Community Health Plan
2010 Basic Health Benefit Table

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About the Basic Health Benefit Table

The Basic Health Benefit Table is a guide to some of the benefits that Community Health Plan offers when they are medically necessary. It does not include all benefits or every detail about the benefits.

Whether your service or treatment can be covered depends on your diagnosis; it is always best to check with your provider or Community Health Plan before you get the service.

If you have a question about a specific service, call the Community Health Plan customer service team at 1-800-440-1561 toll free. If you are hearing or speech impaired, please call TTY 1-866-816-2479 toll free or local 206-613-8875.

More information:

- For more information about prior authorizations and approvals, see "About Prior Authorizations and Referrals" in the *2010 Basic Health Medical Benefits Summary*.
- For details about which services are offered by Community Health Plan:
  - Contact your provider.
  - Call the Community Health Plan customer service team at 1-800-440-1561 toll free. If you are hearing or speech impaired, please call TTY 1-866-816-2479 toll free or local 206-613-8875.

Important notes:

- To check for the most current information, contact the sources listed above under "More information."
- You will need a referral from your PCP and often an authorization from Community Health Plan before you get a service, treatment, or equipment. **If you get a service before you get an authorization or referral, you might have to pay for it yourself.**
- **All services and treatments are covered only if medically necessary.** For more information about what "medically necessary" means, see the section "Medically Necessary" in the *2010 Basic Health Medical Benefits Summary*. For a detailed definition of "medical necessity," see *Appendix A: Schedule of Benefits, I. Medically necessary services, supplies, or interventions* in the Washington State *2010 Basic Health Member Handbook*.

Basic Health Benefit Table

As of January 1, 2010

Note: If you do not find a service listed in this table, please check the list in the "Basic Health Services Not Covered" section.

The headings in the table mean:

- **Benefit:** A description of the benefit.
- **Copay, deductible, coinsurance:** If this service requires a copay or coinsurance or affects your deductible, you will find that information here.
- **Details:** More information about the benefit itself, including whether it requires an approval, such as prior authorization or a referral.

Benefit	Copay, deductible, coinsurance	Details
Acupuncture	20% coinsurance	Prior authorization required for more than 6 visits. Requires physician order for provider in network or plan-approved referral to provider outside network.
Allergy treatment Treatment including testing, serum, injections Allergy office visit	 20% coinsurance $15 copay per visit	 Does not require prior authorization. Requires physician order for provider in network or plan-approved referral to provider outside network. Prior authorization required for more than 12 specialty provider visits per year.
Ambulance services Includes approved transfers from one facility to another.	20% coinsurance; deductible applies	No coinsurance if transfer is required by Community Health Plan.
Anesthesia and anesthesia-related oxygen services		

Benefit	**Copay, deductible, coinsurance**	**Details**
Biofeedback therapy	20% coinsurance	Prior authorization required for more than 6 visits. Requires physician order for provider in network or plan-approved referral to provider outside network.
Blood, blood components, fractions (such as plasma, platelets, packed cells, albumin), and their administration	No copay or coinsurance	Does not require prior authorization. Requires physician order for provider in network or plan-approved referral to provider outside network.
Chemical dependency: residential and outpatient treatment, methadone treatment	$15 copay or outpatient office visits. (See "Office visits" in this table.) 20% coinsurance; deductible applies to inpatient	Does not require prior authorization. Requires physician order for provider in network or plan-approved referral to provider outside network. $300 maximum facility charge per admittance. Limited to $5,000 every 24-month period; $10,000 lifetime maximum.

Benefit	**Copay, deductible, coinsurance**	**Details**
Chiropractic, occupational, physical therapy inpatient or outpatient services	$15 office visit copay; 20% coinsurance; deductible applies	Requires prior authorization. Up to a combined maximum 12 visits per calendar year. Of those, no more than six can be for chiropractic care. Visits qualify only when used as post-operative treatment after reconstructive joint surgery. Visits must be within one year of surgery.
Emergency care		For more information, see "What to Do in an Emergency" in the *2010 Basic Health Medical Benefits Summary*.
In service area	Emergency room visit $100 copay per visit. If admitted, no copay. Hospital coinsurance and deductible apply.	Does not require prior authorization, physician order, or plan-approved referral. • 24 hours a day, 7 days a week. • Any plan-contracted provider (but noncontracted provider allowed if necessary), including ambulance and noncontracted pharmacy medications. • Follow-up care must be provided by contracted provider or from noncontracted provider with prior authorization by Community Health Plan. • If noncontracted provider is used for follow-up care in the hospital, must transfer to contracted facility when stable.
Outside service area	Same as inside area for covered conditions.	Same as inside area for covered conditions.

