

COMMUNITY HEALTH PLAN
of Washington

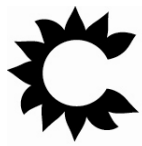
Committed to your health.

2009 Healthy Options Benefit Grid

Enclosed you will find the **July 2009 VERSION** of the *Healthy Options, Children's Health Insurance Program, Basic Health Plan Plus, and Basic Health S-Med* Benefit Grid. In addition to the details listed on the benefit matrix, please note the following:

- **ALL** services must be ordered by the member's Primary Care Provider. Healthy Options is a managed care product 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).
- If a member seeks care from a PCP outside their assigned MSO/PCP, the service **must** have a plan-authorized referral, otherwise the claim will deny.
- PCP Orders should be written and include both visit and length of authorization parameters. An example would be: "Referral to orthopedic surgery for meniscus tear x 3 visits/3 months; evaluate and treat". If verbal orders are given, a note must be written in the **medical chart**, demonstrating PCP intent to refer.
- Once a member is referred to a specialist, the specialist **may** request Prior Authorization from the Plan **directly** when additional services require plan authorization. The specialist is required to notify the member's PCP at the time of the request.
- Services requiring Prior Authorization by CHP Medical Management **must** be requested prior to service and must include a **completed PA form** and appropriate chart notes demonstrating medical necessity. Incomplete requests result in a delay in processing. Prior Authorization can be requested via FAX @ 206.613.8873.
- If CHP is the secondary insurance, **no** authorizations, including PA's are required up front. Coordination of benefits will occur when claims are received with the attached EOB from the primary insurance company.
- **Extended Authorizations:** CHP requires Prior Authorization for **all** services requiring > 12 visits, calculation of prior authorization requirement is based on a **calendar year**.
- **Calendar Year** = This term is used for contractual benefits such as Mental Health. The benefit limits for this type of service renews each January.
- **Rolling Year:** This term is used to describe CHP's Prior Authorization policy on Extended Authorization (see above). A rolling year is calculated by the 1st DOS + 12 months or 365 days.
- **Women's Health Care Providers include:** General Practitioners, Family Medicine, Internal Medicine, OB/GYN, Perinatologist, Maternal & Fetal, Certified Nurse Practitioner, Certified Nurse Midwife, Physician Assistant and Birthing Center.
- **Enrollees with Special Health Care Needs (ESHCN)** have direct access to specialists and standing referrals. Please contact the CHP Customer Service Department for additional information.

Publish Date: January 2009

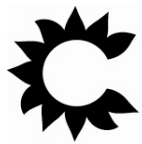


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> Healthy Options (HO) BH S-Med <p align="center">COVERED SERVICE</p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> Healthy Options (HO) BH+ S-CHIP <p align="center">COVERED SERVICE</p>	Covered by DSHS for HO, BH+ & S-CHIP <p align="center">FEE-FOR-SERVICE</p>	Additional Information
Adult Developmental Programs			NO, not covered	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	YES	NO	
→ Testing/Serum	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Office Visit	SOME ¹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 Specialty Provider visits require PA	YES, > 12 Specialty Provider visits require PA	NO	> 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.	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	
Alternative Care						
→ Acupuncture			NO, not covered	NO, not covered	NO	
→ Biofeedback Therapy	SOME ¹	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 6 requires PA	YES, > 6 requires PA	NO	Biofeedback training covered when determined medically necessary specifically for perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry for incontinence. > 6 requires PA
→ Chiropractic Treatment (must be a chiropractor)	SOME ¹	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	NO, not covered for members over 21 YES, covered for adults 19-20 when determined medically necessary during an EPSDT examination, > 12 visits require a PA	NO, not covered for members under 16 YES, covered for children 16-18 when determined medically necessary during an EPSDT examination, > 12 visits require a PA	NO	> 12 visits require a PA
→ Homeopathy			NO, not covered	NO, not covered	NO	

¹ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

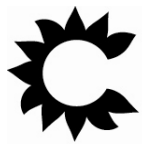


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> Healthy Options (HO) BH S-Med <p align="center">COVERED SERVICE</p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> Healthy Options (HO) BH+ S-CHIP <p align="center">COVERED SERVICE</p>	Covered by DSHS for HO, BH+ & S-CHIP FEE-FOR-SERVICE	Additional Information
Alternative Care, cont						
→ Hypnotherapy			NO, not covered	NO, not covered	NO	
→ Massage Therapy			NO, not covered	NO, not covered	NO	
→ Naturopathy			NO, not covered	NO, not covered	NO	
→ Osteopathic Manipulative Therapy	SOME²	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when performed by a Doctor of Osteopathy (DO)	YES, when performed by a Doctor of Osteopathy (DO)	NO	This is separate from the chiropractic treatment benefit. > 12 visits require PA
Ambulance						
→ Ground	NO	No Requirement (par/non-par)	YES	YES	NO	Must meet the definition of an emergency and be considered the only appropriate method of transportation.
→ Air	NO	No Requirement (par/non-par)	YES	YES	NO	
→ Facility-to-Facility	NO	No Requirement (par/non-par)	YES	YES	NO	
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	YES, >12 Specialty Provider visits require PA	NO	>12 Specialty Provider visits require PA
Surgical Treatment	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	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.	YES, including but not limited to, synthetic factors, plasma expanders, and their administration.	NO	
Cardiac Rehabilitation	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	

