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Molina Healthcare of Washington, Inc. (MHW) Benefits Index

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Abortion	Excluded is voluntary termination of pregnancy. Covered through Medicaid Fee-For-Service (14.15.3.3). Covered is medically necessary termination of pregnancy**.**	See Prenatal Care. Covered is voluntary and medically necessary termination of pregnancy - part of the maternity benefit. No co-pay/coinsurance or deductible. (pages 27-C & 32)
Acupuncture	Excluded - HCA does not reimburse for services performed by any of the following practitioners: Acupuncturists, Homeopaths, Massage therapists, Naturopaths (14.15.5.9, HCA Physician-Related Services/Healthcare Professional Services Billing Instructions page A.8,WAC 182-531-0250 (2 a))	Not specifically listed as covered. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) If authorized, covered as specialty care $15 co-pay for consultation. 20% coinsurance, deductible applies (Other Professional Services page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Alcoholism	See Chemical Dependency	See Chemical Dependency
Ambulance Transportation	Covered is ground and air ambulance transportation for emergency medical conditions as defined in contract including, but not limited to, basic and advanced life support services and other required transportation costs such as tolls and fares. In addition the plan shall cover ambulance under two circumstances for non-emergencies: 1) To transport an enrollee between facilities 2) To transport and enrollee who must be carried on a stretcher or who may require medical attention en route (14.14.19 – 14.14.19.2)	Covered is medically necessary ambulance transportation in an emergency or to transfer a member when preauthorized by the plan. (page 29, G #5). 20% coinsurance, deductible applies. Includes approved transfers from one facility to another. No coinsurance if transfer is required by the Plan. (page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Antigen (Allergy Serum)	Covered is antigen and its administration (14.14.12.4.3)	Covered per MHW Benefits Determination Committee decision. No co-pay/coinsurance or deductible.

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
A.D.D. (Attention Deficit Disorder)	Covered as medical condition if treated by PCP, pediatrician or neurologist. Covered under mental health benefit if treated by a psychiatrist or other mental health professional.	Covered as medical condition if treated by PCP or pediatrician - $15 co-pay for office visit. Covered under mental health benefit (see Mental Health) - if treated by a psychiatrist or other mental health professional. (page 28-E & 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Autologous Blood	See Blood Products	See Blood Products.
Biofeedback	Covered is Bio feedback training when determined medically necessary specifically for perineal muscles, anorectral or urethral sphincter, including EMG and/or manometry for incontinence. (14.14.6.15)	Not specifically listed as covered. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) If authorized, covered as specialty care $15 co-pay for consultation. 20% coinsurance, deductible applies. (Other Professional Services page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Birthing Centers/Home Births	Covered if: • a certified or nurse midwife is contracted with Plan and delivers at home or at a birthing center contracted with Plan • Is expected to deliver the child vaginally and without complication (i.e., with a low risk of adverse birth outcome); and • Passes Department's risk screening criteria. (HCA Planned Home Births and Births in Birthing Centers Billing Instructions page A.1)	For HCTC clients - Covered. For Regular BH clients - Covered for one month following diagnosis of pregnancy. No co-pay/coinsurance or deductible. Member must apply for the Maternity Benefits (Medicaid) Program. If member is ineligible for the Maternity Benefits Program, Plan covers maternity. (page 27-C & 32) Covered are home births if certified or nurse midwife is contracted with Plan and delivers at birthing center contracted with Plan. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Birth Control	Covered are FDA approved contraceptive drugs, devices and supplies, including but not limited to Depo-Provera, Norplant, and OTC products. (14.14.12.4.2)	See Prescriptions
Blood Products	Covered are blood, blood components, human blood products and their administration. (14.14.17)	Covered are blood, blood components and fractions (such as plasma, platelets, packed cells and albumin and their administration. (page 27-B #4) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Braces (Orthopedic)	See Durable Medical Equipment, Prosthetics and Supplies	See Durable Medical Equipment
Braces (Orthodontics)	See Dental Care	See Dental Care

