



COMMUNITY HEALTH PLAN
of Washington™

The power of community

INDIVIDUAL & FAMILY PLANS

2025 Schedule of Benefits



**Cascade Select Silver
Variant 73% 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
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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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)	\$2,500 Individual	\$5,000 Family
Annual Medical and Pharmacy Integrated Out-of-Pocket Maximum (per Calendar Year)	\$7,250 Individual	\$14,500 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.

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Benefit	For Network Providers, You Pay*
 <p>Acupuncture Limited to 12 visits per calendar year. (Unlimited visits for chemical dependency treatment.)</p>	\$30 Copay
 <p>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)</p>	\$325 Copay
 <p>Autologous Blood Donation/Blood Transfusion</p>	30% Coinsurance after Deductible
 <p>Chemotherapy and Radiation</p>	30% Coinsurance after Deductible

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Benefit	For Network Providers, You Pay*
 <p>Dental Anesthesia</p>	<p align="center">Anesthesiologist 30% Coinsurance after Deductible Refer to Hospital Inpatient and Outpatient benefits for surgical services.</p>
 <p>Diabetes Care Management</p>	<p align="center">You Pay Nothing</p>
 <p>Diabetic Education and Diabetic Nutrition Education</p>	<p align="center">You Pay Nothing</p>
 <p>Dialysis Services</p>	<p align="center">30% Coinsurance after Deductible</p>
 <p>Durable Medical Equipment</p>	<p align="center">30% Coinsurance after Deductible</p>
 <p>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)</p>	<p align="center">Emergency Care Services (facility and professional) \$800 Copay after Deductible Copay waived if admitted as an inpatient within 24 hours.</p>




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Benefit	For Network Providers, You Pay*
 <p>Gender Affirming Care</p>	<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>
 <p>Genetic Services</p>	<p align="center">\$40 Copay (Testing and associated services)</p>
 <p>Habilitation Services Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices</p>	<p align="center">Inpatient (facility and professional) \$800 Copay per day after Deductible 30 days per Calendar Year. You pay no more than 5 copayments per stay.</p> <hr/> <p align="center">Outpatient (facility and professional) \$40 Copay per visit Includes physical, speech, and occupational therapies. 25-visit maximum for all habilitation therapy services combined per Calendar Year.</p>
 <p>Hearing</p>	<p align="center">Cochlear Implants 30% Coinsurance after Deductible</p>

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Benefit	For Network Providers, You Pay*
 <p>Home Health Care Limited to 130 visits per Calendar Year</p>	<p>\$30 Copay per day</p>
 <p>Hospice</p>	<p>Hospice Care \$30 Copay per day</p> <hr/> <p>Respite Care \$30 Copay per day 14 days lifetime maximum</p>
 <p>Hospital Inpatient Medical and Surgical Care</p>	<p>Inpatient (facility and professional) \$800 Copay per day after Deductible You pay no more than 5 copayments per stay.</p> <hr/> <p>Inpatient professional (surgeon) Included with facility copay</p> <hr/> <p>Inpatient professional services (assistant surgeon, radiologist, pathologist) Included with facility copay</p>

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Benefit	For Network Providers, You Pay*
 <p>Hospital Outpatient Surgery and Services</p>	<p align="center">Outpatient surgery professional services (surgeon, assistant surgeon, radiologist, pathologist) \$200 Copay after Deductible</p> <hr/> <p align="center">Outpatient Facility Fee (e.g. Ambulatory Surgery Center) \$600 Copay after Deductible</p>
 <p>Infertility Diagnostic Services Limited benefit, see <i>Infertility Diagnostic Services</i> section of the Policy (Evidence of Coverage) for details</p>	<p align="center">30% Coinsurance after Deductible</p>
 <p>Infusion Therapy Includes infusion therapy provided in the home</p>	<p align="center">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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For Network Providers, You Pay*



Inherited Metabolic Disorder – PKU Services

30% Coinsurance after Deductible



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

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For Network Providers, You Pay*



Maternity and Newborn Care

Delivery and all inpatient services for Maternity Care

\$800 Copay per day after Deductible

You pay no more than 5 copayments per stay.

