COMMUNITY HEALTH PLAN of Washington™

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INDIVIDUAL & FAMILY PLANS

2024 Schedule of Benefits

Cascade Select Bronze Limited Cost Share Plan

Schedule of Benefits

Your Provider Network is: CHPW Cascade Care Affiliates Network

Community Health Plan of Washington Cascade Select Bronze Limited Cost Sharing

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

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 Limited Cost Sharing		
Benefit	**For Network Provider, 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

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Benefit	**For Network Provider, You Pay**	
Chemotherapy and Radiation	40%	Coinsurance after Deductible
Chemical Dependency (Substance Use Disorder)		
• **Inpatient** (facility and professional)	40%	Coinsurance after Deductible
• **Office Visits**	$50 per visit Eligible for two visits at $1 copay, after which $50 copay applies.	Copay
• **Other Outpatient Professional and Facility Services**	40%	Coinsurance after Deductible
Dental Anesthesia	40%	Coinsurance after Deductible
Diabetes Care Management	You Pay Nothing	
Diabetic Education and Diabetic Nutrition Education		
• **In Office**	You Pay Nothing	
Dialysis Services	40%	Coinsurance after Deductible
Durable Medical Equipment .		
• **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)** Coinsurance waived if admitted as an inpatient within 24 hours.	40%	Coinsurance after Deductible
• **Urgent Care**	$100	Copay

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Benefit	**For Network Provider, 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 (s*ee associated cost sharing)*.		
Genetic Services		
• **Genetic Services** (Testing and associated services)	40%	Coinsurance after Deductible
Habilitation Services Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices.		
• **Inpatient** (facility and professional). **30 days per Calendar Year.**	40%	Coinsurance after Deductible
• **Outpatient** (facility and professional) Includes physical, speech, and occupational therapies. 25-visit maximum for all habilitation therapy services combined per Calendar Year.	40%	Coinsurance after Deductible
Hearing		
• **Cochlear Implants**	40%	Coinsurance after Deductible
Home Health Care Limited to 130 visits per Calendar Year.		
• **Home Health Care**	$50 per day	Copay
Hospice		
• **Hospice Care**	$50 per day	Copay

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Benefit	**For Network Provider, You Pay**	
• **Respite Care** 14 days lifetime maximum	$50 per day	Copay
Hospital Inpatient Medical and Surgical Care		
• **Inpatient (facility and professional)**	40%	Coinsurance after Deductible
• **Inpatient professional** (surgeon)	Included with facility coinsurance	Coinsurance after Deductible
• **Inpatient professional services** (assistant surgeon, radiologist, pathologist)	Included with facility coinsurance	Coinsurance after Deductible
Hospital Outpatient Surgery and Services		
• **Outpatient surgery professional services** (surgeon)	40%	Coinsurance after Deductible
• **Outpatient surgery professional services** (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 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).*	
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

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Benefit	**For Network Provider, You Pay**	
• **X-Rays and Diagnostic Imaging**	40%	Coinsurance after Deductible
• **Complex Imaging** (Such as MRI, CT, PET)	40%	Coinsurance after Deductible
Maternity and Newborn Care		
• **Delivery and All Inpatient Services for Maternity Care**	40%	Coinsurance after Deductible
• **Prenatal Diagnosis of Congenital Anomalies**	$50 As part of your primary care visits, you are eligible for two visits at $1 copay, after which $50 copay applies.	Copay
• **Maternity specialty care** (global professional fee and all prenatal and postnatal care, except for Preventive Services)	$50 As part of your primary care visits, you are eligible for two visits at $1 copay, after which $50 copay applies.	Copay
• **Termination of Pregnancy** (Voluntary termination of pregnancy services)	You Pay Nothing	
• **Newborn care**	You Pay Nothing	
Mental/Behavioral Health Care		
• **Inpatient** (facility and professional)	40%	Coinsurance after Deductible
• **Outpatient Services:** Office Visit	$50 Eligible for two visits at $1 copay, after which $50 copay applies.	Copay