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Breast Implant Removal	Excluded are services for which plastic surgery or other services are indicated primarily for cosmetic reasons. (14.15.5.3) Covered if medically necessary. Covered are services to correct defects from birth, illness or trauma or for mastectomy reconstruction. (14.14.6.8)	Excluded is cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in the schedule of benefits. (page 30-J) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Breast Reductions	See Plastic Surgery	See Plastic Surgery
Bulimia	See Mental Health	See Mental Health
Cardiac Rehab	Covered is cardiac rehab CPT code 93798 with continuous ECG monitoring only when billed with specific diagnosis codes. (HCA Physician-Related Services/Healthcare Professional Services Billing Instructions Page F.7)	Not specifically listed as covered. EXCLUDED is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Chemical Dependency	Excluded- Substance abuse treatment services covered through the Division of Alcohol and Substance Abuse (DASA). (14.15.4.1) When an enrollee has alcohol and/or chemical dependency and/or mental health diagnosis, the Contractor is responsible for contracted services whether or not the enrollee is also receiving alcohol and/or chemical dependency and/or mental health treatment. (14.14.1)	Covered to a maximum of $5000 per 24 months or $10,000 lifetime. 20% coinsurance, deductible applies. $300 max facility charge per admittance. $15 outpatient co-pay. (pages 28-D & 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Chemotherapy	Covered are services provided in an inpatient or outpatient (e.g. office, clinic, emergency room or home) setting by licensed professionals including but not limited to, physicians, physician assistances, advanced registered nurse practitioners, midwives, podiatrists, audiologists, registered nurses & certified dietitians. (14.14.6)	Covered are chemotherapy & radiation. (page 27-B # 6) Other professional services 20% coinsurance deductible applies. (Other professional services page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Childbirth Classes	Covered through Medicaid fee-for-service with referral by First Steps worker (14.15.3.7, f).	Not specifically listed as covered. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Chiropractic Care	Excluded for adults age 21 and older Covered are chiropractic services for children when referred as a result of an EPSDT exam. (14.14.22.2-14.14.22.2.1, HCA Chiropractic Services for Children Billing Instructions page A.1, B.1, and C.1.) Covered are Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician. 10 manipulations CPT Codes 98925-98929 are covered per calendar year (HCA Physician-Related Services/Healthcare Professional Services Billing Instructions Page B.17- B.18)	Covered are chiropractic manipulations and physical therapy combined into one benefit. Limited to 6-visit total within one year – post operative treatment for reconstructive joint surgery. Applies to inpatient and outpatient. Member can be referred by PCP or may self-refer to par Chiropractors. All chiropractic services require prior auth. (page 27-B #7 & 33) Covered - as specialty care, $15 co-pay for consultation. 20% coinsurance, deductible applies. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Circumcision of Newborns	Excluded are services for which plastic surgery or other services are indicated primarily for cosmetic reasons. (14.15.5.3)	Excluded are cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits". (page 35-B #25) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
	Covered if medically necessary. HCA covers only for ICD-9-CM diagnoses: 605 (Phimosis); 607.1 (Balanoposthistis); and 607.81 (Balanitis Xerotica). (HCA Physician-Related Services/Healthcare Professional Services billing instructions page B.18)	Covered if medically necessary. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Cleft Palate	Covered are services to correct defects from birth, illness or trauma or for mastectomy reconstruction. (14.14.6.8)	Covered to correct a physical functional disorder resulting from a congenital disease or anomaly. $15 co-pay for office visits. 20% coinsurance, deductible applies. $300 max facility charge. (page 30-J #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Colonoscopy	Covered with no authorization if performed in a Plan contracted facility.	Colonoscopy - Covered with no authorization if performed in a Plan contracted facility. No co-pay/coinsurance if part of routine preventive care screening. Routine preventive screening is covered for enrollees over 50, 1 time per 10 year period. (See Preventive Care Guidelines in MHW Member Handbook) Subject to coinsurance if not part of routine preventive exam. (See Other Professional Services page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Complications of Excluded Services	Complications resulting from an excluded service are also excluded for a period of 90 calendar days following the occurrence of the excluded service not counting the date of service. Thereafter complications resulting from an excluded service are a covered service when they would otherwise be a covered service under the provisions of the contract. (14.15.2)	Excluded are direct complications from excluded services. (page 35-B #28)
Counseling	See Mental Health	See Mental Health
Court Ordered Treatment	Excluded are court ordered services. (14.15.5.15)	Covered if medically necessary. (page 28-D & E "NOTE")
Custodial Care	Excluded are community based services (e.g. COPES and personal care services) covered through the Aging and Disability Services Administration (ADSA) (14.15.4.2) Excluded are nursing facilities covered through ADSA. (14.15.4.3)	Excluded are custodial or domiciliary care or rest cures for which facilities of an acute care general hospital are not medically required. (page 34-B #4)

