

Enclosed you will find the **July 2009 VERSION** of the *General Assistance Unemployable* Benefits Grid. In addition to the details listed on the benefit matrix, please note the following:

➤ The enclosed GAU Benefit Grid is **effective** January 1, 2009.

➤ **General Assistance Unemployable** is a state-funded program for individuals with short-term disabilities that prevent them from working for at least 90 days. There must be a verifiable physical and/or mental impairment that prevents the adult from being gainfully employed.

➤ **Effective for DOS 9/1/06, Facility Claims** (billed on a UB-04) will be paid by Health and Recovery Services Administration as follows:

Hardcopy Claims: Health and Recovery Services Administration
Division of Program Support
PO Box 9249
Olympia, WA 98507-9247

Electronic Claims: Submit to HRSA Office of Information Services; instructions for submission are available through the Electronic Billing Instructions available at the HRSA website.

Claims Questions: Call HRSA at 1-800-562-3022

➤ **Effective for DOS 9/1/06, All Other Claims** (billed on a HCFA 1500) will be paid by Community Health Plan as follows:

Hardcopy Claims: Adaptis, Inc.
PO Box 91008
Seattle, WA 98111-9108
FAX: 206.749.9457

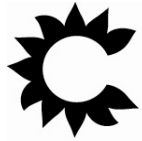
Electronic Claims: Submitted through THIN, use the payer identifier CHPWA
Submitted through WebMD, use the payer identifier SB613

Claims Questions: Call CHP at 1-800-440-1561

➤ The CHP GAU Pilot **is subject** to HRSA's current Prior Authorization/Expedited Prior Authorization guidelines for facility-based care ONLY. Please see the DSHS website at <http://fortress.wa.gov/dshs/maa/Download/PublicationsFees.htm> for specific information. **ALL** other services are subject to CHP's Prior Authorization requirements and guidelines. See specific grid category for additional information.

➤ **ALL** services must be ordered by the member's Primary Care Physician. General Assistance Unemployable is a managed care **pilot project** and the member's assigned PCP must initiate specialty referrals when appropriate, and orders should be the result of a face-to-face encounter. The **only** exception to this rule would be when the benefit allows for member self-referral (e.g. Women's Health). See enclosed Benefit Grid for additional information.

➤ ALL Hospitals/ Facilities **must** have a core agreement with DSHS in order to be reimbursed for services and are subject to DSHS **Billing Instructions** which are manuals that detail how the provider is to bill HRSA for covered facility-based care provided to HRSA-eligible members.

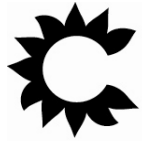


2009 General Assistance Unemployable **BENEFIT GRID**

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	<u>COVERED SERVICE</u> (defined as covered and paid by CHP)	<u>COVERED FEE-FOR-SERVICE</u> (defined as covered and paid by DSHS)	Additional Information
Adult Developmental Programs			NO, not covered	YES, refer to Division of Developmental Disabilities @ 206.568.5700	
Alcohol Abuse			(SEE CHEMICAL DEPENDENCY)		
Allergy					
→ Injections	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
→ Testing/Serum	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
→ Office Visit	SOME¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	NO, not covered	> 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, not genetic (e.g. male pattern baldness) condition. Hair transplants are considered cosmetic and therefore not covered.	NO, not covered	
Alternative Care					
→ Acupuncture			NO, not covered	NO, not covered	Alternative care is not covered for GAU members
→ Biofeedback Therapy			NO, not covered	NO, not covered	Alternative care is not covered for GAU members
→ Chiropractic Treatment			NO, not covered	NO, not covered	Alternative care is not covered for GAU members
→ Homeopathy			NO, not covered	NO, not covered	Alternative care is not covered for GAU members
→ Hypnotherapy			NO, not covered	NO, not covered	Alternative care is not covered for GAU members
→ Massage Therapy			NO, not covered	NO, not covered	Alternative care is not covered for GAU members
→ Naturopathy			NO, not covered	NO, not covered	Alternative care is not covered for GAU members
→ Osteopathic Manipulative Therapy	SOME¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when performed by a Doctor of Osteopathy (DO) > 10 visits require PA	NO, not covered	This is separate from the chiropractic treatment benefit. > 10 visits require PA

¹ See additional information for PA Requirements

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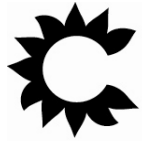


