Community Health Plan of Washington





2026 Schedule of Benefits
Cascade Select

COMMUNITY HEALTH PLAN of Washington™
The power of community

INDIVIDUAL & FAMILY PLANS

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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2026 Schedule of Benefits

Community Health Plan of Washington Cascade Select Bronze

The Schedule of Benefits is a summary of services with applicable cost shares covered under your plan. Benefits listed are subject to all provisions and limitations as outlined in the Evidence of Coverage (EOC). Please refer to the EOC for details regarding the benefits listed below.

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)	**$10,150** Individual	**$20,300** Family

*For Out-of-Network providers you pay 100% of cost, except where indicated

Schedule of 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.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are only required to pay the in-network cost shares. Please refer to the EOC for details regarding your rights under Washington's Balance Billing Protection Act.

Community Health Plan of Washington Cascade Select Bronze	
Benefit	For Network Providers, You Pay*
 **Acupuncture**	**$40 Copay per visit** First two visits at $1 copay, after which stated cost-sharing applies. This two-visit allowance is shared with Primary Care Provider (PCP)/Other Practitioner visits and Spinal Manipulations/Chiropractic Care visits.
 **Allergy Testing**	**$100 Copay per visit**
 **Ambulance Services for Emergency Transportation** 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** Includes Self-Administered Cancer Chemotherapy Medications.

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Community Health Plan of Washington Cascade Select Bronze	
Benefit	For Network Providers, You Pay*
Dental Anesthesia	Anesthesiologist **40% Coinsurance after Deductible** Refer to Hospital Inpatient and Outpatient benefits for surgical services.
Diabetes Care Management	**You pay nothing** Includes diabetes retinal examinations.
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 Instruments	Hearing Instruments **40% Coinsurance** Includes bone conduction hearing devices and cochlear implants. Hearing Exams $40 Copay per visit Limited to 1 hearing exam per Calendar Year and 1 hearing aid per ear every 3 years. Hearing exams are eligible for first two visits at $1 copay, after which stated cost-sharing. This two-visit allowance is shared with Acupuncture and Spinal Manipulations/Chiropractic Care visits.

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Benefit	For Network Providers, You Pay*
Home Health Care	**$50 Copay per day** 130 visits per Calendar Year
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** Sleep Studies **40% Coinsurance after Deductible**
Infertility Diagnostic and Treatment Services Limited benefit includes Artificial Insemination, see ***Infertility Diagnostic and Treatment 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** Routine maternity care (prenatal and postnatal) including prenatal exams and tests, breastfeeding support and counseling, covered under Preventive Care.	Delivery and all inpatient services for Maternity Care **40% Coinsurance after Deductible** Prenatal Diagnosis of Congenital Anomalies **$40 Copay per visit** Eligible for two visits at $1 copay per visit, after which $40 copay per visit applies. Maternity Specialty Care (Global professional fee and all prenatal and postnatal care, except for Preventive Services) **$40 Copay per visit** First two visits at $1 copay, after which stated cost-sharing applies. This two-visit allowance is shared with Acupuncture and Spinal Manipulations/Chiropractic Care visits. Termination of Pregnancy (Voluntary termination of pregnancy services) **You Pay Nothing** Newborn Care (well baby care) **You Pay Nothing** Donor Human Milk **You Pay Nothing** As part of inpatient services for Newborn Care.
 **Mental/Behavioral Health Care**	Inpatient (facility and professional) **40% Coinsurance after Deductible** Mental/Behavioral Health Outpatient Services: Office Visit **$40 Copay per visit** Eligible for two visits at $1 copay per visit, after which $40 copay per visit 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** Prescription Drugs Prescription Drugs prescribed during an inpatient admission or on an outpatient basis related to Mental Health are covered. **See Prescription Drugs for associated cost-sharing details.**

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Benefit	For Network Providers, You Pay*
 **Nutritional Counseling** Also see Diabetic Education and Diabetic Nutrition Education	**You Pay Nothing**
 **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 of lenses and frames). Includes fitting fee.
 **Podiatric Care** Limited benefit includes Routine Foot Care, which is covered when medically necessary, see Podiatric Care section of the Policy (Evidence of Coverage) for details.	**You Pay Nothing**

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Benefit	For Network Providers, You Pay*
 **Prescription Drugs** Administered by Express Scripts, Inc.	Generic Drugs Tier 1 **$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 Tier 2 **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 Tier 3 **40% Coinsurance after Deductible per 30-day supply** Coverage is limited to a 30-day supply Specialty Drugs Tier 4 **40% Coinsurance after Deductible per 30-day supply** Coverage is limited to a 30-day supply at a 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 (PCP)/Other Practitioner **$40 Copay per visit** First two visits at $1 copay, after which stated cost-sharing applies. This two-visit allowance is shared with Acupuncture and Spinal Manipulations/Chiropractic Care visits. (Including naturopaths, nurse practitioners, and physician assistants) Specialist **$100 Copay per visit** Specialist visit performed by a naturopath, nurse practitioner, or physician assistant that is not your PCP, then $40 copay per visit after the deductible. Does not apply if this type of provider is PCP. Mental/Behavioral Health and Substance Use Disorder Providers **$40 Copay per visit** Eligible for two visits at $1 copay per visit, after which $40 copay per visit applies.

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Reconstructive Surgery Limited benefit, see *Plastic and Reconstructive Procedures* section of the Policy (Evidence of Coverage) for details.	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. Cochlear implants are also covered.
Skilled Nursing Facility	**40% Coinsurance after Deductible** 60 days per Calendar Year
Spinal Manipulations (Chiropractic Care)	**$40 Copay per visit** 10 visits per Calendar Year First two visits at $1 copay, after which stated cost-sharing applies. This two-visit allowance is shared with Primary Care Provider (PCP)/Other Practitioner and Acupuncture visits.

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 **Substance Use Disorder**	Inpatient (facility and professional) **40% Coinsurance after Deductible** Office Visits **$40 Copay per visit** Eligible for two visits at $1 copay per visit, after which $40 copay per visit applies. This two-visit allowance is shared with Mental/Behavioral Health Outpatient Services. Other Outpatient Professional and Facility Services **40% Coinsurance after Deductible** Prescription Drugs Prescription Drugs prescribed during an inpatient admission or on an outpatient basis related to Substance Use Disorders are covered. **See Prescription Drugs for associated cost-sharing details.**
 **Temporomandibular Joint Disorder Services**	**40% Coinsurance after Deductible**
 **Transplant Services**	**40% Coinsurance after Deductible**
 **Urgent Care**	**$100 Copay per visit** CHPW Virtual Care visits Powered by MD Live **You Pay Nothing**

CHPW Member Incentives Program

CHPW members can earn gift card rewards by participating in the CHPW MemberFirst™ Rewards program by completing certain preventive care screenings for breast cancer, cervical cancer, or colorectal cancer. Visit individualandfamily.chpw.org/member-center/memberfirst-rewards/ to learn more about the program. Reward programs may vary and are subject to change.

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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

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