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Dental Care	Excluded are services provided by dentists and oral surgeons for dental diagnoses, including physical exams required prior to hospital admissions for oral surgery and anesthesia for dental care. (14.15.3.5) Covered for children under age 21 through DSHS Fee-For-Service. (DSHS Dental Program for Clients Through Age 20 Billing Instructions) Effective 7/1/11 covered for pregnant and qualified aged and disabled adults age 21 and over through DSHS Fee-For-Service. Effective 10/1/11 changes made to qualified disabled adult coverage. (see DSHS numbered memo #11-51, Dental Services: Coverage and Authorization Changes) Excluded is treatment of TMJ/TMD for adults (14.15.5.10, DSHS Dental Program Billing Instructions for Clients Age 21 and older pages C.30 & 35)	Excluded are dental services including orthodontic appliances and services for TMJ problems, except for repair necessitated by accidental injury to sound natural teeth or jaw provided that such repair begins 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 services are provided. Subject to $15 office visit co-pay. 20% coinsurance, deductible applies. $300 max facility charge. (page 35-B #22) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Diabetes Education	Covered is nutritional counseling for specific conditions such as diabetes, high blood pressure and anemia. (14.14.6.14)	Covered per MHW Medical Director. No co-pay/coinsurance or deductible.
Diabetic Supplies	See Prescriptions See Durable Medical Equipment, Prosthetics and Supplies	Covered, see Prescriptions
Dialysis	Covered is hemodialysis or other appropriate procedures to treat renal failure including equipment needed in the course of treatment (14.14.18).	Covered under Other Professional Services. 20% coinsurance, deductible applies. For inpatient $300 max facility charge applies. (page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Diapers (Adult)	See Durable Medical Equipment, Prosthetics and Supplies	See Durable Medical Equipment and Supplies
Durable Medical Equipment (DME), Prosthetics and Supplies	Covered are durable medical equipment and supplies: including but not limited to: DME, surgical appliances, orthopedic appliances and braces, prosthetic and orthotic devices, breast pumps, incontinence supplies for enrollees over three years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless enrollee agrees. (14.14.14) Some limits apply(HCA Prosthetic and Orthotic Devices Billing Instructions) Covered are oxygen and respiratory therapy equipment and supplies. (14.14.15) Excluded are: hairpieces or wigs, procedures or supplies related to gender dysphoria surgery, shoe lifts less than one inch, arch supports and non-orthopedic shoes, physician office visit supplies such as tongue depressors and surgical gloves, prosthetic devices dispensed for cosmetic reasons, home improvements and structural modifications including but not limited to saunas, whirlpools, hot tubs and automatic doors, devices intended to amplify voices, exercise classes or equipment, ergonomic equipment, personal comfort items etc. (WAC 182-543-1300 and HCA Wheelchairs, DME and Supplies Billing Instructions pages D.4 and D.5) See Prescriptions for Enteral and Parenteral Supplements and Supplies.	Excluded are medical equipment and supplies not specifically listed in the Schedule of Benefits except while the member is hospitalized (including but not limited to, hospital beds, wheelchairs and walk aids). (page 35-B #21) Covered is prosthesis internal and external after a mastectomy. Subject to 20% coinsurance, deductible applies. $300 max facility charge. (page 30-J #3) Ostomy supplies and prosthetic limbs are not specifically listed as covered - Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance*.

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Eating Disorders	Covered if medically necessary See Mental Health See Nutritional Counseling See Weight Loss Treatments	Covered if medically necessary. Subject to $15 office visit co-pay for PCP visits. 20% coinsurance, deductible applies and $300 max facility charge for inpatient hospitalization. Also see Nutritional Counseling, Obesity or Weight Loss Surgery. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Emergency Room and Out of Area Care	The plan is not responsible for coverage of any services when an enrollee is outside the US and its territories and possessions (e.g. Puerto Rico is a territory). (14.1.12.5) Covered are emergency services: In service area – The plan shall cover enrollees for all medically necessary services included in the scope of services covered by the contract. (14.1.1) Out of service area – The plan shall cover emergency, post stabilization, urgent care and services that are neither emergent nor urgent but are medically necessary and cannot wait until enrollee's return to the service area. (14.1.12-14.1.12.3) The plan's obligation for services outside the service area is limited to 90 calendar days beginning with the first of the month following the month in which the enrollee leaves the service area or changes residence. (14.1.12.4) The plan will provide all inpatient and outpatient emergency services in accord with 42 CFR 438.114 (prudent layperson). (14.14.4.1.1)	Covered are in-service area and out-of service area emergencies. According to HCA this includes out of country emergencies because they are not specifically Excluded like Medicaid. (page 29-G) $100 co-pay, no co-pay if admitted; hospital coinsurance and deductible apply. (page 32) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Experimental Treatment or Devices	Plans are to use criteria to determine whether an experimental or investigational service is medically necessary. (14.11.2) Medicaid medical necessity determinations for its fee-for-service program described in WAC 182-501-0165. (14.11.1)	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Eye Exams, Routine Refractions	Covered are eye examinations for visual acuity and refraction once every 24 months for adults and 12 months for children under 21 years of age. The limits do not apply to additional services needed for medical conditions. The plan may restrict non-emergent care to participating providers. Enrollees may self refer to participating providers for these services (14.14.9)	Excluded are routine eye examinations, including eye refraction, except when provided as part of a routine examination under preventive care. (page 35-B #17) Covered are exams for medical conditions. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Eye Glasses	Excluded are eyeglass frames, lenses and fabrication services. Covered for children under age 21 through HCA's fee-for-service. (14.15.3.2) Associated fitting and dispensing services covered for all members.	Excluded are eyeglasses, contact lenses except the first intraocular lens following cataract surgery. (page 35-B #17) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Fertility Drugs	Excluded is diagnosis and treatment of infertility, impotence and sexual dysfunction. (14.15.5.11)	Excluded is investigation of or treatment for infertility or impotence. (page 35-B #13)

