	YES, SNF may be covered when considered an alternative to an acute care facility, to be determined by the Plan through Prior Authorization (PA).	NO member cost sharing, <u>if approved by the Plan</u>	NOTE: Custodial or convalescent care is not a covered benefit.
Sleep Study	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, limited to one (1) sleep study per calendar year.	\$15 office visit co-pay 20% co-insurance	Also known as polysomnography Limit does <u>not</u> include Auto-Titration.
Smoking and Tobacco Cessation					
→ Services	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, through Free and Clear program	\$15 office visit co-pay	Free and Clear number: 1.866.QUIT.4.LIFE (784-8454) TTY number: 1-877-777-6534
→ Drugs	NO	Prescription	YES	Pharmacy co-pay	See 2009 CHP Drug Formulary for nicotine replacement covered medications.
→ Nicotine Replacement	NO	Prescription	YES	Pharmacy co-pay	See 2009 CHP Drug Formulary for nicotine replacement covered products
Substance Abuse	(SEE CHEMICAL DEPENDENCY)				
Surgeries					
→ Abortion, Spontaneous (miscarriage)	NO	Member may self-refer to contracted women's health care providers.	YES, member has 30 days of maternity coverage after the date of diagnosis of pregnancy by a provider. HCTC/BH-S: YES, covered in full	NO member cost sharing	Maternity services include termination of pregnancy.
→ Abortion, Voluntary			NO, Not Covered		
→ Ambulatory Surgery (outpatient or same day surgery)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, however some outpatient surgeries require PA. See specific surgery for additional information.	20% co-insurance	
→ Bariatric Surgery/ Procedures (surgical treatment for obesity)			NO, not covered (See Additional Information column)		Including but not limited to gastric bypass, gastroplasty, laparoscopic gastric banding, LAP-BAND, laparoscopic duodenal switch, Roux-en Y gastric bypass.



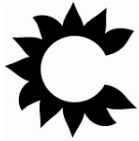
2009 Basic Health BENEFIT GRID

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Surgeries, cont					
→ Bladder Neck Suspension	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	
→ Blepharoplasty	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	Surgical procedure to repair droopy eye lid.
→ Breast Reconstruction, Mammoplasty	SOME⁸	Hospital Notification OR PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, initial reconstruction mammoplasty is covered regardless of whether the member was covered by CHP at the time of the mastectomy. Additional reconstructions & implant removals are covered when medically necessary and not for cosmetic reasons.	\$15 office visit co-pay 20% co-insurance	See 2009 Prior Authorization List
→ Breast Reduction Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	
→ Bunionectomy Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	Expected to be done in an outpatient or ASC setting.
→ Cosmetic Surgeries			NO, not covered (See Additional Information column)		
→ Eye Surgery (Lasik™) (for vision improvement)			NO, not covered		
→ Eye Surgery (laser) (for a medical condition)	SOME⁸	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, surgeries for a medical condition such as glaucoma, retinal detachment and cataracts are covered.	20% co-insurance	See 2009 PA Grids for additional information.
→ Hip Replacement Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
→ Hysterectomy (abdominal, vaginal)	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA) .	20% co-insurance	Elective hysterectomy for the sole purpose of sterilization is not covered
→ Knee Arthroscopy	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA) .	20% co-insurance	

⁸ See additional information for PA Requirements

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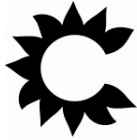


2009 Basic Health BENEFIT GRID

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Surgeries, cont

→ Knee Replacement Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
→ Mastectomy	NO	Hospital Notification or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	20% co-insurance	Mastectomies typically require inpatient admission.
→ Reconstructive, Plastic Surgery and Supplies	YES	Prior Authorization [CHP Guideline]	YES, covered to correct a physical disorder resulting from or following an injury or incidental surgery	20% co-insurance	See Breast Reconstruction Mammoplasty for additional information (NO PA). See Birth Defects for additional information
→ Refractive Surgery			NO, not covered		Includes Lasik surgery
→ Sclerotherapy, leg vein	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA) .	20% co-insurance	
→ Shoulder Replacement	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA) .	20% co-insurance	
→ Skin Tag Removal			NO, not covered		CPT Codes: 11200 – 11201
→ Strabismus Surgery	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, surgical treatment is covered.	20% co-insurance	
→ Tonsillectomy and Adenoidectomy	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	20% co-insurance	
→ UPPP (Uvulopalatopharyngoplasty)	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
→ Vasectomy	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	20% co-insurance	a.k.a. Male Sterilization

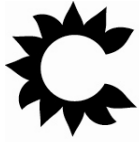


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Temporomandibular Joint (TMJ) & Myofacial Pain Disorder (MPD)	SOME⁹	PCP/Physician Orders (par) Plan Approved Referral (non-par) Or Prior Authorization	YES, initial evaluation <u>or</u> diagnostic test to confirm diagnosis. Treatment is <u>NOT</u> covered. Some diagnostic tests may require a PA (e.g. MRI)	\$15 office visit co-pay (evaluation) NO member cost sharing for outpatient lab work	ER visits with a TMJ diagnosis do not count toward the initial allowed evaluation or diagnostic test.
Transmyocardial Laser Revascularization			NO, not covered		Considered to be experimental and investigational at this time.
Transplants		12 consecutive month waiting period applies to ALL transplants			
→ Corneal Transplant	NO	Hospital Notification OR PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	20% co-insurance	The maximum a member can be charged for inpatient facility co-insurance is \$300 per person, per admission.
→ Transplants (organ or tissue) & Work-up Related to Transplants	YES	Prior Authorization + CHP Case Manager referral [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, kidney and kidney-pancreas transplants is covered.
→ Transplant (organ or tissue) Donation	YES	Prior Authorization + CHP Case Manager referral [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA).	20% co-insurance	
→ Transplant Donor Search (tissue typing of family members)	YES	Prior Authorization [CMS NCD Guideline]	YES, including bone marrow and stem cell donor search and testing.	20% co-insurance	
Transportation (from home to office or from PCP to Specialist)			NO, not covered		
Urgent Care (urgently needed care)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	\$15 office visit co-pay	
Vaccinations			(SEE IMMUNIZATIONS)		

⁹ Some diagnostic tests require an Authorization

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Virtual Endoscopy (wireless or capsule endoscopy)	(SEE EXPERIMENTAL AND INVESTIGATIONAL)				
Virtual Colonoscopy	(SEE EXPERIMENTAL AND INVESTIGATIONAL)				
Vitamins	NO	Prescription	YES, some are covered through the pharmacy benefit. Not covered if over the counter.	Pharmacy co-pay	See 2009 CHP Drug Formulary for additional information.
→ B12 Injections	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, however only covered for the following diagnoses: 123.4, 151-154.8, 157-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579, 648.2	\$15 office visit co-pay for physician encounter only	
Vocational Rehabilitation			NO, not covered		
Wigs			NO, not covered		
Wound Care					
→ Outpatient Wound Care Center	SOME ¹⁰	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	\$15 office visit co-pay	> 12 Specialty Provider visits require PA
→ Home Health Agency	YES	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when considered an alternative to hospitalization in an acute care facility, to be determined by the Plan (PA).	NO member cost sharing, <u>if approved by the Plan</u>	

¹⁰ See additional information for PA requirements

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