Benefit	**Copay, deductible, coinsurance**	**Details**
Family planning services, including: • IUDs, diaphragms, cervical caps, long-acting progestational agents • Elective sterilization • Regular contraception, such as birth control pills, and emergency contraception • Medroxyprogesterone injection	No copay $15 office visit copay; pharmacy copay	Does not require prior authorization. Does not require prior authorization.
Health and wellness education about: • Asthma • Diabetes, including nutrition, exercise, prevention of acute or chronic complications, monitoring, medication	20% coinsurance	Does not require prior authorization. Requires physician order for provider in network or plan-approved referral to provider outside network. Up to 6 visits per calendar year.
Hospice services	No copay or coinsurance	Requires prior authorization.

Benefit	**Copay, deductible, coinsurance**	**Details**
Hospital inpatient and outpatient care: • Semiprivate room and board, including meals; private room and special diets; general and special duty nursing services • Hospital services, such as operating room, intensive care unit, anesthesia, radiology, laboratory • Drugs and medications while inpatient • Dressings, casts, equipment, oxygen services, radiation and inhalation therapy • Normal newborn baby care following birth if you are not eligible for Maternity Benefits Program	20% coinsurance; deductible applies $300 maximum facility charge per admittance	No charges for maternity care (see below) or when readmitted for the same condition within 90 days. **Maternity:** Maternity services are covered under Basic Health for only 30 days after diagnosis of pregnancy, unless: • You have applied for and are not eligible for the Maternity Benefits Program. • You are an HCTC (Health Coverage Tax Credit) Basic Health member. For more information about maternity benefits, see the "When You Are Pregnant" section in the *2010 Basic Health Medical Benefits Summary*.
Immunizations including but not limited to: • Flu (influenza) • Hepatitis A, hepatitis B (once in your lifetime) • Pneumococcal vaccine • Menactra (meningococcal) for certain high-risk patients	No copay or coinsurance for covered preventive immunizations	Does not require prior authorization.

Benefit	Copay, deductible, coinsurance	Details
Injections including but not limited to: • Abatacept (Orencia) • Botulinim (Botox) (not cosmetic) • Infliximab (Remicade) • Hyaluronic acid derivatives (Synvisc or Hyalgan) • Natalizumab (Tysabri) • Omalizumab (Xolair) • Palivizumab (Synagis)/RespiGam (up to 5 injections between November 15 and April 15)	20% coinsurance	Requires prior authorization.
Laboratory and pathology	No copay or coinsurance for outpatient services 20% coinsurance for inpatient hospital-based lab services Deductible applies to services with coinsurance	Does not require prior authorization. Requires physician order for provider in network or Plan-approved referral to provider outside network.
Mammogram	No member cost sharing	

Benefit	**Copay, deductible, coinsurance**	**Details**
Maternity care	No copay	Maternity services are covered under Basic Health for only 30 days after diagnosis of pregnancy, unless: • You applied for and are not eligible for the Maternity Benefits Program. • You are an HCTC (Health Coverage Tax Credit) Basic Health member. For more information about maternity benefits, see the "When You Are Pregnant" section in the *2010 Basic Health Medical Benefits Summary*. Does not require prior authorization. Member may self-refer to women's health care specialist in network.
Mental health	20% coinsurance; deductible applies to inpatient $300 maximum facility charge per admittance Outpatient visits are subject to a $15 copay. (See “Office visits” in this table.)	Outpatient visits require physician order for provider in network or plan-approved referral to provider outside network. No authorization is required for involuntary admissions.

Benefit	**Copay, deductible, coinsurance**	**Details**
Newborn baby care: normal care following birth while in contracting facility, laboratory services, routine newborn exams	No copay	Maternity and newborn services are covered under Basic Health for only 30 days after diagnosis of pregnancy, unless: • You applied for and are not eligible for the Maternity Benefits Program. • You are an HCTC (Health Coverage Tax Credit) Basic Health member. However, if the mother is covered, so is the newborn, even if it is after 30 days following pregnancy diagnosis. For more information about maternity benefits, see the "When You Are Pregnant" section in the *2010 Basic Health Medical Benefits Summary*.
Nutritional counseling		
For obesity diagnosis in patients from newborn to 18 years old	20% coinsurance	Up to 12 visits per year. Does not require prior authorization for up to 12 visits per year. Requires physician order for provider in network or plan-approved referral to provider outside network.
For diagnoses other than obesity	20% coinsurance	Up to 2 visits per year. Does not require prior authorization. Requires physician order for provider in network or plan-approved referral to provider outside network.