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Formula	Infant formula for oral feeding is covered by the Women, infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the Healthy Options pharmacy benefit. (14.15.4.6) Covered are enteral and parenteral nutritional supplements and supplies including prescribed infant formulas for under 21 years of age. (14.14.12.4.1, HCA Enteral Nutrition Billing Instructions) PCP should call WIC at 1-800-841-1410. If not on WIC formulary, Plan responsible under HO contract section 14.14.12.4.1	Not specifically listed as covered. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Gastroplasty	Covered is PCP visit to ascertain if client meets criteria. See stage one in WAC 182-531-1600. If criteria met, the PCP must request prior authorization from HCA before referring client to stage two of the Bariatric surgery process. (WAC 182-531-1600) Covered by fee-for-service are surgical procedures for weight loss or reduction when approved by HCA in accord with WAC 182-531-0200. The plan has no obligation to cover surgical procedures for weight loss or reduction. (14.15.3.16)	Excluded are 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. (page 35-B #23)
Gender Dysphoria	Excluded are gender dysphoria surgery and other services not covered by HCA for gender dysphoria. (14.15.5.16)	Excluded are sex change operations. (page 34-B #12)
Genetic Services	Covered are genetic services when medically necessary for diagnosis of a medical condition. (14.14.6.16)	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Glucometers	See Prescriptions	See Prescriptions
Health Education	Covered is enrollee health education (14.14.6.13) Covered is nutritional counseling for specific conditions such as diabetes, high blood pressure & anemia (14.14.6.14). Also covered under EPSDT. (14.14.22.2 & 14.14.22.2.2)	See Diabetes Education. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Hearing Aids	Excluded are hearing aid devices, including fitting, follow-up care and repair. (14.15.3.6) Covered through Medicaid FFS for children under age 21.	Excluded are hearing aids. (page 35-B #18)
Hearing Testing	Covered when medically necessary.	Covered as any other medically necessary care. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Home Birth	See Birthing Centers/Home Birth	See Maternity Care
Home Health Care/Home Health Aide	Covered are home health services through state-licensed agencies. (14.14.13) Excluded are community based services (e.g. COPES and Personal Care Services covered through the Aging and Disability Services Administration. (14.15.4.2)	Covered as an alternative to hospitalization in an acute care facility, the Plan, at its discretion, may authorize services of a skilled nursing facility or home health care agency – No co-pay/coinsurance or deductible (pages 30-H and 32).
Hospice Care	Covered when the enrollee elects hospice care. Includes facility services. (14.14.16)	Covered are hospice services - no co-pay. (page 30-I & 32)

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Hospitalization	Covered are inpatient services provided by acute care hospitals (licensed under RCW 70.41) or nursing facilities (licensed under RCW 18.51) when nursing facility services are not covered by Aging and Disability Services Administration and the Plan determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included. (14.14.2)	Covered is inpatient hospitalization – Facility charges may include, but not limited to, room and board, prescription drugs provided while an inpatient and other services received as an inpatient. No charges for maternity care or readmit for same condition within 90 days. If member is eligible for Maternity Benefits Program, maternity services can only be covered under BH for 30 days following diagnosis of pregnancy. All other maternity services covered through HCA. (page 32) 20% coinsurance, deductible applies. $300 max facility charge per admit. Facility (pages 26-A & 33) Covered is outpatient hospitalization - 20% coinsurance, deductible applies. (page 33) Also see Other Professional Services (page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Immunizations	See Vaccinations, Travel Immunizations	See Vaccinations, Travel Immunizations
Implants	Covered except for cochlear implants (HCA Physician-Related Services/Healthcare Professional Services Billing Instructions pages A.6, B.26 & F.1 and WAC 182-531-0200(4) (c))	Excluded are implants, except: cardiac devices, artificial joints, first intraocular lens following cataract surgery and implants for plastic and reconstructive services (34-B #11) See Plastic Surgery *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Impotence – Pharmaceutical Treatment of Impotence	Excluded are diagnosis and treatment of infertility, impotence and sexual dysfunction (14.15.5.11)	Excluded is investigation of or treatment for infertility or impotence. (page 35-B #13)

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Incarcerated Members (In Jail or Prison)	Excluded is any service provided to an enrollee while an inmate of a correctional facility (HO Amendment 12 14.15.5.17). When an enrollee who was an inmate of a correctional facility is admitted to the hospital, the Contractor will submit all necessary information to HCA regarding the admission. HCA will determine if the enrollee is eligible for coverage of the hospital stay. If HCA determines that the enrollee is eligible for coverage, the Contractor is responsible for the hospital stay and all associated services.	Excluded are services not provided, ordered or authorized by the Plan or its contracted providers, except in emergency. (page 34-B #2) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Infertility	See Impotence	Excluded is investigation of or treatment for infertility or impotence. (page 35-B #13)
Keratotomy/ Kerato-Plasty (Refractive Lensectomy)	See Plastic Surgery	See Plastic Surgery
Learning Disorders	See Neurodevelopmental Therapy	See Neurodevelopmental Therapy
Lifetime Maximum Benefit Limit	There is no life time maximum limitation on Plan payments.	There is no life time maximum limitation on Plan payments.
Mammogram	Covered are laboratory, radiology and other medical imaging services: screening and diagnostic services and radiation therapy (14.14.8).	Covered are radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services. No co-pay/coinsurance or deductible. (pages 27-B #2 and 33)
Mammaplasty	See Plastic Surgery	See Plastic Surgery

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Massage Therapy	Covered during physical therapy treatment only. (HCA Outpatient Rehabilitation Billing Instructions page C.9) Otherwise excluded - HCA does not reimburse for services performed by any of the following practitioners: Acupuncturists, Homeopaths, Massage therapists, Naturopaths (14.15.5.9, HCA Physician Related Services Billing Instructions. page A.4, WAC 182-531-0250 (2a))	Not specifically listed as covered. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) If authorized, covered as specialty care $15 co-pay for consultation. 20% coinsurance, deductible applies. (Other Professional Services page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Maternity Care	See Prenatal Care	See Prenatal Care