² See additional information for PA requirements

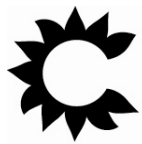
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Chemical Dependency (alcohol and drug)						
→ Detoxification			NO, except in cases when there are medical conditions secondary to chemical dependency treatment that require medical attention in emergent, inpatient or outpatient basis (lacerations, seizure, cirrhosis, dehydration).	NO, except in cases when there are medical conditions secondary to chemical dependency treatment that require medical attention in emergent, inpatient or outpatient basis (lacerations, seizure, cirrhosis, dehydration).	YES, contact DASA certified agencies at 360.438.8207 for additional information.	
→ Inpatient Treatment			NO, not covered	NO, not covered	YES, contact DASA certified agencies at 360.438.8207 for additional info.	
→ Partial Hospitalization Programs			NO, not covered	NO, not covered	NO	
→ Outpatient (counseling sessions)			NO, not covered	NO, not covered	YES, contact DASA certified agencies at 360.438.8207 for more information on coverage.	
→ Residential Treatment Programs/ Facilities			NO, not covered	NO, not covered		This includes wilderness camps and programs.
Circumcision						
→ Routine			NO, not covered	NO, not covered	NO	
→ Medical Condition	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when necessary due to underlying medical condition.	YES, when necessary due to underlying medical condition.	NO	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).	YES, when determined to be medically necessary by the Plan (PA).	NO	Considered a prosthetic not a hearing aid.
Complications from Non-Covered Services	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	Yes, excluded for a period of 90 days, starting the day after the DOS of the non-covered service.	Yes, excluded for a period of 90 days, starting the day after the DOS of the non-covered service.	NO	
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, and hair transplantation.

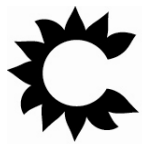
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information	
Court-Ordered Services			NO, not covered	NO, not covered	NO	Services requested solely for forensic or legal reasons or when member has already gone through the judicial system may be covered.	
Custodial/ Convalescent Care			NO, not covered	NO, not covered	YES, refer to the Dept. of Aging and Adult Services at 206.341.7750		
Dental Anesthesia			NO, not covered	NO, not covered	YES, covered by DSHS when it is determined that due to an underlying medical condition.		
Dental Services							
→ Accidental	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when services are not performed by a dentist or oral surgeon.	YES, when services are not performed by a dentist or oral surgeon.	YES, when services are performed by a dentist or oral surgeon.		
→ Routine	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, some services when not performed by a dentist or oral surgeon.	YES, some services when not performed by a dentist or oral surgeon.	YES, when services are performed by a dentist or oral surgeon. See additional Information for details.	DSHS covers the following routine services when performed by a PCP. D0120, D1203 and D9999	
→ 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, when services are not performed by a dentist or oral surgeon.	YES, when services are performed by a dentist or oral surgeon.		
Developmental Disabilities			(SEE NEURODEVELOPMENTAL THERAPY)				
Dialysis (hemodialysis, peritoneal, renal (kidney))	YES	Prior Authorization + CHP CM Referral	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	SOME medications provided during dialysis require PA. See 2008 PA list for specific details.	
Drugs			(SEE PRESCRIPTIONS, PHARMACY)				
Durable Medical Equipment (DME)/Supplies							
→ Aerochamber	NO	Prescription	YES, covered through pharmacy benefit	YES, covered through pharmacy benefit	NO		
→ Apnea Monitor	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, limited to three (3) months of rentals	YES, limited to three (3) months of rentals	NO		
→ 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.	YES, 2 bras are covered per calendar year following a mastectomy.	NO		

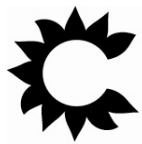
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Durable Medical Equipment (DME)/Supplies, cont						
→ 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.	YES, following a mastectomy benefit allows for replacement of external prostheses when necessitated by normal wear.	NO	
→ Breast Pumps	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	See CHP DME Formulary for additional information.
→ Communication Devices	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	See CHP DME Formulary for additional information.
→ C-PAP/Bi-Pap						
• 2-month Rental, Auto-Titration & Supplies	YES	Prior Authorization	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	2-month rental is required before purchase.
• Purchase	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	See CHP DME Formulary for additional information.
→ CPM Machine	NO	NO Requirement	YES, covered up to 10 days for knee or hip replacement	YES, covered up to 10 days for knee or hip replacement	NO	Continuous Passive Motion Machine
→ 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 #204/30 days) • Glucose monitors/test supplies per formulary. 	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 #204/30 days) • Glucose monitors/test supplies per formulary. 	NO	See 2008 CHP Drug Formulary for additional information on coverage.
→ Diapers (disposable)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, adults have a maximum of 240 pieces per month.	YES, for children more than 3 years of age with a maximum of 300 pieces per month.	NO	Not covered for children ages 0 – 3.
→ Enteral Therapy Formula	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, excluding Oral Nutrition Therapy for ages 21 and older	YES	NO	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) .	YES, must be determined medically necessary by the Plan (PA) .	NO	

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



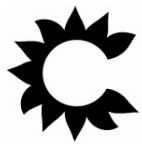
2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
--------------------	-----------------	---	--	---	--	------------------------

Durable Medical Equipment (DME)/Supplies, cont						
→ Fracture Frames	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Hospital Beds	SOME ³	Prior Authorization Or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	See the CHP DME Formulary for additional information
→ Humidifiers	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Insulin Pump & Supplies	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	
→ Lymphedema Sleeve	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered as part of cancer treatment	YES, covered as part of cancer treatment,	NO	
→ Nebulizer	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, purchase only	YES, purchase only	NO	See the CHP DME Formulary for additional information
→ Osteogenic (Bone) Stimulator	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	
→ Oxygen & Related Equipment	YES	Prior Authorization [CMS NCD Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	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) .	YES, must be determined medically necessary by the Plan (PA) .	NO	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) .	YES, must be determined medically necessary by the Plan (PA) .	NO	See CHP DME Formulary for additional information.
→ Suction Pumps	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	See CHP DME Formulary for additional information.