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Ambulance					
→ Ground	NO	No Requirement (par/non-par)	YES	NO, not covered	Must meet the definition of an emergency and be considered the only appropriate method of transportation.
→ Air	NO	No Requirement (par/non-par)	YES	NO, not covered	
→ Facility-to-Facility Transfers	NO	No Requirement (par/non-par)	YES	NO, not covered	
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	NO, not covered	> 12 Specialty Provider visits require PA
→ Surgical Treatment	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	Inpatient surgery requires Hospital Notification
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, not covered	
Cardiac Rehabilitation	YES	Prior Authorization [CMS NCD Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, when performed in a facility-based program.	
Chemical Dependency (alcohol and drug)					
→ Detoxification			NO, except in cases when there are medical condition secondary to chemical dependency treatment that require medical attention in emergent, inpatient or outpatient basis (lacerations, seizure, cirrhosis, dehydration).	YES	

² See additional information for PA Requirements

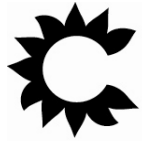
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Chemical Dependency (alcohol and drug), cont					
→ Inpatient Treatment			NO, not covered	YES, GAU members can receive services through DASA-certified treatment agencies Contact the Alcohol /Drug Helpline at 1-800-562-1240 for a list. If residential treatment is needed, the agency can help connect the member.	
→ Partial Hospitalization Programs			NO, not covered	NO, not covered	
→ Outpatient (counseling sessions)			NO, not covered	YES, GAU members can receive services through DASA-certified treatment agencies Contact the Alcohol /Drug Helpline at 1-800-562-1240 for a list. If residential treatment is needed, the agency can help connect the member.	
→ Residential Treatment Programs/ Facilities			NO, not covered	NO, not covered	This includes wilderness camps and programs.
Circumcision					
→ Routine			NO, not covered	NO, not covered	
→ Medical Condition	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when necessary due to underlying medical condition.	NO, not covered	Only covered when billed with the following diagnoses: 605, 607.1, and 607.81.
Cochlear Implants (including BAHA)	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	
Complications from Non-Covered Services			NO, not covered	NO, not covered	
Cosmetic Services			NO, not covered	NO, not covered	Cosmetic surgery including, but not limited to, augmentation mammoplasty, chemical peel, facial implants, dermabrasion, face lifts, lipoplasty, abdominoplasty, hair transplantation.
Court-Ordered Services			NO, not covered	NO, not covered	This exclusion applies to services requested solely for forensic or legal reasons and when member has already gone through the judicial system.

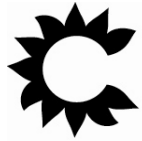
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Custodial/ Convalescent Care			NO, not covered	YES, refer to the Dept. of Aging and Adult Services at 206.341.7750	
Dental Anesthesia	YES	Prior Authorization [CHP Guideline]	YES, however dental coverage is limited to emergency medical conditions only, to be determined by CHP (PA).	NO, not covered	
Dental Services					
→ Accidental			NO, not covered	YES, however coverage is restricted to limited conditions	Subject to HRSA billing guidelines and PA/EPA requirements. See HRSA website for additional information.
→ Routine			NO, not covered	YES, however coverage is restricted to limited conditions	
→ Medically Necessary	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when services are not performed by a dentist or oral surgeon.	YES, however coverage is restricted to limited conditions	
Developmental Disabilities			(SEE NEURODEVELOPMENTAL THERAPY)		
Dialysis (hemodialysis, peritoneal, renal (kidney))	YES	Prior Authorization + CHP CM Referral	NO, not covered	YES	Subject to HRSA billing guidelines and PA/EPA requirements. See HRSA website for additional information.
Drugs			(SEE PRESCRIPTIONS, PHARMACY)		
Durable Medical Equipment (DME)/Supplies					
→ Aerochamber	NO	Prescription	YES, covered through pharmacy benefit	NO, not covered	
→ Apnea Monitor	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, limited to three (3) months of rentals	NO, not covered	
→ Bra's (post surgical)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, 2 bras are covered per calendar year following a mastectomy.	NO, not covered	
→ 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, not covered	
→ Breast Pumps			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	

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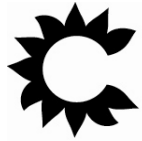


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Durable Medical Equipment (DME)/Supplies, cont					
→ Communication Devices	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
→ C-PAP/Bi-Pap					
• 2-month Rental, Auto-Titration & Supplies	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	2-month rental is required before purchase. See CHP DME Formulary for additional information.
• Purchase	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
→ CPM Machine(Continuous Passive Motion Machine)	NO	NO Requirement	YES, covered up to 10 days for knee or hip replacement	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 • Glucose monitors/test supplies per formulary. 		
→ Diapers (disposable)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, adults have a maximum of 240 pieces per month.	NO, not covered	
→ Enteral Therapy Formula	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, excluding Oral Nutrition Therapy for ages 21 and older	NO, not covered	Oral Nutrition Therapy is not covered for ages 21 and older
→ Enteral Therapy Pump Rental	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	
→ Fracture Frames	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
→ Hospital Beds	SOME³	Prior Authorization	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	See CHP DME Formulary for additional information..

