COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Abortion, Voluntary Termination of Pregnancy (Surgeon)	No Cost Shares	Includes abortion for which public funding is prohibited. Cost shares determined by the service. Prior Authorization is required for services provided in an inpatient setting.	2024: Change to 0 Cost shares
Acupuncture	$1.00 Copay not subject to the deductible	No visit limit.	2026: Reduced to $1.00 from $500. * No visit limits for any diagnosis, changed from 12 visits if not MH or SUD. MH and SUD DX no longer required.
Allergy Care	*$15 copay for E &M service not subject to the deductible. *Allergy tests/lab separate cost share.	Includes allergy tests, allergy injections and serums. Allergy serum is only covered under this benefit if received and administered at a providers office.	2026: Changed E & M to Specialist copay $15.00 not subject to the deductible from 40% coinsurance after the deductible. Allergy tests separate cost share.
Ambulance (Emergency Transportation) ground and air	$75.00 copay		BPT 8.24.20
Ambulance (Non-Emergency)	NOT COVERED	NOT COVERED	EOC
Anesthesiologist (Anesthesia) (professional)	15% coinsurance after deductible does not include facility fee	For the benefit of dental anesthesia provided in a facility, a child must be under 7 yrs. old oris developmentally delayed or if a physician determines a medical condition places the patient at undo risk if performed in the dentist office. Includes services to prepare the jaw for radiation treatment of neoplastic disease. The Dental anesthesia benefit does not include the charges for the dentist or anesthesia performed in a dentist office.	BPT 8.24.20
Applied Behavior Analysis Therapy (ABA)	$1.00 copay not subject to the deductible	Refer to prior authorization list. Must be prescribed. Must be performed by a qualified ABA provider. Must be diagnosis of autism spectrum disorder and meet criteria of the plan.	2026 reduced to $1.00 from $5.00. *Removed Shared $1, 2 visit limits. No longer applied.
Birthing Center (Facility)	$100.00 Copay after deductible		11.8.21 - Changed from $525 per day after deductible to $100.00 Copay After Deductible BPT 8.24.20
Birthing Center Professional, midwife/ midwives)	$25.00 copay not subject to deductible Other 15% after deductible		2025:Added to grid
Birth in the Home Supplies	15% coinsurance after deductible		2025:Added to grid
Birth in the Home Professional, midwife/midwives	$25.00 copay not subject to the deductible Other 15% after deductible		2025:Added to grid
Bariatric Surgery	NOT COVERED	NOT COVERED	EOC
Bone mass measurement (Bone Density)	$0 Cost Share	Prior authorization required if more often than once every 2 years.	BPT 8.24.20

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Breast cancer screening (mammograms, mammography, including 3D mammography)	$0 Cost Share	The first mammogram per calendar year is covered under preventive care regardless of diagnosis. Subsequent mammograms within in the same year are covered under lab and radiology benefits and cost shares will apply.	BPT 8.24.20
Cardiac rehabilitation services	15% coinsurance after deductible	Coverage for cardiac rehabilitation requires that Members have experienced a cardiac event such as myocardial infarction, chronic stable angina, heart transplant or heart and lung transplants.	If not called out in PBT, default is 15% after deductible.
Cervical and vaginal cancer screening (Pap tests, pelvic exams)	$0 Cost Share	For planned preventive services: • All women: Every 24 months • High risk of cervical cancer or abnormal pap: Every 12 months, is not routine care and is subject to cost shares. Diagnostic:30% after the deductible.	2025: Removed preventive that turns diagnostic. BPT 8.24.20
Chemotherapy	15% coinsurance after deductible		BPT 8.24.20
Chiropractor services/Spinal Manipulations	$1.00 copy not subject to the deductible. *Applies to Chiropractors only. Other providers e.g. D.O. 15% after deductible, not subject to the 10 visit limit.*	Limit 10 visits, coverage includes manipulation of the spine and diagnosis and treatment of musculoskeletal disorders, diagnostic radiology, when performed within the scope of the Provider's license. Radiology has separate cost share.	2026: reduced copay to $1.00 from $5.00.