Prenatal Diagnosis of Congenital Anomalies

\$30 Copay

Eligible for two visits at \$1 copay, after which \$30 copay applies.

Maternity Specialty Care

(global professional fee and all prenatal and postnatal care, except for Preventive Services)

\$30 Copay

Eligible for two visits at \$1 copay, after which \$30 copay applies.

Termination of Pregnancy

(Voluntary termination of pregnancy services)

You Pay Nothing

Newborn Care (well baby care)

You Pay Nothing



Mental/Behavioral Health Care

Inpatient (facility and professional)

\$800 Copay per day after Deductible

You pay no more than 5 copayments per stay

Mental/Behavioral Health Outpatient Services: Office Visit

\$30 Copay

Eligible for two visits at \$1 copay, after which \$30 copay applies. This two-visit allowance is shared with Substance Use Disorder Outpatient Services.

Mental/Behavioral Health: Other Outpatient Professional and Facility Services

\$30 Copay per visit

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Nutritional Counseling

also see Diabetic Education and Diabetic Nutrition Education

\$30 Copay

Eligible for two visits at \$1 copay, after which \$30 copay applies.



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

Podiatric Care includes Routine Foot Care, which is covered for diabetics only.

You Pay Nothing

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Prescription Drugs

Administered by Express Scripts, Inc.

Generic Drugs

\$24 Copay per 30-day supply

\$54 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

\$75 Copay per 30-day supply

\$202.50 Copay per 90-day supply

Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.

Non-Preferred Drugs

\$250 Copay after deductible per 30-day supply

Coverage is limited to a 30-day supply

Specialty Drugs

\$250 Copay after deductible

Coverage is limited to a 30-day supply at 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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Benefit	For Network Providers, You Pay*
 <p>Preventive Care 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 align="center">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</p> <hr/> <p align="center">Mammography Diagnostic and supplemental breast examinations, including diagnostic mammography, digital tomosynthesis (3D mammography), MRI, or ultrasound. You Pay Nothing</p> <hr/> <p align="center">Periodic Exams (adult and child) You Pay Nothing</p> <hr/> <p align="center">Routine Maternity Care Routine maternity care (prenatal and postnatal) including prenatal exams and tests, breastfeeding support and counseling. You Pay Nothing</p>
 <p>Professional/Physician Services (Office and Telehealth visits)</p>	<p align="center">Primary Care Provider \$30 Copay per visit Eligible for two visits at \$1 copay, after which \$30 copay applies. (Including naturopaths, nurse practitioners, and physician assistants)</p> <hr/> <p align="center">Specialist \$65 Copay per visit Specialist visit performed by a naturopath, nurse practitioner, or physician assistant that is not your PCP, then \$30 copay per visit after the deductible. Does not apply if this type of provider is PCP.</p> <hr/> <p align="center">Mental/Behavioral Health and Substance Use Disorder Providers \$30 Copay per visit Eligible for two visits at \$1 copay, after which \$30 copay applies.</p>

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Reconstructive Surgery

Reconstructive Surgery may include outpatient and inpatient surgical services. See associated cost-sharing for those services.



Rehabilitation Therapy

Inpatient (facility and professional)
\$800 Copay per day after Deductible
 30 days per Calendar Year. You pay no more than 5 copayments per stay.

Outpatient (facility and professional)
\$40 Copay per visit
 Includes physical, speech, and occupational therapies. 25-visit maximum for all rehabilitation therapy services combined per Calendar Year.



Skilled Nursing Facility

\$800 Copay after Deductible per day
 60 days per Calendar Year



Spinal Manipulations

\$30 Copay
 10 visits per Calendar Year

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**Substance Use Disorder
(Chemical Dependency)**

Inpatient (facility and professional)
\$800 Copay per day after Deductible
You pay no more than 5 copayments per stay.

Office Visits
\$30 Copay per visit
Eligible for two visits at \$1 copay, after which \$30 copay applies.
This two-visit allowance is shared with
Mental/Behavioral Health Outpatient Services.

Other Outpatient Professional and Facility Services
\$30 Copay per visit



**Temporomandibular Joint Disorder
Services**

30% Coinsurance after Deductible



Urgent Care

\$65 Copay

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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