Community Health Plan of Washington

# 2027 Schedule of Benefits
## Cascade Select

COMMUNITY HEALTH PLAN of Washington™
The power of community

INDIVIDUAL & FAMILY PLANS

**Silver AI/AN Limited Cost Share 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
1700 7th Ave, Suite 900
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
1700 7th Ave, Suite 900, Seattle, WA 98101
Phone: (866) 907-1906
Fax: (206) 613-8984

**Appeals**
Community Health Plan of Washington
Attn: Appeals Coordinator
1700 7th Ave, Suite 900, 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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# 2027 Schedule of Benefits

## Community Health Plan of Washington Cascade Select Silver Limited Cost Sharing

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 on the CHPW website 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)** | **$2,800** Individual | **$5,600** Family |
| **Annual Medical and Pharmacy Integrated Out-of-Pocket Maximum (per Calendar Year)** | **$11,200** Individual | **$22,400** 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 Prior-Authorization requirements which must be met. Prior-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.

| Benefit | **Community Health Plan of Washington Cascade Select Silver Limited Cost Sharing**<br>For Network Providers, You Pay* |
|---|---|
| <br>**Acupuncture** | **$20 Copay per visit**<br>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. |
| <br>**Allergy Testing** | **$65 Copay per visit** |
| <br>**Ambulance Services for Emergency Transportation**<br>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. | **$375 Copay per trip** |
| <br>**Autologous Blood Donation/Blood Transfusion** | **30% Coinsurance after Deductible** |
| <br>**Chemotherapy and Radiation** | **30% Coinsurance after Deductible**<br>Includes Self-Administered Cancer Chemotherapy Medications. |

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|---|---|
| Benefit | For Network Providers, You Pay* |
| **Dental Anesthesia** | Anesthesiologist<br>**30% Coinsurance after Deductible**<br>Refer to *Hospital Inpatient* and *Outpatient* benefits for surgical services. |
| **Diabetes Care Management** | **You Pay Nothing**<br>Includes diabetes retinal examinations. |
| **Diabetic Education and Diabetic Nutrition Education** | **You Pay Nothing** |
| **Dialysis Services** | **30% Coinsurance after Deductible** |
| **Durable Medical Equipment** | **30% Coinsurance after Deductible** |
| **Emergency Care Services**<br>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)<br>**$800 Copay per visit after Deductible**<br>Copay waived if admitted as inpatient within 24 hours. |

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|---|---|
| Benefit | For Network Providers, You Pay* |
| <br>**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. |
| <br>**Habilitation Services**<br>Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices | Inpatient (facility and professional)<br>**$800 Copay per day after Deductible**<br>30 days per Calendar Year. You pay no more than 5 copayments per stay.<br><br>Outpatient (facility and professional)<br>**$40 Copay per visit**<br>Includes physical, speech, and occupational therapies.<br>25-visit maximum for all habilitation therapy services combined per Calendar Year. |
| <br>**Hearing Instruments** | Hearing Instruments<br>**30% Coinsurance**<br>Includes bone conduction hearing devices and cochlear implants.<br><br>Hearing Exams<br>**$20 Copay per visit**<br>Limited to 1 hearing exam per Calendar Year and 1 hearing aid per ear every 3 years.<br><br>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** | **$30 Copay per day**<br>130 visits per Calendar Year |
| **Hospice** | Hospice Care<br>**$30 Copay per day**<br><br>Respite Care<br>**$30 Copay per day**<br>14 days lifetime maximum |
| **Hospital Inpatient Medical and Surgical Care** | Inpatient (facility and professional)<br>**$800 Copay per day after Deductible**<br>You pay no more than 5 copayments per stay.<br><br>Inpatient Professional (surgeon)<br>**Included with facility copay**<br><br>Inpatient Professional Services (assistant surgeon, radiologist, pathologist)<br>**Included with facility copay** |