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Benefit	**For Network Provider, You Pay**	
Outpatient Services: Other Outpatient Professional and Facility Services	40%	Coinsurance after Deductible
Prescription Drugs	Administered by Express Scripts, Inc.	
• **Generic Drugs**	$32 per 30-day supply $86.40 per 90-day supply	Copay Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
• **Preferred Brand Drugs**	40% per 30-day supply 40% per 90-day supply	Coinsurance after Deductible. Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
• **Non-Preferred Brand Drugs**	40% per 30-day supply	Coinsurance after Deductible. Coverage is limited to a 30-day supply
• **Specialty Drugs** (exception: Insulin)	40% per 30-day supply *Member cost-sharing for insulin as follows: (1) cap total monthly OOP at $35 / 30-day supply; (2) insulin is not subject to deductible	Coinsurance after Deductible. Coverage is limited to a 30-day supply at specialty pharmacy.
• **Contraceptive Drugs & Devices** (including OTC oral contraceptive drugs and devices, products, and barrier methods, including condoms)	You Pay Nothing	
Podiatric Care *Podiatric Care* includes *Routine Foot Care,* which is covered for diabetics only.	You Pay Nothing	

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Preventive Care Limits listed below 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"). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See *Preventive Care* 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. See *Preventive Care* for details.	You Pay Nothing	
Preventive Care Limits listed below are a guideline only. These limits are not meant to be benefit limitations.		You Pay Nothing
Periodic Exams (adult and child)	You Pay Nothing	
Nutritional Counseling	$50 As part of your primary care visits, you are eligible for two visits at $1 copay, after which $50 copay applies.	Copay
Professional/Physician Services (office visits)		
• **Primary Care Provider** (including naturopaths, nurse practitioners, and physician assistants); includes Telehealth Visits	$50 per visit Eligible for two visits at $1 copay, after which $50 copay applies.	Copay

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Benefit	**For Network Provider, You Pay**	
• **Specialist** • Specialist Visit performed by a naturopath, nurse practitioner, or physician assistant that is not your PCP, then $50 copay per visit. Does not apply if this type of provider is PCP.	$100 per visit	Copay after Deductible
• **Mental/Behavioral Health and Substance Use Disorder Providers**	$50 per visit Eligible for two visits at $1 copay, after which $50 copay applies.	Copay
Reconstructive Surgery	40%	Coinsurance after Deductible
Rehabilitation Therapy		
• **Inpatient** (facility and professional). **30 days per Calendar Year.**	40%	Coinsurance after Deductible
• **Outpatient** (facility and professional) Includes physical, speech, and occupational therapies. **25-visit maximum for all rehabilitation therapy services combined per Calendar Year.**	40%	Coinsurance after Deductible
Skilled Nursing Facility 60 days per Calendar Year	40%	Coinsurance after Deductible
Spinal Manipulations 10 visits per Calendar Year. *Applies to Chiropractors only. Other providers e.g. D.O. 40% after deductible, not subject to the 10 visit limit.	*$50	Copay

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Benefit	**For Network Provider, You Pay**	
Temporomandibular Joint Disorder Services	40%	Coinsurance after Deductible
Pediatric Vision (under age 19)	**Administered by Vision Service Plan (VSP)**	
• **Routine Vision Screening** 1 exam per Calendar Year.	You Pay Nothing	
• **Low Vision Evaluation** (Comprehensive low vision evaluation every five years)	You Pay Nothing	
• **Comprehensive Eye Exam** (including dilation as professionally indicated and with refraction) 1 exam per Calendar Year.	You Pay Nothing	
• **Vision Hardware** 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.	You Pay Nothing	

Note: These benefits assume the patient received care from an Indian Health Care Provider (IHCP) or with IHCP referral at a non-IHCP provider.

Cost-sharing is waived for IHCP providers and at non-IHCP providers with IHCP referral. If you receive care from a non-IHCP provider without a referral from an IHCP provider, your costs may be higher.

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INDIVIDUAL & FAMILY PLANS

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