Benefit	**Copay, deductible, coinsurance**	**Details**
Office visits: evaluation and management	$15 copay Some services subject to coinsurance.	Does not require prior authorization. Requires physician order for provider in network or Plan-approved referral to provider outside network. Copay details: • Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. • No copay for preventive care, laboratory, radiology services, radiation, and chemotherapy.
Organ transplants, including professional and facility fees for inpatient; diagnostic tests and exams; surgery and follow-up care. Includes: • Bone marrow including peripheral stem cell rescue • Cornea (does not require prior authorization) • Heart • Heart-lung • Liver • Kidney • Kidney-pancreas For organ transplant donor: • Initial medical expenses of harvesting • Costs of treating complications	Deductible, coinsurance, and copays apply by specific service 20% coinsurance	Limitations: • After 12-consecutive-month waiting period • When medically necessary 12-month waiting period exceptions: • Newborns • Conditions that are not pre-existing Requires prior authorization and referral from Community Health Plan case manager.

Benefit	**Copay, deductible, coinsurance**	**Details**
For organ transplant recipient: • Services and supplies • Transportation to facility	20% coinsurance	Requires prior authorization and referral from Community Health Plan case manager.
Oxygen, including: • Rental of oxygen equipment • Oxygen contents • Supplies for delivery of oxygen	No copays, coinsurance, or deductible	• Requires prior authorization. • Must be prescribed by contracted provider. • Exempt from pre-existing condition waiting period.
Pharmacy	Tier 1: $10 copay Tier 2: Coinsurance 50% of drug cost	30-day supply. Requires prescription. To find out if a specific drug is covered in your pharmacy benefit, you can visit our web site (www.chpw.org) or refer to the *2010 Community Health Plan Formulary* booklet. For information about how to get this booklet or for more information about Tier 1 and Tier 2 drugs, see "Prescription Drug Services" in the *2010 Basic Health Medical Benefits Summary*.

Benefit	**Copay, deductible, coinsurance**	**Details**
Plastic and reconstructive services **only**: • To correct physical functional disorder resulting from congenital disease or abnormality. • To correct physical functional disorder following an injury or incidental to covered surgery. • In connection with mastectomy. • For equipment and supplies to treat lymphedema in limited circumstances. Cosmetic plastic and reconstructive services are not covered.	$15 office visit copay; 20% coinsurance	For mastectomy or post-mastectomy breast reconstruction, does not require prior authorization. Requires physician order for provider in network or plan-approved referral to provider outside network. Post-mastectomy reconstruction may include: • Reconstruction of breast on which mastectomy performed • Surgery and reconstruction of other breast to produce symmetrical appearance • Internal or external prostheses • Physical complications of all stages of mastectomy For medically necessary breast reduction only: Requires prior authorization.
Radiation therapy, oral chemotherapy, and injectable or infused chemotherapy	$15 office visit copay; 20% coinsurance	• Requires prior authorization for more than 12 specialty provider visits per year. • Requires physician order for provider in network or plan-approved referral to provider outside network. • Some chemotherapy agents require prior authorization.
Radiology, nuclear medicine, ultrasound, laboratory, other diagnostic services PET scan, all MRI imaging, CT-head, CT angiography X-ray, ultrasound, echoes, nuclear medicine	Deductible applies to services with coinsurance 20% coinsurance; deductible applies 20% coinsurance	 Requires prior authorization. Does not require prior authorization. Requires physician order for provider in network or Plan-approved referral to provider outside network.

Benefit	Copay, deductible, coinsurance	Details
Screenings	No copay; 20% coinsurance	
Colonoscopy screening		Does not require prior authorization. Requires physician order for provider in network or Plan-approved referral to provider outside network. Not all colonoscopies are covered. Check with your provider to make sure you have the proper approvals before you get the services.
Diabetes screening		Does not require prior authorization. Requires physician order for provider in network or Plan-approved referral to provider outside network.
Skilled nursing as an alternative to hospitalization in an acute care facility	No copay	Requires prior authorization and referral from Community Health Plan case manager.
Smoking cessation: Nicotine gum and patches	Pharmacy copay	Covered if filled as prescription from your provider.
Surgical services	20% coinsurance; deductible applies $300 maximum facility charge per admittance for inpatient only	Requires physician order for provider in network or plan-approved referral to provider outside network. Always check with your provider to make sure you have the proper approvals before you get the services.
Urgent care	$15 copay	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.

Basic Health Services Not Covered

This is a brief summary of services that Community Health Plan will not pay for.