Clinical Trials	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc.	Refer to prior authorization list. Clinical trial number must be included.	Cost share BPT 5.5.20
Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)	$0 Cost Share	For planned preventive services: For age 45 and older: • Sigmoidoscopy every 48 months • Fecal occult blood test, every 12 months For at high risk of colon cancer: • Screening colonoscopy every 24 months Not at high risk of colon cancer: • Screening colonoscopy every 10 years (120 months) but not within 48 months (2 years) of a screening sigmoidoscopy. Diagnostic 20% after the deductible	2025: Removed preventive screening that turns diagnostic 2024 – Changed age to 45 from 50 BPT 8.24.20
Cosmetic surgery or procedures	NOT COVERED	NOT COVERED	EOC
Custodial Care	NOT COVERED	Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps with activities of daily living, such as bathing or dressing. Custodial care is not *medically necessary.*	EOC

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Deductible,Individual	$00.00 (zero deductible) includes any Rx subject to deductible for in network providers.		2023 - Changed to $00.00 (zero) deductible from $150.00
Deductible,Family	$00.00 (zero deductible) includes any Rx subject to deductible for in network providers.		2023 - Changed to $00.00 (zero) deductible from $300.00
Dental Medical Services (Not Routine Dental), Oral Surgery (Surgeon)	Cost shares determined by the service. • Inpatient Surgery 15% after deductible • Inpatient hospital copay after deductible if applies • Outpatient Surgeon $25.00 copay after deductible • Outpatient facility fee if applies •Anesthesia 15% after deductible •Other 15% coinsurance after deductible	Refer to prior authorization list. Covered services limited to surgery of the jaw or related structures Examples: - setting fractures of the jaw or facial bones - extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease - excision of lesions, cysts and tumors of the jaw, mouth, lip or tongue	2025 – Added anesthesia for clarification. No change in benefits. Cost share BPT 5.5.20
Dental Services, Routine Dental, Orthodontia	NOT COVERED	NOT COVERED	EOC
Depression screening	$0 Cost Share		BPT 8.24.20 & EOC
Diabetic Education and Diabetic Nutrition Education	$0 Cost Share	Must be ordered by a provider. Must be performed through authorized outpatient diabetes education facilities. Includes diabetes education, diabetes self-management training and nutritional counseling services.	11.8.21 - Changed from 15% coinsurance after deductible to $0 Cost Share BPT 8.24.20 & EOC
Diabetic services and diabetes supplies (DME)	15% coinsurance after deductible	Refer to prior authorization list. PA Required if purchase is $500.00 or more or rental is $200.00 per month or more • The Durable Medical Equipment (DME) benefit only covers insulin pumps and insulin infusion devices and supplies related to this equipment. •The Pharmacy Benefit covers, insulin, oral hypoglycemic agents, blood glucose monitors, insulin syringes with needles, blood glucose test strips, urine test strips, ketone test strips, ketone tablets, lancets and lancet devices.	05/25/23 – Changed rental from $500 to $200 BPT 8.24.20 & EOC
Dialysis, Kidney dialysis	15% coinsurance not subject to the deductible.	Covered under applicable benefit (e.g., outpatient or inpatient facility fee cost sharing, Specialist, etc.	2026: Change: Not subject to the deductible. Added wording:Covered under applicable benefit (e.g., outpatient or inpatient facility fee cost sharing, Specialist, etc.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Durable medical equipment (DME) and medical supplies. Includes prosthetic devices.	15% coinsurance after deductible	Refer to prior authorization list. PA Required if purchase is $500.00 or more or rental is $200.00 per month or more	05/25/23 – Changed rental from $500 to $200 BPT 8.24.20 & EOC
Emergency care (ER Physician)	15% after deductible	Emergency Care Only. Out of network same as in-network cost shares.	If not called out in PBT, default is 15% after deductible.