³ See additional information for PA Requirements

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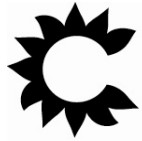
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Durable Medical Equipment (DME)/Supplies, cont

→ Humidifiers	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
→ Insulin Pump & Supplies	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
→ Lymphedema Sleeve	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered as part of cancer treatment	NO, not covered	
→ Nebulizer	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, purchase only	NO, not covered	
→ Osteogenic (Bone) Stimulator	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
→ Oxygen & Related Equipment	YES	Prior Authorization [CMS NCD Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	Oxygen delivery systems will be deemed purchased after 36 months of rental.
→ Parenteral Therapy and Supplies	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	Parenteral Therapy is nutritional support given by means, such as intravenously (IV) other than the GI tract.
→ Patient Lifts	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	See CHP DME Formulary for additional information.
→ Suction Pumps	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	See CHP DME Formulary for additional information.
→ TED Hose (support stockings)	NO	Prescription	YES, covered through the pharmacy benefit.	NO, not covered	
→ TENS Unit	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
→ Trapeze Bars	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
→ Ventilators & Related Equipment	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	See CHP DME Formulary for additional information.

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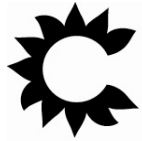
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Durable Medical Equipment (DME)/Supplies, cont					
→ Wheelchairs (Includes parts and repairs)	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	See CHP DME Formulary for additional information.
Emergency Room Services	NO	No Requirement	YES, Professional services are covered by CHP	YES, Facility services are covered by FFS	Out of State care is <u>NOT</u> covered for GAU members. See "Out of State Care" for additional information.
Experimental or Investigational Procedures/Treatment			NO, not covered	NO, not covered	
Eye Ball Polishing	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
Eye Exams					
→ Routine	NO	Members may self refer to contracted providers.	YES, one every twenty- four (24) months.	NO, not covered	
→ Medical Condition (Diagnose and treat disease/conditions of the eye.)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	Covered for medical diagnoses such as glaucoma, cataracts and diabetes.
Eye Glasses, Contact Lenses, Fitting and Dispensing			NO, not covered	YES, fabrication services & associated fitting services are covered.	See HRSA billing instructions for additional information.
Family Planning					
→ Contraception (emergency)	NO	Prescription	YES, at a participating pharmacy.	NO, not covered	Plan B: quantity limit = 2 tablets per prescription
→ Contraceptive Devices, Supplies or Medications					
• Prescriptions	NO	Prescription	YES, birth control pills, medroxy progesterone injection, Nuvaring™, & Ortho-Evra™ are covered.	NO, not covered	Medroxy progesterone injection should be obtained at the pharmacy & administered at the provider's office.
• Injections	NO	Member may self refer to contracted Women's Health Care Providers	YES, Depo Provera™ and Mirena™ are covered.	NO, not covered	
• IUD	NO	Member may self refer to contracted Women's Health Care Providers	YES, cervical caps, diaphragms and IUD's are covered.	NO, not covered	

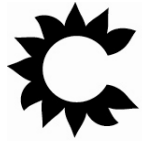
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Family Planning, cont					
• Over-The-Counter (OTC) Products	NO	Prescription	YES, condoms, gels, foams, and creams	NO, not covered	
→ Maternity Services			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
• Birthing Classes			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
• Inpatient			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
• Outpatient			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	Includes observation & short stay
• Office Visits			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
• Home Delivery			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
• Doula Services			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
→ Newborn Care			NO, not covered	NO, not covered	
→ Sterilization for Women (includes tubal ligation)	NO	Member may self refer to contracted Women's Health Care Providers	YES, must be older than 21 y/o, sign consent form & wait 30 days after signature.	YES, for members less than 21 years old and those who do not meet other federal requirements. They must sign a consent form & wait 30 days after signature.	Hysterectomies may require a PA/EPA from HRSA. See HRSA website for additional information. (30-day requirement may be waived in cases of premature delivery or emergency abdominal surgery).
Forensic Exam			NO, not covered	NO, not covered	May be covered under other programs such as crime victims or law enforcement agencies.
Genetic Counseling					
→ Prenatal			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
→ Non-Prenatal			NO, not covered	NO, not covered	
Genetic Testing					
→ Prenatal			NO, maternity and related care is not covered.	NO, maternity and related care is not covered.	
→ Non-Prenatal (Diagnostic)			NO, not covered	NO, not covered	
→ Non-prenatal (Investigational)			NO, not covered	NO, not covered	