³ See additional information for PA requirements

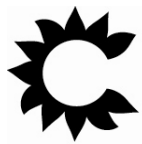
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Durable Medical Equipment (DME)/Supplies, cont						
→ TED Hose (Support stockings)	NO	Prescription	YES, covered through the pharmacy benefit.	YES, covered through the pharmacy benefit.	NO	
→ TENS Unit	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	
→ Trapeze Bars	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Ventilators & Related Equipment	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	See CHP DME Formulary for additional information.
→ Wheelchairs (Includes parts and repairs)	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	See CHP DME Formulary for additional information.
Emergency Room Services	NO	No Requirement	YES	YES	NO	NOTE: Per the Deficit Reduction Act of 2005, ER services provided by non-contracted providers/ facilities are to be paid as if they are contracted providers at the Medicaid rate as payment in full.
Experimental or Investigational Procedures/Treatment			NO, not covered	NO, not covered	NO	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	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
Eye Exams						
→ Routine	NO	Members may self refer to contracted providers.	YES, one every twenty- four (24) months. (for persons >21)	YES, one every twelve (12) months (up to age 21).	NO	All frequency calculations are based on the DOS with a 30 day grace period.
→ Medical Condition (Diagnose and treat disease / conditions of the eye.)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	Covered for medical diagnoses such as glaucoma, cataracts and diabetes.
Eye Glasses, Contact Lenses, Fitting and Dispensing			NO, not covered	NO, not covered	YES, fabrication services & associated fitting services are covered.	

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



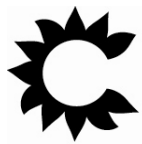
2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> Healthy Options (HO) BH S-Med <p align="center"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> Healthy Options (HO) BH+ S-CHIP <p align="center"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <p align="center"><u>FEE-FOR-SERVICE</u></p>	Additional Information
--------------------	-----------------	---	---	--	--	------------------------

Family Planning						
→ Contraception(emergency)	NO	Prescription	YES, at a participating pharmacy.	YES, at a participating pharmacy.	NO	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.	YES, birth control pills, medroxy progesterone injection, Nuvaring™, & Ortho-Evra™ are covered.	NO	Medroxy progesterone injection should be obtained at the pharmacy & administered at the provider's office.
• Injections	NO	Member may self refer to a contracted Women's Health Care provider.	YES, Depo Provera™ and Mirena™ are covered.	YES, Depo Provera™ and Mirena™ are covered.	YES, if a member self refers to Public Health Dept. or Family Planning Clinic.	
• IUD	NO	Member may self refer to a contracted Women's Health Care provider.	YES, cervical caps, diaphragms and IUD's are covered.	YES, cervical caps, diaphragms and IUD's are covered.	YES, if a member self refers to Public Health Dept. or Family Planning Clinic.	IUD's must be billed as part of the provider's office visit. They cannot be obtained through the outpatient pharmacy benefit.
• Over-The-Counter (OTC) Products	NO	Prescription	YES, condoms, gels, foams, and creams	YES, condoms, gels, foams, and creams	NO	
→ Maternity Services	Although CHP does not require prior authorization for maternity services, notification is needed. Early notification of pregnancy enables the Plan to identify high-risk members, and assess for high-risk case management services.					
• Birthing Classes			NO, not covered	NO, not covered	YES, birthing classes may be covered Fee-For-Service.	
• Inpatient	NO	Hospital Notification	YES	YES	NO	
• Outpatient (includes observation & short stay)	NO	Women may self refer to contracted WHC providers	YES	YES	NO	See cover for list of CHP approved Women's Health Care Provider types.
• Office Visits	SOME⁴	Women may self refer to contracted WHC providers	YES, >12 Specialty Provider visits require PA	YES, >12 Specialty Provider visits require PA	YES, birthing classes may be covered Fee-For-Service.	>12 Specialty Provider visits require PA
• Home Delivery	NO	Women may self refer to contracted WHC providers	YES, however parent must fill out the CHP newborn selection form within 60 days of child's birth to ensure eligibility.	YES, however parent must fill out the CHP newborn selection form within 60 days of child's birth to ensure eligibility.	NO	
• Doula Services			NO, not covered	NO, not covered	NO	

⁴ See additional information for PA requirements

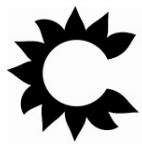
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <p style="text-align: center;"><u>FEE-FOR-SERVICE</u></p>	Additional Information
Family Planning, cont						
→ Newborn Care	NO	Greater than 5 days in the hospital requires a separate Hospital Notification. Less than 5 days is covered under Mom's Notification.	YES, however parent must fill out the CHP newborn selection form within 60 days of child's birth to ensure eligibility.	YES, however parent must fill out the CHP newborn selection form within 60 days of child's birth to ensure eligibility.	NO	
→ 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. (30-day requirement may be waived in cases of premature delivery or emergency abdominal surgery).	NO, not covered	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.	See cover for list of CHP approved Women's Health Care Provider types.
Forensic Exam			NO, not covered	NO, not covered	NO	May be covered under other programs such as crime victims or law enforcement agencies.
Genetic Counseling						
→ Prenatal	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to 3 visits every 11 months during pregnancy and through the end of the month containing the 60th day the pregnancy ends. Must be medically necessary (meaning a change in delivery of care will occur). Not covered if requested for diagnostic purposes only.	YES, covered up to 3 visits every 11 months during pregnancy and through the end of the month containing the 60th day the pregnancy ends. Must be medically necessary (meaning a change in delivery of care will occur). Not covered if requested for diagnostic purposes only.	NO	
→ Non-Prenatal			NO, not covered	NO, not covered	NO	
Genetic Testing						
→ Prenatal	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, if determined medically necessary by provider (meaning a change in delivery of care will occur).	YES, if determined medically necessary by provider (meaning a change in delivery of care will occur).	NO	
→ Non-Prenatal (Diagnostic)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, when medically necessary for diagnosis of a medical condition.	YES, covered for children to rule out underlying genetic disorder or for the purposes of diagnosis.	NO	
→ Non-prenatal (Investigational)			NO, not covered	NO, not covered	NO	Examples include: testing for cancer gene and pre-pregnancy screening tests based on family history of genetic disorder.