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Mental Health	Covered is outpatient Mental Health: 1. Twenty hours of treatment per calendar year, for children 18 years old and younger. Adults (19+) receive twelve hours of treatment per calendar year (This benefit is for enrollees who do not meet the RSN's access standards for receiving treatment.) 2. Psychiatric and psychological testing, evaluation and diagnosis: • Once every twelve (12) months for adults twenty-one (21) and over • Unlimited for children under age twenty-one (21) when identified in an EPSDT visit 3. Unlimited medication management: • Provided by the PCP or by PCP referral • Provided in conjunction with mental health treatment covered by the Contractor 4. Transition to the RSN, as appropriate to the enrollee's condition to assure continuity of care. (14.14.10-14.14.10.8) Excluded are mental health services separately purchased for all Medicaid clients by the Mental Health Division, including 24-hour crisis intervention, outpatient mental health treatment services, Club House, respite care, Supported Employment and inpatient psychiatric services. (14.15.4.4) When an enrollee has alcohol and/or chemical dependency and/or mental health diagnosis, the Contractor is responsible for contracted services whether or not the enrollee is also receiving alcohol and/or chemical dependency and/or mental health treatment. (14.14.1)	Covered is outpatient care including individual and family counseling. $15 office visit co-pay. Health plans may use lower co-pays if applicable for group sessions. Visits for the sole purpose of medication management are covered as other provider visits. Covered is inpatient care in a participating hospital or other appropriate licensed facility approved by the plan 20% coinsurance, deductible applies. $300 max facility charge. (pages 28-E & 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Military Coverage (VA Benefits)	Until such time as HCA terminates the enrollment of an enrollee who has comparable coverage the services and benefits available under this agreement shall be secondary to any other medical coverage. (14.16.1.1)	Excluded are medical services received from or paid for by the Veterans Administration or by state or local government except where in conflict with WA state or federal law or regulation. (page 35-B #26)
Naturopathy	Excluded- HCA does not reimburse for services performed by any of the following practitioners: Acupuncturists, Homeopaths, Massage therapists, Naturopaths (14.15.5.9, HCA Physician-Related Services/Healthcare Professional Services Billing Instructions page A.8, WAC 182-531-0250 (2a))	Not specifically listed as covered. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) If authorized, covered as specialty care $15 co-pay for consultation. 20% coinsurance, deductible applies. (Other Professional Services page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Neurodevelopmental Therapy – Long Term PT, OT and Speech	Excluded are health care services provided by a neurodevelopmental center recognized by HCA. (14.15.3.9) Covered are Neurodevelopmental Services, Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability when provided by a facility that is not a HCA recognized neurodevelopmental center. The Plan may refer children to a HCA recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of the HO contract are met (14.14.11)	Excluded is speech and recreation therapy. (page 35-B #20) See Physical Therapy

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Nicorette Gum	See Smoking Cessation	See Smoking Cessation
Norplant-Implantable Contraceptives	Covered are all FDA approved contraceptive drugs, devices & supplies including but not limited to DepoProvera, Norplant and OTC products. (14.14.12.4.2)	Covered (page 27-B #9) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Nursing Homes	See Skilled Nursing Facilities	See Skilled Nursing Facilities
Nutritional Counseling	Covered is nutritional counseling for specific conditions such as diabetes, high blood pressure and anemia (14.14.6.14) Covered when referred as a result of an EPSDT exam: Nutritional counseling (14.14.22.2 & 14.14.22.2.2) Per EPSDT guidelines includes counseling by certified dieticians for children with growth disorders, metabolic diseases, or inadequate dietary intake.	Covered per Molina Healthcare decision - CPT: 97802 – 97804 for Nutritional Counseling - no auth needed with contracted provider. Otherwise, not addressed in contract and would be considered excluded - any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Obesity Treatments	See Nutritional Counseling See Weight Loss Treatments	Excluded are 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) and weight loss programs. (pages 35-B #23 & 24)
Occupational Therapy	See Physical Therapy	See Physical Therapy