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| <br>**Hospital Outpatient Surgery and Services** | Outpatient Surgery Professional Services (surgeon, assistant surgeon, radiologist, pathologist)<br>**$200 Copay per visit after Deductible**<br><br>Outpatient Facility Fee<br>(e.g. Ambulatory Surgery Center)<br>**$600 Copay per visit after Deductible**<br><br>Sleep Studies<br>**$600 Copay per visit after Deductible** |
| <br>**Infertility Diagnostic and Treatment Services**<br>Limited benefit includes Artificial Insemination, see ***Infertility Diagnostic and Treatment Services*** section of the Policy (Evidence of Coverage) for details. | **30% Coinsurance after Deductible** |
| <br>**Infusion Therapy**<br>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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| **Inherited Metabolic Disorder – PKU Services** | **30% Coinsurance after Deductible** |
| **Lab and Radiology Services**<br>Non-routine, facility and professional services (this includes testing and associated services related to Genetic Services). | Laboratory Outpatient and Professional Services<br>**$40 Copay per visit**<br><br>X-Rays and Diagnostic Imaging<br>**$65 Copay per visit**<br><br>Complex Imaging (Such as MRI, CT, PET)<br>**30% Coinsurance after Deductible** |
| **Maternity and Newborn Care**<br>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<br>**$800 Copay per day after Deductible**<br>You pay no more than 5 copayments per stay.<br><br>Prenatal Diagnosis of Congenital Anomalies<br>**$20 Copay per visit**<br>Eligible for two visits at $1 copay, after which $20 copay **per visit** applies.<br><br>Maternity Specialty Care<br>(Global professional fee and all prenatal and postnatal care, except for Preventive Services)<br>**$20 Copay per visit**<br>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.<br><br>Termination of Pregnancy<br>(Voluntary termination of pregnancy services)<br>**You Pay Nothing**<br><br>Newborn Care (well baby care)<br>**You Pay Nothing**<br><br>Donor Human Milk<br>**You Pay Nothing**<br>As part of inpatient services for Newborn Care. |

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| <br>**Mental/Behavioral Health Care and Substance Use Disorder** | Inpatient (facility and professional)<br>**$800 Copay per day after Deductible**<br>You pay no more than 5 copayments per stay<br><br>Mental/Behavioral Health and Substance Use Disorder Outpatient Services: Office Visit<br>**$20 Copay per visit**<br>Eligible for two visits at $1 copay, after which $20 copay applies.<br><br>Mental/Behavioral Health and Substance Use Disorder: Other Outpatient Professional and Facility Services<br>**$20 Copay per visit**<br><br>Prescription Drugs<br>Prescription Drugs prescribed during an inpatient admission or on an outpatient basis related to Mental Health or Substance Use Disorders are covered.<br>**See *Prescription Drugs* for associated cost-sharing details.** |
| <br>**Nutritional Counseling**<br>Also see *Diabetic Education* and *Diabetic Nutrition Education* | **You Pay Nothing** |

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| <br>**Pediatric Vision (under age 19)**<br>Administered by VSP | Routine Vision Screening<br>**You Pay Nothing**<br>1 exam per Calendar Year<br><br>Low Vision Evaluation<br>**You Pay Nothing**<br>(Comprehensive low vision evaluation every five years)<br><br>Comprehensive Eye Exam<br>**You Pay Nothing**<br>(Including dilation as professionally indicated and with refraction)<br>1 exam per Calendar Year<br><br>Vision Hardware<br>**You Pay Nothing**<br>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. |
| <br>**Podiatric Care**<br>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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| <br>**Prescription Drugs**<br>Administered by Express Scripts, Inc. | Generic Drugs<br>Tier 1<br>**$25 Copay per 30-day supply**<br>**$67.50 Copay per 90-day supply**<br>Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.<br><br>Preferred Drugs<br>Tier 2<br>**$75 Copay per 30-day supply**<br>**$202.50 Copay per 90-day supply**<br>Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.<br><br>Non-Preferred Drugs<br>Tier 3<br>**$250 Copay after Deductible per 30-day supply**<br>Coverage is limited to a 30-day supply<br><br>Specialty Drugs<br>Tier 4<br>**$250 Copay after Deductible per 30-day supply**<br>Coverage is limited to a 30-day supply at a specialty pharmacy.<br><br>Asthma Inhalers (corticosteroid, and corticosteroid combination), EpiPens, Epinephrine Auto Injectors, & Insulin<br><br>Member cost-sharing for asthma Inhalers (corticosteroid and inhaled corticosteroid combination), EpiPens, epinephrine auto injectors (products containing at least 2 auto injectors) & 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.<br><br>Contraceptive Drugs & Devices<br>**You Pay Nothing**<br>(Including OTC oral contraceptive drugs and devices, products, and barrier methods, including condoms)<br><br>Tobacco Cessation Drugs<br>**You Pay Nothing**<br>(Nicotine Habit Breaking/ Stop Smoking Drugs) |