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

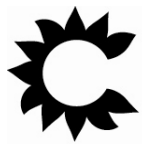


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> Healthy Options (HO) BH S-Med <p align="center">COVERED SERVICE</p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> Healthy Options (HO) BH+ S-CHIP <p align="center">COVERED SERVICE</p>	Covered by DSHS for HO, BH+ & S-CHIP <p align="center">FEE-FOR-SERVICE</p>	Additional Information
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.	YES, covered up to 6 combined (group &/or individual) visits per calendar year.	NO	
→ 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.	YES, limited to 6 combined (group and/or individual) visits per calendar year.	NO	Group and/or individual sessions count towards the visit maximum.
→ Nutritional Counseling						
• Obesity Dx.	SOME⁵	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	NO, not covered	YES, to a certified dietitian for appropriate medical conditions. > 12 visits require PA	NO	> 12 visits require PA
• Other Medical Dx.	SOME⁵	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, to a certified dietitian for appropriate medical conditions. > 12 visits require PA	YES, to a certified dietitian for appropriate medical conditions. > 12 visits require PA	NO	> 12 visits require PA
Hearing Aids			NO, not covered	NO, not covered	YES, including fitting and repair	
Hearing Exams (audiology)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, examinations to determine hearing loss.	YES, examinations to determine hearing loss.	NO	
HIV/AIDS Testing	NO	No requirement (par/non-par)	YES	YES	YES, if member self-refers to the Public Health Departments or Family Planning Clinics.	
Home Health Care	YES	Prior Authorization	YES, must be determined medically necessary by the Plan (PA) . Includes Private Duty Nursing per HRSA guidelines.	YES, must be determined medically necessary by the Plan (PA) . Includes Private Duty Nursing per HRSA guidelines.	NO	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 by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	If member is being discharged from the hospital, refer immediately to the CHP UM department to assess coverage. See Medical Nutritional Therapy for additional information.

⁵ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

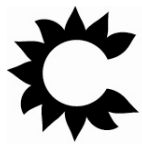


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <input type="checkbox"/> Healthy Options (HO) <input type="checkbox"/> BH S-Med <u>COVERED SERVICE</u>	Children (Persons age 18 and younger) <input type="checkbox"/> Healthy Options (HO) <input type="checkbox"/> BH+ <input type="checkbox"/> S-CHIP <u>COVERED SERVICE</u>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Home Intrauterine Activity Monitoring			NO, not covered	NO, not covered	NO	Considered to be experimental and investigational.
Home Phototherapy for Hyperbilirubinemia	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	This includes the equipment and skilled nursing visit.
Hospice Care	YES	Prior Authorization + CHP CM Referral [CHP Guideline]	YES, must be determined medically necessary or palliative. (PA) .	YES, must be determined medically necessary or palliative. (PA) .	NO	
Hospital Care						
• Inpatient	SOME ⁶	Prior Authorization Or Hospital Notification	YES, PA is required for elective inpatient stays. Hospital Notification is required for all non-elective inpatient stays.	YES, PA is required for elective inpatient stays. Hospital Notification is required for all non-elective inpatient stays.	NO	Hospitals are required to notify CHP of all inpatient admissions within one business day of admission by calling 1-800-440-1561. Hospital Notifications take the place of a referral.
• Outpatient Surgery	SOME ⁶	Prior Authorization Or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	See cover for list of CHP approved Women's Health Care Provider types.
HPV (Human Papilloma Virus) Test	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	Women may self refer to contracted WHC providers
Hyperbaric Oxygen Pressurization	YES	Prior Authorization [CMS NCD Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	

⁶ See additional information for PA requirements

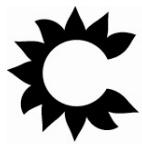
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Immunizations	NO	No requirement when administered by the PCP and/or Public Health Dept. (par only)	YES	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	YES FluMist™ is covered for ages 2-49 only	NO	Coverage for FluMist™ will be determined on a year-by-year basis.
→ 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	NO, not covered	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"> • Children ages 11-12 • Teenagers age 15 • 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, 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 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	YES, for children only; non-covered for adults	
→ Pediatrix			NO, not covered	NO, not covered	YES, for children only; non-covered for adults	
→ Rotavirus Vaccine (Rotateq™)			NO, not covered	NO, not covered	YES, covered for Healthy Options members by DSHS FFS.	
→ Zostavax™ (Varicella vaccine)			NO, not covered	NO, not covered	NO	Vaccine for shingles
Impotence Treatment			NO, not covered	NO, not covered	NO	
Incarcerated Care			NO, not covered	NO, not covered	NO	
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.	NO, including but not limited to testing and treatment of infertility, sterility, artificial insemination, sterilization reversal and in vitro fertilization.	NO	

