COMMUNITY HEALTH PLAN of Washington™

The power of community

INDIVIDUAL & FAMILY PLANS

2025 Schedule of Benefits

Cascade Select Bronze Plan

CONTACT INFORMATION

Where to Send Claims

MAIL YOUR CLAIMS TO
CHP Claims
PO Box 269002
Plano, TX 75026-9002

MAIL YOUR PRESCRIPTION DRUG CLAIMS TO
Express Scripts, Inc.
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711
Fax: (608) 741-5475

Contact the Pharmacy Benefit Administrator at
Phone: (866) 907-1906
www.express-scripts.com

Customer Service

Mailing Address
Community Health Plan of Washington
1111 Third Avenue, Suite 400
Seattle, WA 98101

Phone Numbers
Local and toll-free: (866) 907-1906 (TTY:711)

Complaints and Appeals

Feedback
Community Health Plan of Washington
Attn: Customer Experience Manager
1111 Third Avenue, Suite 400, Seattle, WA 98101
Phone: (866) 907-1906
Fax: (206) 613-8984

Appeals
Community Health Plan of Washington
Attn: Appeals Coordinator
1111 Third Avenue, Suite 400, Seattle, WA 98101
Phone: (866) 907-1906
Fax: (206) 613-8984

Website

Visit our website **individualandfamily.chpw.org** for more information and secure online access to claims information in your myCHPW member portal.

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Your Provider Network is: CHPW Cascade Care Affiliates Network

Deductible and Out-of-Pocket Maximums	For Network Providers, You Pay*	
Annual Medical and Pharmacy Integrated Deductible (per Calendar Year)	**$6,000** Individual	**$12,000** Family
Annual Medical and Pharmacy Integrated Out-of-Pocket Maximum (per Calendar Year)	**$9,200** Individual	**$18,400** Family

*For Out-of-Network providers you pay 100% of cost

Schedule of Medical Benefits

Medical and Surgical Services, Behavioral Health Services, and Professionally Administered Medications have specific Pre-Authorization requirements which must be met. Pre-Authorization requirements can be found on the CHPW website. You may request a paper copy be mailed to you by calling Customer Service.

Community Health Plan of Washington Cascade Select Bronze	
Benefit	For Network Providers, You Pay*
Acupuncture Limited to 12 visits per calendar year. (Unlimited visits for chemical dependency treatment.)	**$50 Copay**
Ambulance Services (Cost-sharing for Emergency Care Services is the same whether a member obtains services from an in-network or out-of-network provider in an emergency situation)	**40% Coinsurance after Deductible**
Autologous Blood Donation/Blood Transfusion	**40% Coinsurance after Deductible**
Chemotherapy and Radiation	**40% Coinsurance after Deductible**

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Community Health Plan of Washington Cascade Select Bronze	
Benefit	For Network Providers, You Pay*
Dental Anesthesia	**40% Coinsurance after Deductible**
Diabetes Care Management	**You pay nothing**
Diabetic Education and Diabetic Nutrition Education	**You pay nothing**
Dialysis Services	**40% Coinsurance after Deductible**
Durable Medical Equipment	**40% Coinsurance after Deductible**
Emergency Care Services (Cost-sharing for Emergency Care Services is the same whether a member obtains services from an in-network or out-of-network provider in an emergency situation)	Emergency Care Services (facility and professional) **40% Coinsurance after Deductible**

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Community Health Plan of Washington Cascade Select Bronze	
Benefit	For Network Providers, You Pay*
 **Gender Affirming Care**	Gender Affirming Care includes health care services prescribed to treat any condition related to the individual's gender identity and may include primary care visits, specialty care, outpatient mental health services, prescription drug benefits, and surgical services. See associated cost-sharing for those services.
 **Genetic Services**	**40% Coinsurance after Deductible** (Testing and associated services)
 **Habilitation Services** Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices	Inpatient (facility and professional) **40% Coinsurance after Deductible** Outpatient (facility and professional) **40% Coinsurance after Deductible** Includes physical, speech, and occupational therapies. 25-visit maximum for all habilitation therapy services combined per Calendar Year.
 **Hearing**	Cochlear Implants **40% Coinsurance after Deductible**

