



**COMMUNITY HEALTH PLAN**  
of Washington™

The power of community

**INDIVIDUAL & FAMILY PLANS**

# 2025 Schedule of Benefits



**Cascade Select Silver**  
**AI/AN Zero Cost Share Plan**

## CONTACT INFORMATION

### Where to Send Claims

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#### 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](http://www.express-scripts.com)

### Customer Service

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#### 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

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#### 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

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Visit our website **[individualandfamily.chpw.org](http://individualandfamily.chpw.org)** for more information and secure online access to claims information in your myCHPW member portal.



# 2025 Schedule of Benefits

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





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)		<b>\$0</b> Individual	<b>\$0</b> Family
Annual Medical and Pharmacy Integrated Out-of-Pocket Maximum (per Calendar Year)		<b>\$0</b> Individual	<b>\$0</b> 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 Silver Zero Cost Sharing	
Benefit	For Network Providers, You Pay*
 <b>Acupuncture</b> Limited to 12 visits per calendar year. (Unlimited visits for chemical dependency treatment.)	<b>You Pay Nothing</b>
 <b>Ambulance Services</b> (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)	<b>You Pay Nothing</b>
 <b>Autologous Blood Donation/Blood Transfusion</b>	<b>You Pay Nothing</b>
 <b>Chemotherapy and Radiation</b>	<b>You Pay Nothing</b>

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

Benefit	For Network Providers, You Pay*
 <b>Dental Anesthesia</b>	Anesthesiologist <b>You Pay Nothing</b> Refer to Hospital Inpatient and Outpatient benefits for surgical services.
 <b>Diabetes Care Management</b>	<b>You Pay Nothing</b>
 <b>Diabetic Education and Diabetic Nutrition Education</b>	<b>You Pay Nothing</b>
 <b>Dialysis Services</b>	<b>You Pay Nothing</b>
 <b>Durable Medical Equipment</b>	<b>You Pay Nothing</b>
 <b>Emergency Care Services</b> (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) <b>You Pay Nothing</b>




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

Benefit	For Network Providers, You Pay*
 <b>Gender Affirming Care</b>	<p>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.</p>
 <b>Genetic Services</b>	<p><b>You Pay Nothing</b> (Testing and associated services)</p>
 <b>Habilitation Services</b> Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices	<p>Inpatient (facility and professional)  <b>You Pay Nothing</b>  30 days per Calendar Year.</p> <hr/> <p>Outpatient (facility and professional)  <b>You Pay Nothing</b>  Includes physical, speech, and occupational therapies. 25-visit maximum for all habilitation therapy services combined per Calendar Year.</p>
 <b>Hearing</b>	<p>Cochlear Implants  <b>You Pay Nothing</b></p>




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

Benefit	For Network Providers, You Pay*
 <p><b>Home Health Care</b> Limited to 130 visits per Calendar Year</p>	<p><b>You Pay Nothing</b></p>
 <p><b>Hospice</b></p>	<p>Hospice Care <b>You Pay Nothing</b></p> <hr/> <p>Respite Care <b>You Pay Nothing</b> 14 days lifetime maximum</p>
 <p><b>Hospital Inpatient Medical and Surgical Care</b></p>	<p>Inpatient (facility and professional) <b>You Pay Nothing</b></p> <hr/> <p>Inpatient professional (surgeon) <b>You Pay Nothing</b></p> <hr/> <p>Inpatient professional services (assistant surgeon, radiologist, pathologist) <b>You Pay Nothing</b></p>

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

Benefit	For Network Providers, You Pay*
 <p><b>Hospital Outpatient Surgery and Services</b></p>	<p>Outpatient surgery professional services (surgeon, assistant surgeon, radiologist, pathologist) <b>You Pay Nothing</b></p> <hr/> <p>Outpatient Facility Fee (e.g. Ambulatory Surgery Center) <b>You Pay Nothing</b></p>
 <p><b>Infertility Diagnostic Services</b> Limited benefit, see <i>Infertility Diagnostic Services</i> section of the Policy (Evidence of Coverage) for details</p>	<p><b>You Pay Nothing</b></p>
 <p><b>Infusion Therapy</b> Includes infusion therapy provided in the home</p>	<p>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).</p>

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

Benefit	For Network Providers, You Pay*
 <b>Inherited Metabolic Disorder – PKU Services</b>	<b>You Pay Nothing</b>
 <b>Lab and Radiology Services</b> (non-routine, facility and professional services)	<div>Laboratory Outpatient and Professional Services <b>You Pay Nothing</b></div> <hr/> <div>X-Rays and Diagnostic Imaging <b>You Pay Nothing</b></div> <hr/> <div>Complex Imaging (Such as MRI, CT, PET) <b>You Pay Nothing</b></div>




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Benefit	For Network Providers, You Pay*
 <b>Maternity and Newborn Care</b>	Delivery and all inpatient services for Maternity Care <b>You Pay Nothing.</b>
	Prenatal Diagnosis of Congenital Anomalies <b>You Pay Nothing</b>
	Maternity Specialty Care (global professional fee and all prenatal and postnatal care, except for Preventive Services) <b>You Pay Nothing</b>
	Termination of Pregnancy (Voluntary termination of pregnancy services) <b>You Pay Nothing</b>
	Newborn Care (well baby care) <b>You Pay Nothing</b>
 <b>Mental/Behavioral Health Care</b>	Inpatient (facility and professional) <b>You Pay Nothing</b>
	Mental/Behavioral Health Outpatient Services: Office Visit <b>You Pay Nothing</b>
	Mental/Behavioral Health: Other Outpatient Professional and Facility Services <b>You Pay Nothing</b>