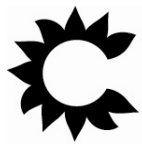
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Injections						
→ Botox™ Injections	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	Cosmetic Botox is not covered.
→ 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) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	
→ Euflexxa™	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	Used to treat osteoarthritis
→ 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) .	YES, must be determined medically necessary by the Plan (PA) .	NO	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) .	YES, must be determined medically necessary by the Plan (PA) .	NO	Medication used to treat rheumatoid arthritis.
→ Orthovisc™	YES	Prior Authorization [CHP Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	
→ Remicade™ Infusion	YES	Prior Authorization [CHP Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	
→ Synagis™/RespiGam™ Injections	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	
→ Synvisc™/Hyalgan™ Injections	YES	Prior Authorization [CMS Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	Also known as Viscosupplementation
→ Tysabri™ (natalizumab)	YES	Prior Authorization [CMS NCD Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	Medication used to treat multiple sclerosis.
→ Xolair™	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA) .	YES, when determined to be medically necessary by the Plan (PA) .	NO	Medication to treat asthma

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

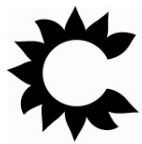


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Interpreter Services			NO, except for administrative issues only, i.e., handling member complaints and appeals. (See DSHS Column for additional services available)	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 Hearings. 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	SOME⁷	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	See 2009 Prior Authorization List for additional information.
→ Home	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA) .	YES, must be determined medically necessary by the Plan (PA) .	NO	
Learning Disabilities			NO, not covered	NO, not covered	NO	
Lymphedema Treatment	SOME⁷	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits requires PA	YES > 12 visits requires PA		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	YES	NO	
(SEE CHIROPRACTIC CARE AND OSTEOPATHIC MANIPULATION)						
Manipulation of Spine & Extremities						
Medical Nutritional Therapy			NO, not covered	NO, not covered	NO	Including oral supplements

⁷ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

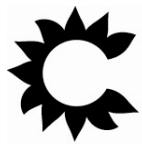


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Mental Health Care						
→ Inpatient			NO	NO	YES, covered Fee-For-Service.	Involuntary admissions do not require written or verbal authorization for payment per RCW 48.44.343.
→ Outpatient	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, 12 visits per calendar year if the member does not meet the RSN access criteria.	YES, 20 visits per calendar year if the member does not meet the RSN access criteria.	YES, covered by DSHS fee-for-service for those members that meet the RSN access criteria. For info: 360.902.8070	The RSN denial should be filed in the patients chart when making a non-RSN referral.
→ Partial Hospitalization Programs			NO, not covered	NO, not covered	NO	NOTE: medication management does not count against the 12-visit benefit limit maximum (CPT 90862).
→ Psychological Evaluations	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, once every 12 months for adults and unlimited for children less than 21 when testing, evaluations are ordered by PCP as part of an EPSDT exam.	YES, unlimited for children less than 21 when testing, evaluations are ordered by PCP as part of an EPSDT exam.	NO	
→ Residential Mental Health Treatment Programs/ Facilities			NO, not covered	NO, not covered	NO	This includes wilderness camps and programs.
Methadone Treatment			NO, not covered	NO, not covered	YES, Covered by DASA. 1.800.662.9111	Methadone may be covered through the CHP pharmacy benefit for non-chemical dependency diagnosis.
Neurodevelopmental Therapy	SOME⁸	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits requires PA	YES > 12 visits requires PA	YES, refer to Neurodevelopmental Early Intervention Program. If school age refer to member's school district.	> 12 visits requires PA
Neuropsychological Testing	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered up to 12-combined visits per member per lifetime.	YES, covered up to 12-combined visits per member per lifetime.	NO	
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	NO	

⁸ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

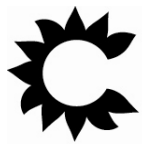


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;">COVERED SERVICE</p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;">COVERED SERVICE</p>	Covered by DSHS for HO, BH+ & S-CHIP <p style="text-align: center;">FEE-FOR-SERVICE</p>	Additional Information
Office Visit	SOME⁹	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, >12 Specialty Provider visits require PA	YES, >12 Specialty Provider visits require PA	NO	aka: 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.	YES, when deemed medically necessary by the plan.	NO	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	NO	When a member moves out of the service area, coverage is limited to 90 days beginning with the first of the month in which the member changes residence.
→ Urgent Care (urgently needed care)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Inpatient	NO	Hospital Notification	YES, only if related to an urgent or emergent medical condition.	YES, only if related to an urgent or emergent medical condition.	NO	
→ ER	NO	No Requirement (par/non-par)	YES	YES	NO	
Outpatient Diagnostic Services						
→ Procedures/Test	NO	No Requirement (par/non-par)	YES	YES	YES, DASA is responsible for toxicology procedures for DASA clients who are pregnant or post partum on methadone.	
→ Laboratory Services	NO	No Requirement (par/non-par)	YES	YES	YES, DASA is responsible for toxicology procedures for DASA clients who are pregnant or post partum on methadone.	
→ Radiological Services	SOME⁹	Prior Authorization	YES, PET Scans, some MRI.MRA, CT-head, and CT Angiography require a PA.	YES, PET Scans, some MRI.MRA, CT-head, and CT Angiography require a PA.	NO	Includes x-rays, ultrasounds, echo's & nuclear medicine. See 2009 Prior Authorization list for additional

⁹ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

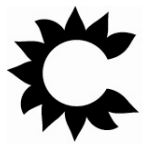
Benefit or Service	Prior Auth (PA)	REQUIRED: <input checked="" type="checkbox"/> Physician Orders (par) <input checked="" type="checkbox"/> Referral (non-par) <input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Hospital Notification <input checked="" type="checkbox"/> Prescription	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <p style="text-align: center;"><u>FEE-FOR-SERVICE</u></p>	Additional Information
--------------------	-----------------	---	--	---	---	------------------------

Over the counter medications (SEE 2008 CHP DRUG FORMULARY)

Pain Clinic						
→ Office Visits	NO	Prior Authorization Or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, >12 Specialty Provider visits require PA	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	SOME ¹⁰	Prior Authorization Or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits require PA	YES > 12 visits require PA	NO	
→ Alternative Care			NO, not covered	NO, not covered	NO	
→ Treatment (e.g. nerve block, epidural steroid injection)	SOME ¹⁰	Prior Authorization Or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES > 12 visits requires PA	YES > 12 visits requires PA	NO	
Pain Management	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
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).	YES, covered in conjunction with hospice and must be determined medically necessary by the Plan (PA).	NO	
Pathology Services	NO	No Requirement (par/non-par)	YES	YES	YES, DASA is responsible for toxicology procedures for DASA clients who are pregnant or post partum on methadone.	
Penile Prosthesis			NO, not covered	NO, not covered	NO	
Physical Exams	NO	No requirement when done by the PCP	YES	YES	NO	NOTE: does not include physicals for program eligibility, insurance, employment or immigration.