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Oral surgery	See Dental Care	See Dental Care
Organ Transplants	Covered are tissue and organ transplants: heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel and peripheral blood stem cell. (14.14.7) Per MHW Medical Director transplant coverage decisions are complex. Providers must contact Plan to obtain specific information. Some transplants are well proven by medical research. Others are not and may not work for an enrollee's situation. The provider needs to contact the Plan about each situation.	Covered are services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow up care. This benefit includes covered donor expenses. Heart, heart-lung, liver, bone marrow (includes peripheral stem cell rescue), cornea, kidney, kidney-pancreas human organ transplants are covered when the BH definition of medical necessity is met. Recipient and donor language is included. (pages 28-F) Deductible, coinsurance/ co-pays apply by specific service. Per MHW Medical Director transplant coverage decisions are complex. Providers must contact the Plan to obtain specific information. Some transplants are well proven by medical research. Others are not and may not work for an enrollee's situation. The provider needs to contact the Plan about each situation. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Orthotics	See Durable Medical Equipment, Prosthetics and Supplies	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Out of Area Care	See Emergency Room and Out of Area Care	See Emergency Care
Outpatient Surgery	Covered are services provided at ambulatory surgery centers. (14.14.5)	Covered are surgical services. (page 271B #1) 20% coinsurance, deductible applies. (Other Professional Services page 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Over-Age Dependents	Not applicable, DSHS determines eligibility. (4.2)	Covered are unmarried dependents under age 26 (page 2) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Oxygen	Covered is Oxygen and Respiratory Services: Oxygen, and respiratory therapy equipment and supplies. (14.14.15)	Oxygen will be covered when prescribed by a contracted provider and when authorized by a contracted health plan. The health plan, at its discretion, may require an assessment to determine if oxygen therapy is still an appropriate treatment before authorizing continued oxygen treatment. Coverage for oxygen will include the rental of oxygen equipment, oxygen contents, and supplies for the delivery of oxygen. Portable oxygen is not covered when provided only as a backup to a stationary oxygen system. Oxygen is not subject to a co-pay or coinsurance, and is excluded from the Durable Medical Equipment exclusion. (pages 30-M & 32) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Pain Clinics	Covered is one inpatient hospital stay, up to 21 days, once per lifetime. The Plan may cover Plan-contracted facilities. (WAC 182-550-2400)	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Physical Exams	Excluded are medical examinations for Social Security Disability (14.15.5.2.) Physical examinations required for obtaining continuing employment, insurance or governmental licensing (14.15.5.4.) Sports physicals (14.15.5.5.) Covered are medical exams including wellness exams for adults and EPSDT for children. (14.14.6.1)	Covered are preventive care services provided as described in the schedule provided by the health Plan. (MHW member handbook) No co-pay/coinsurance or deductible. (pages 230-K & 32) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Physical Therapy	Covered are Neurodevelopmental Services, Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability when provided by a facility that is not a HCA recognized neurodevelopmental center. The Plan may refer children to a HCA recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of the HO contract are met (14.14.11) As of April 1, 2011 Limits have been placed on PT/OT/ST. See WAC 182-545-0200 & HCA Outpatient Rehabilitation Billing Instructions for more information	Covered are inpatient and outpatient chiropractic, occupational, and physical therapy services for only post-operative treatment of reconstructive joint surgery when received within one year following surgery. A combined maximum of 12 visits per calendar year are covered, but no more than six visits can be covered for chiropractic care. Diagnostic or other imaging procedures solely for determination of therapy service are not covered. (pages 27-B #7 & 33) Covered chiropractic services may be referred or self-referred to contracted providers. Covered as specialty care, $15 co-pay for consultation. 20% coinsurance, deductible applies. *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Plastic & Reconstructive Surgery	Excluded are services for which plastic surgery or other services are indicated primarily for cosmetic reasons. (14.15.5.3) Covered are services to correct defects from birth, illness, or trauma, or for mastectomy reconstruction. (14.14.6.8)	Excluded are cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in the Schedule of Benefits. (page 35-B #25) Covered are plastic and reconstructive services (including implants) to correct a physical functional disorder following congenital disease or anomaly, or injury, or incidental to covered surgery and for members receiving benefits in connection with a mastectomy. Subject to 20% coinsurance, deductible applies. $300 max facility charge. (page 30-J) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Podiatry	Covered are services for children under age 21. For adults age 21 and older coverage is based on diagnosis (HCA Physician-Related Services/Healthcare Professional Services Billing Instructions PagesA.6, D.19-D.24, J7-J8)	Excluded are orthopedic shoes and routine foot care. (page 35-B #19)
Pre-existing Conditions	The plan is responsible for covering medically necessary services…(7.13.6 & 14.1 – 14.1.1.3)	Beginning January 1, 2012 there is no waiting period for pre-existing conditions. (page 22)

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Prenatal Care	Covered is maternity care. (14.14.6.3)	See Maternity Care For BH enrollees determined eligible for medical assistance through Medicaid, BH only covers maternity care for a period not to exceed 30 days following diagnosis of pregnancy. Confirmed by a medical provider. (page 22-23) For enrollees determined ineligible for medical assistance through Medicaid covered are diagnosis of pregnancy, full prenatal care after pregnancy is confirmed, delivery, postpartum care, care for complications of pregnancy, preventive care, physician services, hospital services, operating or other special procedure rooms, radiology and lab services, medications, anesthesia, normal newborn care such as but not limited to nursery services, pediatric exams and termination of pregnancy (including voluntary termination of pregnancy). No co-pay/coinsurance or deductible. (pages 27-C & 32) If enrollee does not apply for medical assistance (the Maternity Benefits Program) BH will not cover the cost of any maternity services beyond 30 days after pregnancy is confirmed by a medical provider. (pages 22-23) HCTC enrollees are not required to apply for the medical assistance Maternity Benefits Program. HCTC BH covers maternity benefits as described on page 30 of state's member handbook for members "determined ineligible for medical assistance through Medicaid." (see ineligible above). (pages 27-C, 37-38) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Prenatal Genetic Counseling	Excluded -covered by HCA - Prenatal diagnosis genetic counseling is provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing. (14.15.3.17) See Genetic Services	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Prescriptions	Excluded are pharmaceutical products prescribed by any provider related to services provided under a separate contract with HCA. (14.15.3.13) Example: Providers mentioned in 14.15.4 (e.g. Substance Abuse treatment 14.15.4.1) Covered are prescription drug products according to a HCA approved formulary which includes both legend and over the counter (OTC) products. The plan's formulary shall include all therapeutic classes in HCA's FFS drug file and a sufficient variety of drugs in each therapeutic class to meet enrollees' medically necessary health care needs. The plan shall provide contracted pharmacies and providers with its formulary and info about how to request non-formulary drugs.	Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determines no formulary drugs are an acceptable medication for the patient. Basic Health covers drugs of all types including prescribed creams, ointments and injections. Prescriptions are not subject to the deductible and will not apply towards the annual out-of-pocket max. Prescriptions are limited to a 30-day supply. Drugs for cosmetic purposes are excluded unless preauthorized.