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Benefit	For Network Providers, You Pay*
Home Health Care Limited to 130 visits per Calendar Year	**$50 Copay per day**
Hospice	Hospice Care **$50 Copay per day** Respite Care **$50 Copay per day** 14 days lifetime maximum
Hospital Inpatient Medical and Surgical Care	Inpatient (facility and professional) **40% Coinsurance after Deductible** Inpatient professional services (assistant surgeon, radiologist, pathologist) **Included with facility coinsurance** Inpatient professional (surgeon) **Included with facility coinsurance**

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Benefit	For Network Providers, You Pay*
Hospital Outpatient Surgery and Services	Outpatient surgery professional services (surgeon, assistant surgeon, radiologist, pathologist) **40% Coinsurance after Deductible** Outpatient Facility Fee (e.g. Ambulatory Surgery Center) **40% Coinsurance after Deductible**
Infertility Diagnostic Services Limited benefit, see *Infertility Diagnostic Services* section of the Policy (Evidence of Coverage) for details	**40% Coinsurance after Deductible**
Infusion Therapy Includes infusion therapy provided in the home	Coverage is based on place of service. Infusion therapies provided as part of an inpatient Hospital stay or Office Visit are covered under those benefits (see associated cost sharing). Services performed at-home or at a freestanding infusion site are covered under Office Visit (see associated cost sharing).

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Benefit	For Network Providers, You Pay*
Inherited Metabolic Disorder – PKU Services	**40% Coinsurance after Deductible**
Lab and Radiology Services (non-routine, facility and professional services)	Laboratory Outpatient and Professional Services **40% Coinsurance after Deductible** X-Rays and Diagnostic Imaging **40% Coinsurance after Deductible** Complex Imaging (Such as MRI, CT, PET) **40% Coinsurance after Deductible**

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Benefit	For Network Providers, You Pay*
Maternity and Newborn Care	Delivery and all inpatient services for Maternity Care **40% Coinsurance after Deductible** Prenatal Diagnosis of Congenital Anomalies **$50 Copay** Eligible for two visits at $1 copay, after which $50 copay applies. Maternity Specialty Care (global professional fee and all prenatal and postnatal care, except for Preventive Services) **$50 Copay** Eligible for two visits at $1 copay, after which $50 copay applies. Termination of Pregnancy (Voluntary termination of pregnancy services) **You Pay Nothing** Newborn Care (well baby care) **You Pay Nothing**
Mental/Behavioral Health Care	Inpatient (facility and professional) **40% Coinsurance after Deductible** Mental/Behavioral Health Outpatient Services: Office Visit **$50 Copay** Eligible for two visits at $1 copay, after which $50 copay applies. This two-visit allowance is shared with Substance Use Disorder Outpatient Services. Mental/Behavioral Health: Other Outpatient Professional and Facility Services **40% Coinsurance after Deductible**

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Benefit	For Network Providers, You Pay*
 **Nutritional Counseling** also see Diabetic Education and Diabetic Nutrition Education	**$50 Copay** Eligible for two visits at $1 copay, after which $50 copay applies.
 **Pediatric Vision (under age 19)** Administered by VSP	Routine Vision Screening **You Pay Nothing** 1 exam per Calendar Year Low Vision Evaluation **You Pay Nothing** (Comprehensive low vision evaluation every five years) Comprehensive Eye Exam **You Pay Nothing** (Including dilation as professionally indicated and with refraction) 1 exam per Calendar Year Vision Hardware **You Pay Nothing** Limited to children under age 19. One pair of prescription lenses or contacts every Calendar Year, including polycarbonate lenses and scratch-resistant coating. One pair of frames per Calendar Year, or contact lenses (in lieu or lenses and frames). Includes fitting fee.
 **Podiatric Care** Podiatric Care includes Routine Foot Care, which is covered for diabetics only.	**You Pay Nothing**

