COMMUNITY HEALTH PLAN of Washington™

The power of community

INDIVIDUAL & FAMILY PLANS

# 2024 Schedule of Benefits

## Cascade Select Silver Variant 73% Cost Share Plan

# Schedule of Benefits

**Your Provider Network is:** CHPW Cascade Care Affiliates Network

**Community Health Plan of Washington Cascade Select Silver Variant 73%**

| Deductible and Out-of-Pocket Maximums | For Network Providers, You Pay |
|---|---|
| **Annual Medical and Pharmacy Integrated Deductible (per Calendar Year)** | |
| Individual | $2,500 |
| Family | $5,000 |
| **Annual Medical and Pharmacy Integrated Deductible Out-of-Pocket Maximum (per Calendar Year)** | |
| Individual | $7,550 |
| Family | $15,100 |

## 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 Variant 73% | | |
|---|---|---|
| **Benefit** | **For Network Provider, You Pay** | |
| **Acupuncture** Limited to 12 visits per calendar year. (Unlimited visits for chemical dependency treatment.) | $30 | 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) | $325 | Copay |
| **Autologous Blood Donation/Blood Transfusion** | 30% | Coinsurance after Deductible |

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|---|---|---|
| **Benefit** | **For Network Provider, You Pay** | |
| **Chemotherapy and Radiation** | 30% | Coinsurance<br>after Deductible |
| **Chemical Dependency (Substance Use Disorder)** | | |
| • **Inpatient** (facility and professional)<br>You pay no more than 5 copayments per stay. | $800 per day | Copay after<br>Deductible |
| • **Office Visits** | $30 per visit<br>Eligible for two visits at $1 copay, after which $30 copay applies. | Copay |
| • **Other Outpatient Professional and Facility Services** | $30 per visit | Copay |
| **Dental Anesthesia** | 30% | Coinsurance<br>after Deductible |
| **Diabetes Care Management** | You Pay Nothing | |
| **Diabetic Education and Diabetic Nutrition Education** | | |
| • **In Office** | You Pay Nothing | |
| **Dialysis Services** | 30% | Coinsurance<br>after Deductible |
| **Durable Medical Equipment** | | |
| • **Durable Medical Equipment** | 30% | Coinsurance<br>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)<br>Copay waived if admitted as an inpatient within 24 hours. | $800 | Copay after<br>Deductible |
| • **Urgent Care** | $65 | Copay |

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|---|---|---|
| **Benefit** | **For Network Provider, You Pay** | |
| **Gender Affirming Care**<br>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 | Copay |
| **Habilitation Services**<br>Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices. | | |
| • **Inpatient** (facility and professional).<br>30 days per Calendar Year. You pay no more than 5 copayments per stay. | $800 per day | Copay after Deductible |
| • **Outpatient** (facility and professional)<br>Includes physical, speech, and occupational therapies. 25-visit maximum for all habilitation therapy services combined per Calendar Year. | $40 per visit | Copay |
| **Hearing** | | |
| • **Cochlear Implants** | 30% | Coinsurance after Deductible |
| **Home Health Care**<br>Limited to 130 visits per Calendar Year. | | |
| • **Home Health Care** | $30 per day | Copay |
| **Hospice** | | |
| • **Hospice Care** | $30 per day | Copay |

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|---|---|---|
| **Benefit** | **For Network Provider, You Pay** | |
| • **Respite Care** 14 days lifetime maximum | $30 per day | Copay |
| **Hospital Inpatient Medical and Surgical Care** | | |
| • **Inpatient (facility and professional**) You pay no more than 5 copayments per stay**.** | $800 per day | Copay after Deductible |
| • **Inpatient professional** (surgeon) | Included with facility copay | Copay after Deductible |
| • **Inpatient professional services** (assistant surgeon, radiologist, pathologist) | Included with facility copay | Copay after Deductible |
| **Hospital Outpatient Surgery and Services** | | |
| • **Outpatient surgery professional services** (surgeon) | $200 | Copay after Deductible |
| • **Outpatient surgery professional services** (assistant surgeon, radiologist, pathologist) | $200 | Copay after Deductible |
| • **Outpatient Facility Fee** (e.g. Ambulatory Surgery Center) | $600 | Copay after Deductible |
| **Infertility Diagnostic Services** Limited benefit, see *Infertility Diagnostic Services* section of the Policy for details. | 30% | 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** | 30% | Coinsurance after Deductible |