For details, see *Appendix A: Schedule of Benefits, B. Exclusions* of the Washington State *2010 Basic Health Member Handbook* or call the Community Health Plan customer service team at 1-800-440-1561 (toll free). If you are hearing or speech impaired, please call TTY 1-866-816-2479 (toll free) or local 206-613-8875.

General Exclusions

- Any service or supply not specifically listed as a covered service unless it is medically necessary, prescribed by a contracting provider, and authorized in advance by Community Health Plan, including:
  - Services that do not meet the definition of medical necessity.
    For a detailed definition of "medical necessity," see *Appendix A: Schedule of Benefits, I. Medically necessary services, supplies, or interventions* of the Washington State *2010 Basic Health Member Handbook*.
  - Services not provided, ordered, or authorized by Community Health Plan or our contracted providers, except in an emergency.
    If you get non-emergency service from a noncontracted provider, you might need to pay for some or all of the service yourself.
  - Services you got before your effective date of coverage with Community Health Plan.

Specific Exclusions

- Birthing classes.
- Charges for missed appointments or failure to provide timely notice for cancellation of appointments; charges for completing or copying records or forms.
- Chiropractic, occupational, or physical therapy, diagnostic or imaging procedures for determination of therapy services only.
- Conditions resulting from acts of war.
- Cosmetic surgery, including treatment for complications of cosmetic surgery, except as specified in the Washington State *2010 Basic Health Member Handbook*.
- Custodial or domiciliary care or rest cures. For additional information, see the Washington State *2010 Basic Health Member Handbook*.
- Dental services, including orthodontic appliances, and services for temporomandibular joint (TMJ) problems, except for repair necessitated by accidental injury to sound natural teeth or jaw. The repair must begin within 90 days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
- Direct complications arising from excluded services.
- Doula services.
- Emergency facility services for nonemergency conditions.

- Equipment or supplies (except when member is in hospital) including:
  - Apnea monitor
  - Breast pump
  - Communication device
  - CPM (continuous passive motion) machine
  - C-PAP machine
  - Crutches
  - Disposable diapers (for children and adults)
  - Enteral or parenteral formula and pump
  - Fracture frame
  - Hospital bed
  - Humidifier
  - Insulin pump and supplies
  - Osteogenic (bone) stimulator
  - Ostomy supplies
  - Patient lift
  - Suction pump
  - TED hose (support stockings)
  - TENS unit
  - Trapeze bar
  - Ventilator and related equipment
  - Walk aids
  - Wheelchairs
- Evaluation and treatment of learning disabilities, including dyslexia.
- Eye care, including:
  - Eye exams, including eye refraction, except when provided as part of a routine preventive care exam.
  - Eyeglasses or contact lenses, except the first intraocular lens following cataract surgery.
- Hearing aids
- Homeopathy
- Hospital charges for personal comfort items such as telephones, televisions, and guest trays; a private room unless authorized by Community Health Plan.
- HPV immunization (Gardasil) for members 19 or older.
- Immunizations (except as covered for preventive care) for travel, for employment, or because of where you live.
- Implants, except:
  - Artificial joints.
  - Cardiac devices.
  - Implants as defined in the "Plastic and Reconstructive Surgery" benefit in the Washington State *2010 Basic Health Member Handbook*.
  - Intraocular lenses, except the first intraocular lens following cataract surgery.
- Infertility treatments, such as investigation of or treatment for infertility or impotence; reversal of sterilization; artificial insemination; in-vitro fertilization.

- Interpreter services for office visits. (Community Health Plan covers interpreter services for administrative issues such as grievance hearings.)
- Lasik eye surgery.
- Maternity care beyond 30 days after diagnosis, unless:
    - You applied for and are not eligible for the Maternity Benefits Program.
    - You are an HCTC (Health Coverage Tax Credit) Basic Health member.
- Medical services you got from or were paid for by the Veterans Administration or by state or local government, except when in conflict with Washington State or federal law or regulation. For more information, see the Washington State *2010 Basic Health Member Handbook*.
- Medical services, drugs, supplies, or surgery directly related to the treatment of obesity including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).
- Neurodevelopmental therapy for children age 6 or younger.
- Obesity (bariatric) surgeries.
- Orthopedic shoes and routine foot care.
- Portable oxygen, if only a backup to stationary oxygen system.
- Recreation therapy.
- Replacement for lost or stolen medications.
- Rotavirus immunization.
- Sexual reassignment surgery.
- Shingles vaccination (Zostavax or varicella).
- Sleep studies, except initial sleep study authorized by the Plan.
- Speech therapy.
- Transportation except as specified under "Organ Transplants" and "Emergency Care" in the Washington State *2010 Basic Health Member Handbook*.
- Vocational rehabilitation.
- Weight loss programs.