Emergency Room, ER (facility)	$150.00 facility copay. Copay cannot exceed the actual cost of the service. For example if the service is $50.00 the copay will be $50.00.	• Professional fees are separate from the facility fees. • Copay waived if admitted as inpatient within 24 hours of ER visit. • Includes Medically Necessary detoxification services, including Chemical Dependency detoxification. • Prescription medications associated with a Medical Emergency, including those purchased in a foreign country, are also covered.	11.8.21 - No change BPT 8.24.20 & EOC
Enteral Feedings, Tube Feedings,PKU	15% coinsurance after deductible	Refer to prior authorization list.	BPT 8.24.20
Enteral Formula, Nutritional and Dietary Formulas,PKU	15% coinsurance after deductible	Refer to prior authorization list. Covered for nutritional and dietary formulas, including elemental formulas, and medical foods, is provided when Medically Necessary. The following conditions must be met: • The formula is a specialized formula for treatment of a recognized life-threatening metabolic deficiency such as phenylketonuria; or • The formula is the significant source of a patient's primary nutrition or is administered in conjunction with intravenous nutrition.	BPT 8.24.20
Eye exam - Medical (medical vision disease)	Diabetic Retinal Exam - $0 cost share 30% coinsurance after deductible	Covered, Exams to diagnose diseases and conditions of the eye. Not covered, Orthoptics or vision training and any associated supplemental testing.	2025:Added Diabetic Retinal Exam $0 Cost share
Eye exam - Routine Vision (VSP) Children, Up to 19 years of age (Pediatric Vision) AGE 19 and OVER NOT COVERED	Must be VSP network. Out of Network is not covered. $0 Cost share.	Once per calendar year.	2023 Added Frequency BPT 8.24.20

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Eye Wear - Medical Vision Hardware	15% coinsurance after deductible	Covered under DME for the following conditions of the eye: - Corneal ulcer - bullous keratopathy - recurrent erosion of cornea - tear film insufficiency - aphakia - Sjorgren's disease - Congenital cataract - Corneal abrasion - Keratoconus	If not called out in PBT, default is 15% after deductible.
Eye Wear - Routine Vision Hardware (VSP) Children, Up to 19 years of age (Pediatric Vision) AGE 19 and OVER NOT COVERED Prescription Contacts, frames,vision lenses,upgrades, glasses	Must be VSP network. Out of Network is not covered. $0 Cost share.	FRAMES: • Once per calendar year. Frames from the Otis & Piper Eyewear Collection. Includes fitting fee. • Repair of glasses or replacement of lost or stolen glasses is not covered. SPECTACLE LENSES: • Once per calendar year. Includes impact-resistant plastic or glass lenses, scratch resistant coating and ultraviolet coating. • Lens Enhancements: Member elected non-covered enhancements are member responsibility. Members save an average of 20-25%. CONTACT LENSES IN LIEU OF LENSES AND FRAMES: • Once per calendar year. Includes fitting fees. • Standard lenses (one pair, 1 contact lens per eye, total 2 lenses) per year. • Monthly lenses (six month supply, 6 lenses per eye, total 12 lenses,) per year • Bi-weekly lenses (three month supply, 90 lenses per eye, total 180 lenses) per year Dailies (three month supply, one year supply)	2023 added frequency and specifics for vision hardware BPT 8.24.20 & EOC
Eye and Vision Routine Services Not Covered	Not Covered	Not covered: Eyeglasses or contact lenses for conditions not listed under medical eye wear,vision hardware or covered under the Pediatric Vision benefit.	EOC

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Family Planning, contraception, birth control	$0 Cost Share	FDA-approved contraceptive services provided in the office or outpatient setting, includes IUDs, subdermal implants, including the insertion and removal, and voluntary sterilization procedures, including vasectomy and tubal ligation with no Cost-Sharing when provided by Network Providers. • Contraceptive methods that require a prescription, including oral contraceptives, transdermal patches, the vaginal ring, Medroxyprogesterone injections and emergency contraceptives, are covered under the Prescription Drug benefit. • FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides, are covered under the Prescription Drug benefit only when prescribed by a qualified Provider.	EOC
Genetic Testing, includes prenatal testing for congenital disorders	$5.00 copay	Refer to prior authorization list. • One copay when technical component and professional component are performed by the same provider. • Separate cost shares when the components are performed by separate providers. • Not covered, genetic tests of a child's father as a part of prenatal or newborn care.	11.8.21 - Changed from 15% coinsurance after deductible to lab $5 Copay BPT 8.24.20 (same as outpatient lab)
Habilitative Inpatient	Days: 1-5 - $100.00 per day No more than 5 days of copayments per stay. $0 Cost Shares for professional services when Habilitative Inpatient.	Refer to prior authorization list. Limit of 30 Days Per Calendar Year All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.	11.8.21 -Added $0 Cost Shares for professional services when Habilitative Inpatient.