¹⁰ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

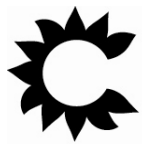


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <p style="text-align: center;"><u>FEE-FOR-SERVICE</u></p>	Additional Information
PKU (Phenylketonuria)						
→ Formula	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Screening			NO, not covered	NO, not covered	YES, DSHS will reimburse hospitals for newborn screenings for PKU and other metabolic disorders.	
Podiatry (including diabetic foot care)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	Routine foot care is <u>not</u> covered, unless member has diabetes.
Prescriptions, Pharmacy						
→ Inpatient Drugs	NO	Covered under Hospital Notification (except inpatient psychiatric care, which is covered by DSHS).	YES	YES	YES, for pharmacy products and prescriptions for self-referred services from health depts., family planning clinics, RSN's, DASA programs and dentists.	Prescriptions written by an RSN provider during an inpatient stay for psychiatric medications are covered by DSHS Fee-For-Service.
→ Out of Area Drugs	SOME ¹¹	Prescription	YES, members can obtain prescriptions when out of the service area and filled at a participating pharmacy.	YES, members can obtain prescriptions when out of the service area and filled at a participating pharmacy.	NO	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.
→ Outpatient Drugs (obtained from pharmacy)	SOME ¹¹	Prescription	YES, must be purchased at a participating pharmacy. Generic drugs will be dispensed unless the generic equivalent is not available. Protease Inhibitors are not covered by CHP.	YES, must be purchased at a participating pharmacy. Generic drugs will be dispensed unless the generic equivalent is not available. Protease Inhibitors are not covered by CHP.	YES, for Protease Inhibitors.	
→ Mail Order Prescriptions /Extended Day Supply			NO, not covered	NO, not covered	NO	This number is available 24 hours per day, 7 days a week NOTE: CHP Formulary applies to all prescription drugs.
→ Take Home Drugs (dispensed upon discharge from the hospital)			NO, must be obtained with a prescription at a participating pharmacy.	NO, must be obtained with a prescription at a participating pharmacy.	NO	
Preventive Care	NO	No requirement when done by the PCP	YES, including but not limited to immunizations, well-child checks, screening colonoscopies, mammograms and bone density testing.	YES, including but not limited to immunizations, well-child checks, screening colonoscopies, mammograms and bone density testing.	NO	Preventive health services are covered and paid without restriction regarding frequency.

¹¹ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

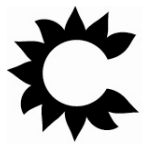


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Prostheses (arm or leg)	SOME¹²	Prior Authorization	YES (See CHP DME Formulary)	YES (See CHP DME Formulary)	NO	Dental & penile prosthesis are not covered.
Psychiatric Treatment	(SEE MENTAL HEALTH)					
Pulmonary Rehabilitation			NO, not covered	NO, not covered	NO	
Radiation & Chemotherapy						
→ Radiation Treatment	SOME¹²	PCP/Physician Orders (par) Plan Approved Referral (non-par) or Prior Authorization	YES, some agents require PA	YES, some agents require PA.	NO	See 2009 PA list for specifics.
→ Oral Chemotherapy	SOME¹²	PCP/Physician Orders (par) Plan Approved Referral (non-par) or Prior Authorization	YES, some agents require PA.	YES, some agents require PA.	NO	See 2009 PA list for specifics.
→ Injectable/Infused Chemotherapy	SOME¹²	PCP/Physician Orders (par) Plan Approved Referral (non-par) or Prior Authorization	YES, some agents require PA.	YES, some agents require PA.	NO	See 2009 PA list for specifics.
Rehabilitation (Inpatient)	YES	Prior Authorization [CMS NCD Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, must be determined medically necessary by the Plan (PA).	NO	This service MUST be pre-authorized by a CHP Case Manager.
Rehabilitation (outpatient)						
→ Physical Therapy	SOME¹²	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 visits require PA Evaluations allowed 1 per calendar year	YES, > 12 visits require PA Evaluations are an unlimited benefit for ages 0-21.	NO	> 12 visits require PA
→ Occupational Therapy	SOME¹²	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 visits require PA Evaluations allowed 1 per calendar year	YES, > 12 visits require PA Evaluations are an unlimited benefit for ages 0-21.	NO	> 12 visits require PA
→ Speech Therapy	SOME¹³	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, > 12 visits require PA Evaluations allowed 1 per calendar year	YES, > 12 visits require PA Evaluations are an unlimited benefit for ages 0-21.	NO	> 12 visits require PA