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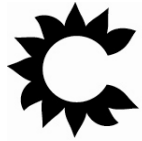


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Health Education/Wellness Program					
→ Asthma Education	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to 6 combined (group &/or individual) visits per calendar year.	NO, not covered	
→ Diabetic Education	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, limited to 6 combined (group and/or individual) visits per calendar year.	NO, not covered	Group and/or individual sessions count towards the visit maximum.
→ Nutritional Counseling					
• Obesity Diagnosis			NO, not covered for this diagnosis.	NO, not covered	
• Other Diagnosis	SOME⁴	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, to a Certified Dietitian for appropriate medical conditions. > 12 visits require PA	NO, not covered	> 12 visits require PA
Hearing Aids					
Hearing Exams (audiology)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, examinations to determine hearing loss.	NO, not covered	
HIV/AIDS Testing	NO	No requirement (par/non-par)	YES	YES, if member self-refers to Health Departments or Family Planning Clinics.	
Home Health Care	YES	Prior Authorization	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	
Home Infusion Therapy	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	
Home Intrauterine Activity Monitoring					
Home Phototherapy for Hyperbilirubinemia			NO, not covered	NO, not covered	Children are not covered under GA-U
Hospice Care					
			NO, not covered	NO, not covered	

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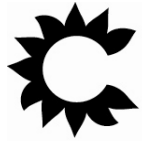


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Hospital Care					
• Inpatient	NO	Hospital Notification	YES, Professional Services are covered by CHP Hospital Notification is required for all non-elective inpatient stays.	YES, Facility Services are covered by FFS	Hospitals are required to notify CHP of inpatient admissions within 24 hours of admission by calling 1-800-440-1561.
• Outpatient Surgery	SOME ⁵	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when surgery is performed in an Ambulatory Surgery Center (ASC). All professional services are covered by CHP.	YES, when surgery is performed in an Outpatient Hospital.	Some surgeries may require a PA/EPA from HRSA. See HRSA website for additional information.
HPV Test	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
Hyperbaric Oxygen Pressurization	YES	Prior Authorization [CMS NCD Guideline]	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	
Immunizations	NO	No requirement when administered by the PCP	YES	YES, if member self refers to Public Health Dept.	International travel and work-related immunizations are NOT covered.
→ Flu Vaccinations	NO	No requirement when administered by the PCP and/or Public Health Dept. (par only)	YES FluMist™ is covered for ages 2-49 only	NO, not covered	CHP will reimburse members up to \$20 when a receipt is provided.
→ HPV (Human Papilloma Virus)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered for members ages 19 – 20 NO, Not covered for members over the age of 20	YES, covered for members ages 9-18 through the free vaccine program only	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"> • Teenagers age 18-19, if entering college as a freshman and living in a dorm • Patients with functional or anatomic asplenia • Patients with terminal complement component deficiencies • Patients with HIV/AIDS 	YES, if member self refers to Public Health Dept.	
→ Proquad			NO, not covered	NO, not covered	
→ Pediatrix			NO, not covered	NO, not covered	

⁵ See additional information for PA Requirements

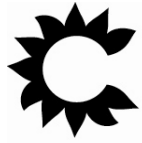
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2009 General Assistance Unemployable **BENEFIT GRID**

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Immunizations, cont					
→ Rotavirus Vaccine (Rotateq™)			NO, not covered	NO, not covered	
→ Zostavax™ (Varicella vaccine)			NO, not covered	NO, not covered	Vaccine for shingles
Impotence Treatment			NO, not covered	NO, not covered	
Incarcerated Care			NO, not covered	NO, not covered	Includes entire time in legal custody.
Infertility/Sterility Testing and Treatment			NO, not covered	NO, not covered	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) .	NO, not covered	Cosmetic Botox is not covered.
→ Enbrel™	YES	Prescription + ESI PA (if self administered) Prior Authorization (ONLY if member is unable to self-administer)	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	PA requirement applies to all FDA approved indications. [CHP Guideline]
→ Euflexxa™	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	PA requirement applies to all FDA approved indications. [CHP Guideline]
→ Growth Hormone Therapy	YES	Prescription + ESI PA (if self administered) Prior Authorization (ONLY if member is unable to self-administer)	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	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) .	NO, not covered	Medication used to treat rheumatoid arthritis.
→ Orthovisc™	YES	Prior Authorization [CHP Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	

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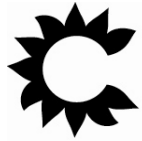