Habilitative Outpatient	$5.00 copay	*25 combined visit limit per calendar year. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits. * Limit does not apply to these services with a behavioral health (mental health) diagnosis	Question out for clarification. BPT 8.24.20
Hearing exam (Medical)	15% coinsurance after deductible		2026: Removed wording, - Routine not covered
Hearing exam (Routine)	$1.00 copay	Annual Exam	2026 -NEW- Changed to covered from not covered.
Hearing services, Instruments, hearing aid, hearing aid fittings	15% deductible does not apply	Coverage is limited to one hearing aid per ear every 3 years. Also see Cochlear Implants.	2026 -NEW- Changed to covered from not covered.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Hearing services, Cochlear Implants	Cost share determined by service: Outpatient Surgeon $75.00 copay, facility fee if applicable, 15% coinsurance after deductible for DME (implants), anesthesia, etc.	*Coverage for Adults and Children *The following conditions must be met: -Services are to keep, restore and significantly improve function that was previously present but lost or impaired due to Disability, Injury or Illness; -Services are not for palliative, recreational, relaxation or maintenance therapy; and -Loss of function was not the result of a work-related Injury.	2026: No change, just clarification, covered for both adults and children.
HIV screening	$0 Cost Share	For planned preventive services that become diagnostic during the screening, cost sharing may apply.	BPT 8.24.20
HIV PrEP	$0 Cost Share	Pre-exposure prophylaxis (PrEP) covered for people at high risk of HIV infection.	2025: NEW
Home health agency care	$5.00 copay not subject to the deductible.	Refer to prior authorization list. 130 Visits per year limit • The patient must be homebound and require Skilled Care services. Home health care is covered when provided as an alternative to hospitalization and prescribed by a physician. • Covers Home infusion Therapy • Home health care listed below is not covered: - Custodial Care; - Private duty nursing; - Housekeeping or meal services; - Maintenance care; or - Shift or hourly care services. 15% coinsurance for durable medical equipment (DME) also applies when related to Home Health services. Review Prior Authorization list for related services.	2024: Changing wording to 130 visits from 130 Days.
Hospice care	Cost share determined be where services are performed. Inpatient Hospital copays or in Home $5.00 copay not subject to the deductible.	Refer to prior authorization list. Hospice care listed below is not covered: - Custodial Care or maintenance care, except palliative care to the terminally ill patient - Financial or legal counseling services; - Housekeeping or meal services; -Services by a Subscriber or the patient's Family or Volunteers; - Services not specifically listed as covered hospice services under this plan; - Supportive equipment such as handrails or ramps; or - Transportation.	2023 - Change 'home' to $5.00 copay not subject to the deductible from 15% coinsurance after the deductible.
Hospice Respite Care	In home $5.00 copay not subject to the deductible.	Refer to prior authorization list. 14 Days per year limit	2023 - Change 'home' to $5.00 copay not subject to the deductible from 15% coinsurance after the deductible.