¹² See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

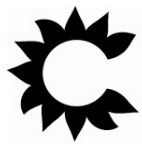


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> Healthy Options (HO) BH S-Med <p align="center">COVERED SERVICE</p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> Healthy Options (HO) BH+ S-CHIP <p align="center">COVERED SERVICE</p>	Covered by DSHS for HO, BH+ & S-CHIP <p align="center">FEE-FOR-SERVICE</p>	Additional Information
Respite Care (hospice)			(SEE HOSPICE CARE)			
Reversal of Sterilization			NO, not covered	NO, not covered	NO	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).	YES, must be determined medically necessary by the Plan (PA).	NO	
Saliva Testing			NO, not covered	NO, not covered	NO	This service is considered experimental and investigational.
School Nurse Services			NO, not covered	NO, not covered	Only for special education students with individual/family special education plan (IFSP). School bills fee-for-service.	
Screening Exams (preventive)						
→ Colorectal (colonoscopy)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, screening and diagnostic colonoscopies are covered	YES, screening and diagnostic colonoscopies are covered	NO	Only G0105, G0121 and 45378 are considered screening colonoscopies.
→ Mammography	NO	No Requirement (par/non-par)	YES	YES	NO	
Sexual Reassignment (Surgery, Services and Supplies)			NO, not covered	NO, not covered	YES, may be covered by DSHS	
Skilled Nursing Facility	YES	Prior Authorization + CHP CM case referral [CHP Guideline]	YES, when medically necessary and when nursing facility services are not covered by Dept of Aging and Adult Services Administration (PA). NOTE: CHP covers all physician services done at the SNF.	YES, when medically necessary and when nursing facility services are not covered by Dept of Aging and Adult Services Administration (PA). NOTE: CHP covers all physician services done at the SNF.	YES, when approved by Dept. of Aging and Adult Services (AAS) 1-800-422-3263	Custodial facility or convalescent care is not covered by CHP.
Sleep Study	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, covered 1 per calendar year.	YES, covered 1 per calendar year.	NO	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, Ages 18 and older are covered through Free and Clear	YES, including counseling services	NO	Free and Clear number: 1.866.QUIT.4.LIFE (784-8454) TTY number: 1-877-777-6534

¹³ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

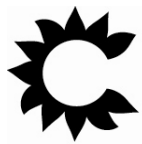


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Smoking and Tobacco Cessation, cont						
→ Drugs	NO	Prescription	YES	YES	NO	See 2009 CHP Drug Formulary for nicotine replacement covered medications.
→ Nicotine Replacement	NO	Prescription	YES, some may be covered	YES, some may be covered	NO	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	NO	See cover for list of CHP approved Women's Health Care provider types.
→ Abortion, Voluntary			NO, not covered.	NO, not covered	YES	
→ Ambulatory Surgery (outpatient or same day surgery)	SOME¹⁴	Prior Authorization or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, however some outpatient surgeries require PA. See specific surgery for additional information.	YES, however some outpatient surgeries require PA. See specific surgery for additional information.	NO	When PCP orders to a specialist authorize outpatient surgery, this covers any associated facility charges.
→ Bariatric Surgery/ Procedures (surgical treatment for obesity)			NO, not covered	NO, not covered	YES, some surgical obesity treatment may be covered by DSHS. Contact DSHS or see WAC 388-531-0220 for coverage information.	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, must be determined medically necessary by the Plan (PA).	NO	
→ Blepharoplasty	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, must be determined medically necessary by the Plan (PA).	NO	Surgical procedure to repair droopy eye lid.

¹⁴ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



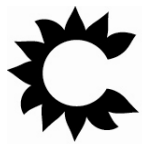
2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
--------------------	-----------------	---	--	---	--	------------------------

Surgeries, cont						
→ Breast Reconstruction, Mammoplasty	SOME¹⁵	Prior Authorization <u>or</u> 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 original mastectomy. Additional reconstructions & implant removals are covered when medically necessary and not for cosmetic reasons.	YES, initial reconstruction mammoplasty is covered regardless of whether the member was covered by CHP at the time of the original mastectomy. Additional reconstructions & implant removals are covered when medically necessary and not for cosmetic reasons.	NO	Breast augmentation, when performed cosmetically, is <u>not</u> covered. See Surgeries, cosmetic for additional information. See 2009 PA Authorization for additional information.
→ Breast Reduction Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, must be determined medically necessary by the Plan (PA).	NO	
→ Bunionectomy Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, must be determined medically necessary by the Plan (PA).	NO	
→ Cosmetic Surgeries			NO, not covered (See Additional Information column)	NO, not covered (See Additional Information column)	NO	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	NO	Surgery to correct refractive errors is not covered.
→ Eye Surgery (laser) (for a medical condition)	SOME¹⁵	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, surgeries for a medical condition such as glaucoma, retinal detachment and cataracts are covered.	NO	See 2009 PA Authorization for additional information.
→ Hip Replacement Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, must be determined medically necessary by the Plan (PA).	NO	
→ Hysterectomy (abdominal, vaginal)	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA).	YES, when determined to be medically necessary by the Plan (PA).	NO	Elective hysterectomy for the sole purpose of sterilization is not covered