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Injections, cont					
→ Remicade™ Infusion	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
→ Synagis™/RespiGam™ Injections			NO, not covered	NO, not covered	Synagis/RespiGam indicated for children only.
→ Synvisc™/Hyalgan™ Injections	YES	Prior Authorization [CMS Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	Also known as Viscosupplementation
→ Tysabri™ (natalizumab)	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	Medication used to treat multiple sclerosis.
→ Xolair™	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	Medication to treat asthma
Interpreter Services			NO, except for administrative issues only, i.e., handling member complaints and appeals. (See DSHS Column for additional services available)	YES, for medical encounters & DSHS Fair Hearing. Interpreter must be certified w/DSHS.	Hospitals are responsible for interpreter services during an inpatient stay. The Title VI, Civil Rights Act of 1964 prohibits exclusion from health care services and discrimination on grounds of race, color or national origin, including non-English or Limited English Proficiency, if the provider receives any reimbursement from a federal program.
IV Therapy					
→ Outpatient	SOME⁶	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES, Facility Services are covered by FFS	See 2009 PA list for details.
→ Home	YES	Prior Authorization (when covered) [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
Learning Disabilities			NO, not covered	NO, not covered	

⁶ See additional information for PA Requirements

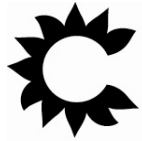
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Lymphedema Treatment	SOME⁶	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits requires PA.	NO, not covered	This treatment, commonly done by a physical therapist, is separate from the PT benefit after reconstructive joint surgery. > 12 visits requires PA
Mammogram (routine and diagnostic)	NO	No Requirement (par/non-par)	YES, when done at a free-standing imaging center.	YES, when done at a hospital radiology center.	
Manipulation of Spine & Extremities	(SEE CHIROPRACTIC CARE AND OSTEOPATHIC MANIPULATION)				
Medical Nutritional Therapy			NO, not covered	NO, not covered	
Mental Health Care					
→ Inpatient			NO, mental health services are not covered for GAU members.	YES, inpatient psychiatric professional and facility services	The Care Coordinators screen GAU Managed Care clients for mental health services. For clients who need care, the Care Coordinators will provide Level I services or refer clients to Level II. The Care Coordinators work closely with primary care providers at the clinics, as well as consult with project psychiatrists.
→ Outpatient	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, CHP covers limited Mental Health services	NO, mental health services are not covered for GAU members.	
→ Partial Hospitalization Programs			NO, not covered	NO, not covered	
→ Psychological Evaluations			NO, not covered	NO, not covered	If a psychological evaluation is needed for eligibility, contact the CSO.
→ Residential Mental Health Treatment Programs/ Facilities			NO, not covered	NO, not covered	This includes wilderness camps and programs.
Methadone Treatment			NO, not covered	YES, covered by DASA	Methadone <u>may</u> be covered through the CHP pharmacy benefit for non-chemical dependency diagnosis.
Neurodevelopmental Therapy			NO, not covered	NO, not covered	

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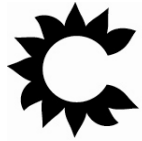


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Neuropsychological Testing	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to 12-combined visits per member per lifetime.	NO, not covered	Covered to rule out underlying <u>medical</u> condition.
Obesity Services			NO, not covered	NO, not covered	Gastroplasty covered by DSHS Fee-For-Service. See Nutrition Counseling for additional information
Occupational Injuries			NO, not covered	NO, not covered	
Office Visit	SOME⁷	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	NO, not covered	Evaluation and Management > 12 Specialty Provider visits require PA
Orthopedic Shoes	(SEE CHP DME FORMULARY FOR ITEM SPECIFIC INFORMATION)				
Orthoptic Therapy	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when deemed medically necessary by the plan.	NO, not covered	Aka eye training
Out of Area Coverage	(Defined as outside of Washington State, within the USA and its territories and possessions)				
→ Routine			NO, not covered	NO, not covered	See WAC 388-501-0175 for additional information
→ Urgent Care (urgently needed care)			NO, not covered	NO, not covered	
→ Inpatient			NO, not covered	NO, not covered	
→ ER			NO, not covered	NO, not covered	
Outpatient Diagnostic Services					
→ Procedures/Test	NO	No Requirement (par/non-par)	YES	YES, if done in a hospital setting	
→ Laboratory Services	NO	No Requirement (par/non-par)	YES	YES, if done in a hospital setting	
→ Radiological Services	SOME⁷	Prior Authorization	YES, PET Scans, some MRI.MRA, CT-head, and CT Angiography require a PA .	YES, when done at a hospital radiology center	See the 2009 PA list for details.