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 **Prescription Drugs** Administered by Express Scripts, Inc.	Generic Drugs **$32 Copay per 30-day supply** **$86.40 Copay per 90-day supply** Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order. Preferred Drugs **40% Coinsurance after Deductible per 30-day supply** **40% Coinsurance after Deductible 90-day supply** Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order. Non-Preferred Drugs **40% Coinsurance after Deductible per 30-day supply** Coverage is limited to a 30-day supply Specialty Drugs **40% Coinsurance after Deductible** Coverage is limited to a 30-day supply at specialty pharmacy. Asthma inhalers (corticosteroid, and corticosteroid combination), EpiPens, epinephrine auto injectors & Insulin *Member cost-sharing for asthma inhalers (corticosteroid and inhaled corticosteroid combination), EpiPens, epinephrine auto injectors (products containing at least 2 autoinjectors) & insulin as follows: (1) cap total monthly OOP at $35/30-day supply; (2) asthma inhalers (corticosteroid & corticosteroid combination), EpiPens, epinephrine auto injectors & insulin are not subject to deductible.* Contraceptive Drugs & Devices **You Pay Nothing** *(including OTC oral contraceptive drugs and devices, products, and barrier methods, including condoms)* Tobacco Cessation Drugs **You Pay Nothing** *(Nicotine Habit Breaking/ Stop Smoking Drugs)*

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 **Preventive Care** Limits listed are a guideline only. These limits are not meant to be benefit limitations. Preventive Care Services are covered in accordance with the recommendations set forth by the US Preventive Services Task Force ("USPSTF") and the Health Resources and Services Administration ("HRSA"). Here is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See "Preventive Care" in the Evidence of Coverage for more details.	Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. **You Pay Nothing** Mammography Diagnostic and supplemental breast examinations, including diagnostic mammography, digital tomosynthesis (3D mammography), MRI, or ultrasound. **You Pay Nothing** Periodic Exams (adult and child) **You Pay Nothing** Routine Maternity Care Routine maternity care (prenatal and postnatal) including prenatal exams and tests, breastfeeding support and counseling. **You Pay Nothing**
 **Professional/Physician Services (Office and Telehealth visits)**	Primary Care Provider **$50 Copay per visit** Eligible for two visits at $1 copay, after which $50 copay applies. (Including naturopaths, nurse practitioners, and physician assistants) Specialist **$100 Copay per visit after Deductible** Specialist visit performed by a naturopath, nurse practitioner, or physician assistant that is not your PCP, then $50 copay per visit after the deductible. Does not apply if this type of provider is PCP. Mental/Behavioral Health and Substance Use Disorder Providers **$50 Copay per visit** Eligible for two visits at $1 copay, after which $50 copay applies.

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 **Reconstructive Surgery**	Reconstructive Surgery may include outpatient and inpatient surgical services. See associated cost-sharing for those services.
 **Rehabilitation Therapy**	Inpatient (facility and professional) **40% Coinsurance after Deductible** 30 days per Calendar Year. Outpatient (facility and professional) **40% Coinsurance after Deductible** Includes physical, speech, and occupational therapies. 25-visit maximum for all rehabilitation therapy services combined per Calendar Year.
 **Skilled Nursing Facility**	**40% Coinsurance after Deductible** 60 days per Calendar Year
 **Spinal Manipulations**	**$50 Copay** 10 visits per Calendar Year

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Benefit	For Network Providers, You Pay*
 **Substance Use Disorder (Chemical Dependency)**	Inpatient (facility and professional) **40% Coinsurance after Deductible** Office Visits **$50 Copay per visit** Eligible for two visits at $1 copay, after which $50 copay applies. This two-visit allowance is shared with Mental/Behavioral Health Outpatient Services. Other Outpatient Professional and Facility Services **40% Coinsurance after Deductible**
 **Temporomandibular Joint Disorder Services**	**40% Coinsurance after Deductible**
 **Urgent Care**	**$100 Copay**

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Contact us

Prospective Members
1-833-993-0181

Current Members
1-866-907-1906

TTY: 711

8 a.m. to 5 p.m.
Monday through Friday

1111 3rd Ave, Suite 400
Seattle, WA 98101-3207

individualandfamily.chpw.org