¹⁵ See additional information for PA requirements

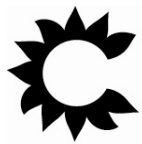
**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Surgeries, cont						
→ Knee Arthroscopy	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA).	YES, when determined to be medically necessary by the Plan (PA).	NO	a.k.a. Knee Surgery
→ Knee Replacement Surgery	YES	Prior Authorization [Milliman™ Guideline]	YES, when determined to be medically necessary by the Plan (PA).	YES, when determined to be medically necessary by the Plan (PA).	NO	
→ Mastectomy	NO	Hospital Notification Or PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	Mastectomies typically require inpatient admission.
→ Reconstructive, Plastic Surgery and Supplies	YES	Prior Authorization [CHP Guideline]	YES, for the following: Plastic & reconstructive services (including implants after a mastectomy) To correct a physical disorder following an injury or incidental to covered surgery.	YES, for the following: Plastic & reconstructive services (including implants after a mastectomy) To correct a physical disorder following an injury or incidental to covered surgery.	NO	Includes blepharoplasty surgery Cosmetic services are not covered.
→ Refractive Surgery			(SEE EYE SURGERY)			
→ Rhinoplasty and Septoplasty	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA).	YES, when determined to be medically necessary by the Plan (PA).	NO	
→ Sclerotherapy, leg vein	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA).	YES, when determined to be medically necessary by the Plan (PA).	NO	
→ Shoulder Replacement Surgery	YES	Prior Authorization	YES, when determined to be medically necessary by the Plan (PA).	YES, when determined to be medically necessary by the Plan (PA).	NO	
→ Skin Tag Removal			NO, Not Covered	NO, Not Covered	NO	CPT Codes: 11200 – 11201
→ Strabismus Surgery	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Tonsillectomy and Adenoidectomy	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

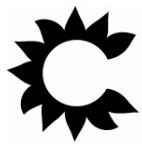


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> Healthy Options (HO) BH S-Med <p align="center">COVERED SERVICE</p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> Healthy Options (HO) BH+ S-CHIP <p align="center">COVERED SERVICE</p>	Covered by DSHS for HO, BH+ & S-CHIP <p align="center">FEE-FOR-SERVICE</p>	Additional Information
Surgeries, cont						
→ UPPP (Uvulopalatopharyngoplasty)	YES	Prior Authorization [Milliman™ Guideline]	YES, must be determined medically necessary by the Plan (PA).	YES, must be determined medically necessary by the Plan (PA).	NO	
→ 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.	NO	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)	SOME¹⁶	PCP/Physician Orders (par) Plan Approved Referral (non-par) Or Prior Authorization	YES, medical treatment only. Dental Services are not covered (See DSHS column for dental services). Some diagnostic tests may require a PA (e.g. MRI TMJ and Surgical Treatment)	YES, medical treatment only. Dental Services are not covered (See DSHS column for dental services). Some diagnostic tests may require a PA (e.g. MRI TMJ and Surgical Treatment)	YES, services provided by a dentist or that are billed with American Dental Assoc. codes are paid Fee-For-Service by DSHS.	ER visits with a TMJ diagnosis will be paid by CHP. Some diagnostic tests may require a PA (e.g. MRI TMJ and Surgical Treatment)
Transmyocardial Laser Revascularization			NO, not covered	NO, not covered	NO	Considered to be experimental and investigational at this time.
Transplants						
→ Corneal Transplant	NO	Hospital Notification OR PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
→ Transplants (organ or tissue) & Work-up Related to Transplants	YES	Prior Authorization + CHP Case Manager referral [CMS NCD Guideline]	YES, transplants for: heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea & peripheral blood stem cell (PA).	YES, transplants for: heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea & peripheral blood stem cell (PA).	NO	This service MUST be pre-authorized by a CHP Case Manager.
→ Transplant (organ or tissue) Donation	YES	Prior Authorization + CHP Case Manager referral [CMS NCD Guideline]	YES, covered by CHP for 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. (PA).	YES, covered by CHP for 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. (PA).	NO	This service MUST be pre-authorized by a CHP Case Manager.

¹⁶ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.

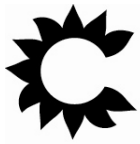


2009 Healthy Options/S-CHIP/BH+/ S-Med BENEFIT GRID

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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Transplants, cont						
→ Transplant Donor Search (tissue typing of family members)	YES	Prior Authorization [CMS NCD Guideline]	YES, covered up to 15 searches per calendar year.	YES, covered up to 15 searches per calendar year.	NO	Includes the following CPT codes : 86812-86822
Transportation (from home to office or from PCP to Specialist)			NO, not covered	NO, not covered	YES, through Transportation Broker. Contact transportation program manager at 360.725.1317	
Urgent Care (urgently needed care)	NO	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES	YES	NO	
Vaccinations	(SEE IMMUNIZATIONS)					
Virtual Endoscopy (wireless or capsule endoscopy)	(SEE EXPERIMENTAL AND INVESTIGATIONAL)					
Virtual Colonoscopy	(SEE EXPERIMENTAL AND INVESTIGATIONAL)					
Vitamins	SOME¹⁷	Prescription	YES, some are covered through the pharmacy benefit. Not covered if over the counter.	YES, some are covered through the pharmacy benefit. Not covered if over the counter.	NO	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	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	
Vocational Rehabilitation			NO, not covered	NO, not covered	NO	
Wigs			NO, not covered	NO, not covered	NO	

¹⁷ See 2009 CHP Drug Formulary for additional information.

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.



2009 Healthy Options/S-CHIP/BH+/ S-Med 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	Adults (Persons age 19 and older) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH S-Med <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Children (Persons age 18 and younger) <ul style="list-style-type: none"> ▪ Healthy Options (HO) ▪ BH+ ▪ S-CHIP <p style="text-align: center;"><u>COVERED SERVICE</u></p>	Covered by DSHS for HO, BH+ & S-CHIP <u>FEE-FOR-SERVICE</u>	Additional Information
Wound Care						
→ Outpatient Wound Care	SOME¹⁸	PCP/Physician Orders (par) Plan Approved Referral (non-par)	YES, >12 Specialty Provider visits require PA.	YES, >12 Specialty Provider visits require PA.	NO	>12 Specialty Provider visits require PA.
→ Home Health Agency	YES	Prior Authorization	YES, must be determined medically necessary by the Plan (PA).	YES, must be determined medically necessary by the Plan (PA).	NO	

¹⁸ See additional information for PA requirements

**The benefit information contained in the Benefit Grids are provided only as a guide and are not a guarantee of coverage.