⁷ See additional information for PA Requirements

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Over the counter medications

(SEE 2008 CHP DRUG FORMULARY)

Pain Clinic

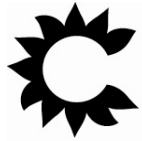
→ Office Visits	SOME⁸	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	NO	Referrals to a pain clinic should be written for a specific service recommended in a treatment plan from the pain clinic. > 12 Specialty Provider visits require PA
→ Outpatient Rehabilitation	SOME⁸	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits require PA	NO	
→ Alternative Care			NO, not covered	NO, not covered	
→ Treatment (e.g. nerve block, epidural steroid injection)	SOME⁸	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits requires PA	NO, not covered	
Pain Management	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES, when pain management program is hospital-based.	See Pain Clinic for additional information.
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, not covered	
Pathology Services	NO	No Requirement (par/non-par)	YES	NO, not covered	
Penile Prosthesis			NO, not covered	NO, not covered	
Physical Exams	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	NOTE: does not include physicals for program eligibility, insurance, employment or immigration.

PKU (Phenylketonuria)

→ Formula	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
→ Screening			NO, not covered	NO, not covered	

⁸ See additional information for PA Requirements

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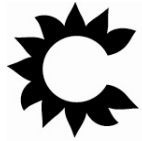


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Podiatry (including diabetic foot care)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, see additional information column for limitations.	NO, not covered	Routine foot care is <u>not</u> covered.
Prescriptions, Pharmacy					
→ Inpatient Drugs	NO	Covered under Hospital Notification	YES	YES, for Protease Inhibitors and HIV Drugs.	
→ Out of Area Drugs			NO, not covered	NO, not covered	
→ Outpatient Drugs (obtained from pharmacy)	SOME [°]	Prescription	YES, in accordance with CHP Formulary & at participating pharmacies Protease Inhibitors and HIV Drugs are not covered by CHP.	YES, for Protease Inhibitors and HIV Drugs. Can be billed using HRSA's Point of Sale (POS) system.	See 2008 CHP Drug Formulary for additional information. For all Prior Authorization drug requests call Express Scripts PA Service Specialist at 1.888.256.6132.
→ Mail Order Prescriptions /Extended Day Supply			NO, not covered	NO, not covered	This number is available 24 hours per day, 7 days a week NOTE: CHP Formulary applies to all prescription drugs.
→ Take Home Drugs			NO, must be obtained with a prescription at a participating pharmacy.	NO, not covered	Dispensed upon discharge from the hospital
Preventive Care	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, including but not limited to immunizations, well-child checks, screening colonoscopies, mammograms and bone density testing.	NO, not covered	
Prostheses (arm or leg)	SOME [°]	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	Dental & penile prosthesis are not covered. See DME formulary for PA guidelines.
Psychiatric Treatment	(SEE MENTAL HEALTH)				
Pulmonary Rehabilitation			NO, not covered	NO, not covered	

[°] See additional information for PA Requirements

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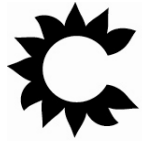


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Radiation & Chemotherapy					
→ Radiation Treatment	SOME ¹⁰	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, some agents require PA.	YES, when chemotherapy/ radiation therapy is performed in an Outpatient Hospital.	See 2009 PA list for details.
→ Oral Chemotherapy	SOME ¹⁰	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, some agents require PA.	YES, when chemotherapy/ radiation therapy is performed in an Outpatient Hospital.	See 2009 PA list for details.
→ Injectable/Infused Chemotherapy	SOME ¹⁰	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)]	YES, some agents require PA.	YES, when chemotherapy/ radiation therapy is performed in an Outpatient Hospital.	PA requests should include a treatment plan and protocol they will be using.
Rehabilitation (Inpatient)	YES	Prior Authorization [CMS NCD Guideline]	YES, Professional Services are covered by CHP. Must be determined medically necessary by the Plan (PA).	YES, Facility Services are covered by FFS	This service MUST be pre-authorized by a CHP Case Manager.
Rehabilitation (outpatient)					
→ Physical Therapy	SOME ¹⁰	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits require PA Evaluations allowed 1 per calendar year	YES, when performed at an outpatient hospital PT department.	> 12 visits require PA
→ Occupational Therapy	SOME ¹⁰	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits require PA Evaluations allowed 1 per calendar year	YES, when performed at an outpatient hospital PT department.	> 12 visits require PA
→ Speech Therapy	SOME ¹⁰	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits require PA Evaluations allowed 1 per calendar year	YES, when performed at an outpatient hospital PT department.	> 12 visits require PA
Respite Care (hospice)	(SEE HOSPICE CARE)				
Reversal of Sterilization			NO, not covered	NO, not covered	See Infertility/Sterility Testing and Treatment for additional information.
Rituxan™ (rituximab)	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	