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
	Covered drug products shall include: enteral and parenteral nutritional supplements and supplies including prescribed infant formulas, FDA approved contraceptive drugs, devices and supplies; including but not limited to Depo-Provera, Norplant and OTC products, antigens and allergens, therapeutic vitamins and iron prescribed for prenatal and postnatal care. (14.14.12) Glucometers are covered under MHW policy that provides TrueTrack or True Result glucometer. Requests for other glucometers require prior authorization through Pharmacy on Pharmacy Request Form to demonstrate why member must use other meter.	Covered - under a two tiered system: **Generic drugs**, all oral contraceptives and diabetic supplies (syringes, needles, diabetic test strips, lancets and insulin) Inhaled short-acting beta-agonists, inhaled steroids, inhaled anticholinergic bronchodilators, beta-blockers for severe heart failure, and anti-platelet clotting inhibitors for patients after intra-arterial stent placement in the Plan's formulary - $10 **Brand name drugs** in the Plan's formulary - 50% (pages 31-L [Tier 1 & 2] & 32) Covered are contraceptive supplies and devices (such as but not limited to IUDs, diaphragms, cervical caps, long-acting progestational agents). Over-the-counter supplies such as condoms and spermicides are covered only when part of plan protocol at plan discretion. (page 27-B #9) IV Drug Therapy - Covered under other professional services. 20% coinsurance deductible applies. (page 33) Glucometers are covered under MHW policy that provides TrueTrack or True Result glucometer. Requests for other glucometers require prior authorization through Pharmacy on Pharmacy Request Form to demonstrate why member must use other meter. Emergency Care/Prescription Drugs - Prescription drugs purchased from a non-contracted facility or pharmacy are covered subject to applicable co-pay when in connection with covered emergency treatment. (page 29-G #4) Excluded is replacement of lost or stolen medications. (page 35-B #29)

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
		American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.
Preventive Care	Covered are medical examinations including wellness exams for adults and EPSDT for children. (14.14.6.1) See preventive care guidelines in MHW Member Handbook.	Covered are routine physicals, immunizations, PAP tests, mammograms and other screening and testing when provided as part of the preventive care visit. No co-pay/coinsurance or deductible. (page 32) See preventive care guidelines in MHW Member Handbook.
Prosthetic Limbs	See Durable Medical Equipment, Prosthetics and Supplies	See Durable Medical Equipment Excluded (page 36-B #21)
Pulmonary Rehab	Excluded- Pulmonary ICD9 procedure codes 786.52 (symptoms involving respiratory system and other chest symptoms) & 496 (chronic airway obstruction not elsewhere classified) HCPCS codes G0237 & G0238 appear as # (not covered). (RBRVS Physician Related Fee Schedule in the Physician Related Services Billing Instructions)	Not specifically listed as covered. Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Psychiatric Disorders	See Mental Health	See Mental Health
Radial Keratotomy	See Plastic Surgery	Excluded (page 35-B #25)

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Molina Healthcare of Washington, Inc. (MHW) Benefits Index

All covered services must be MEDICALLY NECESSARY and are SUBJECT TO PREAUTHORIZATION TABLE REQUIREMENTS. Reference or page numbers refer to the contract, DSHS/HCA Billing Instructions, schedule of benefits or WAC.

2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Radiology	Covered are laboratory, radiology and other medical imaging services: screening and diagnostic services and radiation therapy. (14.14.8)	Covered is radiology. 20% coinsurance/deductible applies except for outpatient x-ray and ultrasound and other screening and testing when provided as part of the preventive care visit. (page 27-B #2 & 33) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Reconstructive Surgery	See Plastic Surgery	See Plastic Surgery
Second Opinions	The Plan must authorize a second opinion regarding the enrollee's health care from a qualified health care professional within the Plan's network, or authorize for the enrollee to obtain a second opinion outside the Plan's network, if the Plan's network is unable to provide for a qualified health care professional, at no cost to the enrollee. (14.9.)	Covered are provider visits including diagnosis and treatment in the hospital, outpatient facility or office consultations, treatment and second opinions by the PCP or by a referral provider. (page 27-B #5) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Skilled Nursing Facilities	Covered are inpatient services provided by acute care hospitals (licensed under RCW 70.41) or nursing facilities (licensed under RCW 18.51) when nursing facility services are not covered by DSHS's Aging and Disability Services Administration and the Plan determines that nursing facility care is more appropriate than acute hospital care. Inpatient physical rehabilitation services are included. (14.14.2) Aging and Disability Services Administration - 360-725-2300; ask for the number of the local Home & Community Service (HCS) office. HCS arranges for the ADSA assessment.	Covered are skilled nursing and home health care benefits as an alternative to hospitalization in acute care facility the Plan, at it's discretion may authorize benefits for services of a skilled nursing facility or home health care agency. No co-pay/coinsurance or deductible (pages 30-H & 32)
Sleep Disorders	Covered as a medical condition.	Covered as a medical condition. One sleep study per member per calendar year. (page 34-B #8)