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

Benefit	For Network Providers, You Pay*
 <p><b>Nutritional Counseling</b> also see Diabetic Education and Diabetic Nutrition Education</p>	<p><b>You Pay Nothing</b></p>
 <p><b>Pediatric Vision (under age 19)</b> Administered by VSP</p>	<p>Routine Vision Screening <b>You Pay Nothing</b> 1 exam per Calendar Year</p> <hr/> <p>Low Vision Evaluation <b>You Pay Nothing</b> (Comprehensive low vision evaluation every five years)</p> <hr/> <p>Comprehensive Eye Exam <b>You Pay Nothing</b> (Including dilation as professionally indicated and with refraction) 1 exam per Calendar Year</p> <hr/> <p>Vision Hardware <b>You Pay Nothing</b> 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.</p>
 <p><b>Podiatric Care</b> Podiatric Care includes Routine Foot Care, which is covered for diabetics only.</p>	<p><b>You Pay Nothing</b></p>



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Benefit	For Network Providers, You Pay*
 <p><b>Prescription Drugs</b> Administered by Express Scripts, Inc.</p>	<p><b>Generic Drugs</b> <b>You Pay Nothing</b></p> <p>Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.</p>
	<p><b>Preferred Drugs</b> <b>You Pay Nothing</b></p> <p>Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.</p>
	<p><b>Non-Preferred Drugs</b> <b>You Pay Nothing</b></p> <p>Coverage is limited to a 30-day supply</p>
	<p><b>Specialty Drugs</b> <b>You Pay Nothing</b></p> <p>Coverage is limited to a 30-day supply at specialty pharmacy.</p>
	<p><b>Contraceptive Drugs &amp; Devices</b> <b>You Pay Nothing</b></p> <p><i>(including OTC oral contraceptive drugs and devices, products, and barrier methods, including condoms)</i></p>
	<p><b>Tobacco Cessation Drugs</b> <b>You Pay Nothing</b></p> <p><i>(Nicotine Habit Breaking/ Stop Smoking Drugs)</i></p>





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Benefit	For Network Providers, You Pay*
 <p><b>Preventive Care</b> Limits listed are a guideline only. These limits are not meant to be benefit limitations.</p> <p>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.</p>	<p><b>Immunizations</b> Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. <b>You Pay Nothing</b></p> <hr/> <p><b>Mammography</b> Diagnostic and supplemental breast examinations, including diagnostic mammography, digital tomosynthesis (3D mammography), MRI, or ultrasound. <b>You Pay Nothing</b></p> <hr/> <p><b>Periodic Exams (adult and child)</b> <b>You Pay Nothing</b></p> <hr/> <p><b>Routine Maternity Care</b> Routine maternity care (prenatal and postnatal) including prenatal exams and tests, breastfeeding support and counseling. <b>You Pay Nothing</b></p>
 <p><b>Professional/Physician Services (Office and Telehealth visits)</b></p>	<p><b>Primary Care Provider</b> <b>You Pay Nothing</b> (Including naturopaths, nurse practitioners, and physician assistants)</p> <hr/> <p><b>Specialist</b> <b>You Pay Nothing</b> Specialist visit performed by a naturopath, nurse practitioner, or physician assistant that is not your PCP</p> <hr/> <p><b>Mental/Behavioral Health and Substance Use Disorder Providers</b> <b>You Pay Nothing</b></p>




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Benefit	For Network Providers, You Pay*
 <p><b>Reconstructive Surgery</b></p>	<p>Reconstructive Surgery may include outpatient and inpatient surgical services. See associated cost-sharing for those services.</p>
 <p><b>Rehabilitation Therapy</b></p>	<p>Inpatient (facility and professional)  <b>You Pay Nothing</b>  30 days per Calendar Year.</p> <hr/> <p>Outpatient (facility and professional)  <b>You Pay Nothing</b>  Includes physical, speech, and occupational therapies.  25-visit maximum for all rehabilitation therapy services combined per Calendar Year.</p>
 <p><b>Skilled Nursing Facility</b></p>	<p><b>You Pay Nothing</b>  60 days per Calendar Year</p>
 <p><b>Spinal Manipulations</b></p>	<p><b>You Pay Nothing*</b>  10 visits per Calendar Year</p>

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Benefit	For Network Providers, You Pay*
 <b>Substance Use Disorder (Chemical Dependency)</b>	<p>Inpatient (facility and professional) <b>You Pay Nothing</b></p> <hr/> <p>Office Visits <b>You Pay Nothing</b></p> <hr/> <p>Other Outpatient Professional and Facility Services <b>You Pay Nothing</b></p>
 <b>Temporomandibular Joint Disorder Services</b>	<p><b>You Pay Nothing</b></p>
 <b>Urgent Care</b>	<p><b>You Pay Nothing</b></p>

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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](https://individualandfamily.chpw.org)