¹⁰ See additional information for PA Requirements

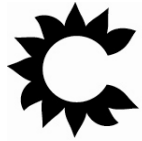
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Saliva Testing			NO, not covered	NO, not covered	This service is considered experimental and investigational.
School Nurse Services			NO, not covered	NO, not covered	
Screening Exams (preventive)					
→ Colorectal (colonoscopy)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, screening and diagnostic colonoscopies are covered	YES, Facility services are covered by FFS	Only G0105, G0121 and 45378 are considered screening colonoscopies.
→ Mammography	NO	No Requirement (par/non-par)	YES	YES, Facility services are covered by FFS	
Sexual Reassignment (Surgery, Services and Supplies)			NO, not covered	NO, not covered	
Skilled Nursing Facility	YES	Prior Authorization + CHP CM case referral [CHP Guideline]	YES, Professional services are covered by CHP	YES, Facility services are covered by FFS	
Sleep Study	SOME	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered 1 per calendar year. See additional notes for PA requirements.	YES, Facility services are covered by FFS	2 or more Sleep Studies per calendar year require a Prior Authorization,
Smoking and Tobacco Cessation					
→ Services	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered through Free and Clear	YES, Facility services are covered by FFS	Free and Clear number: 1.866.QUIT.4.LIFE (784-8454) TTY number: 1-877-777-6534
→ Drugs	NO	Prescription	YES	YES	See 2009 CHP Drug Formulary for nicotine replacement covered medications.
→ Nicotine Replacement	NO	Prescription	YES, some may be covered	YES, some may be covered	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	YES, Facility services are covered by FFS	All professional services are covered by CHP.
→ Abortion, Voluntary			NO, not covered	YES	

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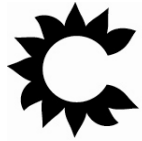


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Surgeries, cont					
→ Ambulatory Surgery (outpatient or same day surgery)	SOME ¹¹	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when surgery is performed in an ambulatory surgery center (ASC).	YES, Facility services are covered by FFS	All professional services are covered by CHP.
→ Bariatric Surgery/ Procedures (surgical treatment for obesity)			NO, not covered	YES, some surgical obesity treatment <u>may</u> be covered by DSHS.	Including but not limited to gastric bypass, gastroplasty, laparoscopic gastric banding, LAP-BAND, laparoscopic duodenal switch, Roux-en Y gastric bypass.
→ Bladder Neck Suspension	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, when surgery is performed in an Outpatient Hospital.	Some surgeries may require a PA/EPA from HRSA. See HRSA website for additional information. All professional services are covered by CHP.
→ Blepharoplasty	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	NO	Surgical procedure to repair droopy eye lid.
→ Breast Reconstruction, Mammoplasty	SOME ¹¹	Prior Authorization <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when surgery is performed in an Ambulatory Surgery Center (ASC). Breast augmentation, when performed cosmetically, is <u>not</u> covered.	YES, when surgery is performed in an Inpatient or Outpatient Hospital. Breast augmentation, when performed cosmetically, is <u>not</u> covered.	The initial reconstruction mammoplasty is covered regardless of whether the member was covered by CHP at the time of the original mammoplasty. Additional reconstructions & implant removals are covered when medically necessary and not for cosmetic reasons.
→ Breast Reduction Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, when surgery is performed in an Ambulatory Surgery Center (ASC) and determined to be medically necessary by the Plan (PA).	YES, when surgery is performed in an Inpatient or Outpatient Hospital.	Some surgeries may require a PA/EPA from HRSA. See HRSA website for additional information. All professional services are covered by CHP.
→ Bunionectomy Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, when surgery is performed in an Inpatient or Outpatient Hospital.	All professional services are covered by CHP.
→ Cosmetic Surgeries			NO, not covered (See Additional Information column)	NO, not covered (See Additional Information column)	Cosmetic surgery including, but not limited to, augmentation mammoplasty, chemical peel, facial implants, dermabrasion, face lifts, lipoplasty, abdominoplasty, hair transplantation are not covered.
→ Eye Surgery (Lasik™) (for vision improvement)			NO, not covered	NO, not covered	Surgery to correct refractive errors is not covered.
→ Eye Surgery (laser) (for a medical condition)	SOME ¹¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, surgeries for a medical condition such as glaucoma, retinal detachment and cataracts are covered.	YES, when surgery is performed at an Outpatient Hospital.	All professional services are covered by CHP. See 2009 PA Grids for additional information.