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Molina Healthcare of Washington, Inc. (MHW) Benefits Index

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2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
		American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.
Smoking Cessation	Covered are smoking cessation services. (14.14.20) MHW policy- Covered for all members 18 and over. Limit three enrollments per lifetime unless pregnant (Benefits Determination Committee 11/21/2003).	MHW policy covered for all members 18 and over. Limit three enrollments per lifetime unless pregnant. (Benefits Determination Committee 11/21/2003) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Speech Therapy	See Physical Therapy	Excluded are Speech and Recreation Therapy. (page 35-B #20)
Spinal Manipulations	See Chiropractic Care	See Chiropractic Care
Sterilization (Tubal Ligation or Vasectomy)	Covered for enrollees over age 21. The plan shall assure all sterilizations and hysterectomies performed under the contract are in compliance with 42 CFR 441 Subpart F and that the HCA Sterilization Consent Form or its equivalent is used. (14.10, HCA Physician Related Services/Healthcare Professional Services Billing Instructions G.23 - G.33.	Covered – co-pay is $15, office visit. Outpatient surgery - 20% coinsurance, deductible applies. Inpatient surgery - 20% coinsurance, deductible applies. $300 max facility charge. (page 27-B #9) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
	Excluded are sterilizations for enrollees under age 21 or those that do not meet other federal requirements (42 CFR 441 Subpart F). (14.15.3.8) Covered through Medicaid Fee-For-Service - HCA sterilization consent form must be completed see above. Excluded is reversal of voluntary induced sterilization. (14.15.5.6)	Excluded is reversal of sterilization. (page 35-B #14)
Supplies (Non-Durable)	See Durable Medical Equipment, Prosthetics and Supplies	Excluded (page 35-B #21)
TMJ	See Dental Care	Excluded (page 35-B #22)

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Molina Healthcare of Washington, Inc. (MHW) Benefits Index

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Reference or page numbers refer to the contract, DSHS/HCA Billing Instructions, schedule of benefits or WAC.

2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
Transplants	See Organ Transplants	See Organ Transplants
Travel Immunizations	Excluded are immunizations required for international travel purposes only. (14.15.5.14)	Excluded are immunizations for the purpose of travel, employment or required because of where you reside. (page 34-B #10)
Urgent Care	Covered are urgent care services associated with the presentation of medical signs that require immediate attention but are not life threatening. (14.1.12.2)	Covered is urgent care $15 co-pay for office visit only when provided in an urgent care setting. Deductible and coinsurance apply to all other services. (page 32) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Vaccinations (Immunizations)	Covered are immunizations. (14.14.6.2, HCA Professional-Related Services/ Healthcare Professional Services Billing Instructions pages C.1-C.10.) See preventive care schedule in Plan member handbook. Covered is HPV (HCA Prescription Drug Program Billing Instructions page F.12). • Ages 9-18 # 90649 SL (SL shows received through DOH program for kids.) • Ages 19-20 #90649 no SL modifier & #90471 for administration.	Covered are routine physicals, immunizations, PAP tests, mammograms and other screening and testing when provided as part of the preventive care visit. No co-pay/coinsurance or deductible.(page 30-K & 34-B #10) See preventive care schedule in Plan member handbook.
Vasectomy	See Sterilization	See Sterilization
Vocational Rehabilitation	Long term in-depth vocational rehabilitation is covered through DSHS Fee-For-Service under the Division of Vocational Rehabilitation (http://www.dshs.wa.gov/dvr/).	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1)

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Molina Healthcare of Washington, Inc. (MHW) Benefits Index

All covered services must be MEDICALLY NECESSARY and are SUBJECT TO PREAUTHORIZATION TABLE REQUIREMENTS.
Reference or page numbers refer to the contract, DSHS/HCA Billing Instructions, schedule of benefits or WAC.

2012	HO, CHIP, BH Plus and BH Maternity	Basic Health (Deductible Applies to Services with Coinsurance)
	Short term- See Physical Therapy	*American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Vitamins	Covered are therapeutic vitamins and iron prescribed for prenatal and postnatal care. (14.14.12.4.4)	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Vision Therapy	Covered. (14.15.5.3, HCA Professional-Related Services/ Healthcare Professional Services Billing Instructions page B.42)	Excluded is any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracted provider and prior authorized by the Plan. (page 34-B #1) *American Indian/Alaska Native (AI/AN) members receive benefits without having to pay co-pays, deductible or coinsurance.*
Weight Loss Drugs	Excluded (HCA Fee-For-Service Prescription Drug Program Billing Instructions C.1- C.4) See Weight Loss Treatments	Excluded are 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). (pages 35-B #23-24)
Weight Loss Treatments	Excluded is weight reduction and control services, procedures, treatments, devices, drugs, products, gym memberships, equipment for the purpose of weight reduction, or the application of associated services. (WAC 182-531-0150) See Gastroplasty.	Excluded are 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). (pages 35-B #23-24)