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| <br>**Preventive Care**<br>Limits listed are a guideline only. These limits are not meant to be benefit limitations.<br>Preventive Care Services are covered in accordance with the recommendations set forth by the Centers for Disease Control's Advisory Committee on Immunization Practices; Health Resources and Services Administration guidelines, including Bright Futures guidelines set forth by the American Academy of Pediatricians and women's preventive and wellness services guidelines in effect on June 30, 2025; and U.S. Preventive Services Task Force for Prevention and Chronic Care, which includes screening and tests for A and B recommendations in effect on June 30, 2025 for prevention and chronic care. Items and services required by Washington state rule or regulation. 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<br>Immunizations for children and adults are covered.<br>**You Pay Nothing**<br><br>Mammography<br>Diagnostic and supplemental breast examinations, including diagnostic mammography, digital tomosynthesis (3D mammography), MRI, or ultrasound.<br>**You Pay Nothing**<br><br>Periodic Exams (adult and child)<br>**You Pay Nothing**<br><br>Preventive and Wellness Services, Tests, and Screenings<br>**You Pay Nothing**<br><br>Routine Maternity Care<br>Routine prenatal and postnatal care including prenatal exams and tests, breastfeeding support and counseling.<br>**You Pay Nothing** |

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| <br>**Professional/Physician Services (Office and Telemedicine visits)** | Primary Care Provider (PCP)<br>**$20 Copay per visit**<br>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.<br><br>Other Practitioner<br>**$20 Copay per visit**<br>(Visits performed by a naturopath, nurse practitioner, or physician assistant that is not your PCP)<br>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.<br><br>Specialist<br>**$65 Copay per visit**<br><br>Mental/Behavioral Health and Substance Use Disorder Providers<br>**$20 Copay per visit**<br>Eligible for two visits at $1 copay per visit, after which $20 copay per visit applies. |
| <br>**Prosthetics/Prosthetic Devices** | Inpatient (facility and professional)<br>**$800 Copay per day after Deductible**<br>You pay no more than 5 copayments per stay<br><br>Durable Medical Equipment (DME)<br>**30% Coinsurance after Deductible** |
| <br>**Reconstructive Surgery**<br>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. |

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| <br>**Rehabilitation Therapy** | Inpatient (facility and professional)<br>**$800 Copay per day after Deductible**<br>30 days per Calendar Year. You pay no more than 5 copayments per stay.<br><br>Outpatient (facility and professional)<br>**$40 Copay per visit**<br>Includes physical, speech, and occupational therapies. 25-visit maximum for all rehabilitation therapy services combined per Calendar Year.<br><br>Cochlear implants are also covered. |
| <br>**Skilled Nursing Facility** | **$800 Copay after Deducible per day**<br>60 days per Calendar Year |
| <br>**Spinal Manipulations (Chiropractic Care)** | **$20 Copay per visit**<br>10 visits per Calendar Year<br>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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| <br>**Temporomandibular Joint Disorder Services** | **30% Coinsurance after Deductible** |
| <br>**Transplant Services** | **$800 Copay per day after Deductible**<br>You pay no more than 5 copayments per stay. |
| <br>**Urgent Care** | **$65 Copay per visit**<br>CHPW Virtual Care visits Powered by MD Live<br>**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.

Note: Cost-sharing is waived if the patient receives care from an Indian Health Care Provider (IHCP) or with IHCP referral at a non-IHCP provider. 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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# 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

**individualandfamily.chpw.org**