¹¹ See 2009 Prior Authorization List for details

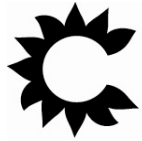
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Benefit or Service	Prior Auth (PA)	REQUIRED: <input checked="" type="checkbox"/> Physician Orders (par) <input checked="" type="checkbox"/> Referral (non-par) <input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Hospital Notification <input checked="" type="checkbox"/> Prescription	<u>COVERED SERVICE</u> (defined as covered and paid by CHP)	<u>COVERED FEE-FOR-SERVICE</u> (defined as covered and paid by DSHS)	Additional Information
Surgeries, cont					
→ Hip Replacement Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	NO, not covered	
→ Hysterectomy (abdominal, vaginal)	YES	Prior Authorization	YES, when surgery is performed at an ambulatory surgery center (ASC)	YES, a hysterectomy consent form must be attached to the claim in order for the claim to be paid.	Some surgeries may require a PA/EPA from HRSA. See HRSA website for additional information. All professional services are covered by CHP.
→ Knee Arthroscopy	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA) .	YES, when surgery is performed in a hospital setting, Facility fee covered by Fee for Service	
→ Knee Replacement Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	NO, not covered	
→ Mastectomy	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when surgery is performed at an ambulatory surgery center (ASC).	YES, when surgery is performed in a hospital setting.	Some surgeries may require a PA/EPA from HRSA. See HRSA website for additional information. All professional services are covered by CHP.
→ 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	YES, when performed at an Outpatient Hospital	Some surgeries may require a PA/EPA from HRSA. See HRSA website for additional information. All professional services are covered by CHP.
→ Refractive Surgery			(SEE EYE SURGERY)		
→ Rhinoplasty and Septoplasty	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA).	NO, not covered	
→ Skin Tag Removal			NO, not covered	NO, not covered	CPT Codes: 11200 – 11201
→ Strabismus Surgery	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when performed in an ambulatory surgery center or physicians office.	YES, when performed in an outpatient hospital.	All professional services are covered by CHP.
→ Tonsillectomy and Adenoidectomy	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when performed in an ambulatory surgery center and physicians office.	YES, when performed in an outpatient hospital.	All professional services are covered by CHP.

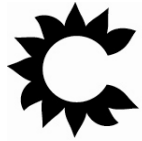
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Surgeries, cont					
→ UPPP (Uvulopalatopharyngoplasty)	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	
→ Vasectomy	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, must be more than 21 y/o, sign consent form & wait 30 days after signature.	YES, for members less than 21 years old and those who do not meet other federal requirements. They must sign a consent form & wait 30 days after signature.	a.k.a. Male Sterilization
Temporomandibular Joint (TMJ) & Myofacial Pain Disorder (MPD)			NO, not covered	NO, not covered	
Transmyocardial Laser Revascularization			NO, not covered	NO, not covered	Considered to be experimental and investigational at this time.
Transplants					
→ Corneal Transplant	NO	Hospital Notification <u>or</u> PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, Professional services are covered by CHP	YES, Facility services are covered by FFS	Some surgeries may require a PA/EPA from HRSA. See HRSA website for additional information. All professional services are covered by CHP.
→ Transplants (organ or tissue) & Work-up Related to Transplants	YES	Prior Authorization + CHP Case Manager referral [CMS NCD Guideline]	YES, professional services are covered by CHP.	YES, transplants for: heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea & peripheral blood stem cell.	Must be performed at an HRSA approved Center of Excellence facility. See HRSA Billing Instructions for additional information All professional services are covered by CHP.
→ Transplant (organ or tissue) Donation	YES	Prior Authorization + CHP Case Manager referral [CMS NCD Guideline]	YES, professional services are covered by CHP.	YES, covered for a donor's initial medical expenses relating to harvesting of the organ(s) as well as the costs of treating complications directly resulting from the procedure(s), provided the organ recipient is a member of CHP and is not eligible for such coverage under any other health care plan or government programs.	Must be performed at an HRSA approved Center of Excellence facility. See HRSA Billing Instructions for additional information All professional services are covered by CHP.
→ Transplant Donor Search (tissue typing of family members)	YES	Prior Authorization [CMS NCD Guideline]	YES, covered up to 15 searches per calendar year.	NO, not covered	Includes the following CPT codes : 86812-86822

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Transportation (from home to office or from PCP to Specialist)			NO, not covered	YES, through Transportation Broker. For additional information see the DSHS Website and click on "Transportation Services": http://fortress.wa.gov/dshs/MAA/	
Urgent Care (urgently needed care)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
Vaccinations	(SEE IMMUNIZATIONS)				
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.	NO, not covered	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	NO, not covered	
Vocational Rehabilitation			NO, not covered	NO, not covered	
Wigs			NO, not covered	NO, not covered	
Wound Care	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	NO, not covered	
→ Outpatient Wound Care Center	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	NO, not covered	
→ Home Health Agency	YES	Prior Authorization	YES, must be determined medically necessary by the Plan (PA).	NO, not covered	

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