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|---|---|---|
| **Benefit** | **For Network Provider, You Pay** | |
| **Lab and Radiology Services** (non-routine, facility and professional services) | | |
| • **Laboratory outpatient and Professional Services** | $40 | Copay |
| • **X-Rays and Diagnostic Imaging** | $65 | Copay |
| • **Complex Imaging** (Such as MRI, CT, PET) | 30% | Coinsurance after Deductible |
| **Maternity and Newborn Care** | | |
| • **Delivery and All Inpatient Services for Maternity Care** You pay no more than 5 copayments per stay. | $800 per day | Copay after Deductible |
| • **Prenatal Diagnosis of Congenital Anomalies** | $30<br>As part of your primary care visits, you are eligible for two visits at $1 copay, after which $30 copay applies. | Copay |
| • **Maternity specialty care** (global professional fee and all prenatal and postnatal care, except for Preventive Services) | $30<br>As part of your primary care visits, you are eligible for two visits at $1 copay, after which $30 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 andprofessional)** You pay no more than 5 copayments per stay. | $800 per day | Copay after Deductible |
| • **Outpatient Services:** office visits | $30<br>Eligible for two visits at $1 copay, after which $30 copay applies. | Copay |

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| **Benefit** | **For Network Provider, You Pay** | |
| • **Outpatient Services:** Other Outpatient Professional and Facility Services | $30 per visit | Copay |
| **Prescription Drugs** | Administered by Express Scripts, Inc. | |
| • **Generic Drugs** | $24 per 30-day supply<br>$54.00 per 90-day supply | Copay<br>Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order. |
| • **Preferred Brand Drugs** | $75 per 30-day supply<br>$202.50 per 90-day supply | Copay<br>Prescription drugs are provided upto a 90-day supply at participating retail pharmacies or through mail order. |
| • **Non-Preferred Brand Drugs** | $250 per 30-day supply | Copay after deductible.<br>Coverage is limited to a 30-day supply. |
| • **Specialty Drugs (exception: Insulin)** | $250 per 30-day supply<br>*Enrollee cost sharing for insulin as follows: (1) cap total monthly OOP at $35 / 30-day supply;<br>(2) insulin is not subject to deductible | Copay after deductible.<br>Coverage is limited to a 30-daysupply at specialty pharmacy. |
| • **Contraceptive Drugs & Devices** (including OTC oral contraceptive drugs and devices, products, and barrier methods, including condoms) | You Pay Nothing | |
| **Podiatric Care**<br>*Podiatric Care* includes *Routine Foot Care,* which is covered for diabetics only. | You Pay Nothing | |
| **Preventive Care**<br>Limits listed below 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 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. | | |

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| **Benefit** | **For Network Provider, You Pay** | |
| **Immunizations**<br>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**<br>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** | $30<br>As part of your primary care visits, you are eligible for two visits at $1 copay, after which $30 copay applies. | Copay |
| **Professional/Physician Services** (office visits) | | |
| • **Primary Care Provider** (including naturopaths, nurse practitioners, and physician assistants); includes Telehealth visits | $30 per visit<br>Eligible for two visits at $1 copay, after which $30 copay applies. | Copay |
| • **Specialist**<br>• Specialist Visit performed by a naturopath, nurse practitioner, or physician assistant that is not your PCP, then $65 copay per visit. Does not apply if this type of provider is PCP. | $65 per visit | Copay |
| • **Mental Health and Substance Use Disorder Providers** | $30 per visit<br>Eligible for two visits at $1 copay, after which $30 copay applies. | Copay |
| **Reconstructive Surgery** | 30% | Coinsurance<br>After Deductible |

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| **Benefit** | **For Network Provider, You Pay** | |
| **Rehabilitation Therapy** | | |
| • **Inpatient** (facility and professional). **30 days per CalendarYear. You pay no more than 5 copayments per stay.** | $800 per day | Copay after Deductible |
| • **Outpatient** (facility and professional) Includes physical, speech, and occupational therapies. **25-visit maximum for all rehabilitation therapy services combined per CalendarYear.** | $40 per visit | Copay |
| **Skilled Nursing Facility** 60 days per Calendar Year | $800 per day | Copay after Deductible |
| **Spinal Manipulations** 10 visits per Calendar Year. *Applies to Chiropractors only. Other providers e.g. D.O. 30% after deductible, not subject to the 10 visit limit. | $30 | Copay |
| **Temporomandibular Joint Disorder Services** | 30% | 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 | |

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