Hyperbaric oxygen treatment	15% coinsurance after deductible	Refer to prior authorization list.	If not called out in PBT, default is 15% after deductible.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Immunizations	$0 Cost Share	Immunizations administered by pharmacists must be billed as a professional claim (HCFA form).	BPT 8.24.20
Infertility Diagnostic Services and Treatment Services	Cost share determined by service: Surgeon, facility fee if applicable, 15% coinsurance after deductible for, anesthesia, etc.	*Prior Authorization is required for services provided in an inpatient setting. *Coverage is provided for the initial evaluation and diagnosis of infertility. Examples of Covered Services for the initial diagnosis of infertility include: endometrial biopsy, hysterosalpingography, reproductive screening services, or sperm count. *Artificial insemination procedures are covered. * Surrogacy, surrogate mother, surrogate pregnancy, an assisted reproduction process, resulting in pregnancy of a child intended for other parents. Not covered.	***NEW*** 2026: Added 'and treatment services'. *Removed procedures for pregnancy not covered. *Added: Artificial insemination procedures are covered. *Added: Surrogacy, surrogate mother, surrogate pregnancy, an assisted reproduction process, resulting in pregnancy of a child intended for other parents. Not covered.
Infusion Therapy	15% coinsurance after deductible	*PA Required if provided in home or feestanding infusion site *Cost share determined by applicable benefit, (e.g. inpatient hospital, outpatient hospital, Home Health, Specialist, ect.).	2026:No change in benefits. Clarification added, Cost share determined by applicable benefit, (e.g. inpatient hospital, outpatient hospital, specialist).
Injections, Injectable drugs	15% after deductible.	Refer to prior authorization list. Note: All Unclassified biologics (J3590) require a prior authorization. Drugs that are administered under the supervision of physician, through home infusion or within a medical facility. Includes chemotherapy related drugs, drugs related to home dialysis, B12, etc. Self injectable drugs are covered under the pharmacy benefit.	If not called out in PBT, default is 15% after deductible.
Inpatient hospital Blood (including inpatient skilled nursing facility/SNF)	15% coinsurance after deductible		If not called out in PBT, default is 15% after deductible.
Outpatient Blood	15% coinsurance after deductible		If not called out in PBT, default is 15% after deductible.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Inpatient hospital (acute) care	Days: 1-5 - $100.00 per day No more than 5 days of copayments per stay. Professional: • $0 Cost Share performed inpatient for surgeons, asst. surgeon and pathologist professional services. All other inpatient professional services 15% coinsurance after the deductible. EXCEPTIONS: • Reconstructive surgery - inpatient - 15% coinsurance after the deductible • Transplant surgery - inpatient - 15% coinsurance after the deductible • Voluntary Termination of Pregnancy - inpatient - 15% coinsurance after the deductible.	Refer to prior authorization list. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.	11.8.21 - Added Cost Shares for inpatient professional services.
Inpatient Professional Services including SNF	Cost shares determined by the service.		11.8.21 - Removed inpatient visits only
Inpatient Hospital mental health, psychiatric, psychiatrist-care (facility)	Days: 1-5 - $100.00.00 per day No more than 5 days of copayments per stay. $0 Cost Shares for professional services when Psychiatric Inpatient.	Refer to prior authorization list. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.	11.8.21 - Added $0 Cost Shares for professional services when Psychiatric Inpatient.
Inpatient rehabilitation (facility)	Days: 1-5 - $100.00 per day No more than 5 days of copayments per stay. $0 Cost Shares for professional services when Inpatient Rehabilitation.	Refer to prior authorization list. 30 Days Per Calendar Year All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.	11.8.21 - Added $0 Cost Shares for professional services when Inpatient rehabilitation .

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Inpatient substance disuse, SUD, chemical dependency (facility)	Days: 1-5 - $100.00 per day No more than 5 days of copayments per stay. $0 Cost Shares for professional services when Inpatient SUD.	Refer to prior authorization list. Same cost shares applies to residential treatment.	11.8.21 -Added $0 Cost Shares for professional services when Inpatient SUD .
Mastectomy related bras and supplies (DME)	15% cost share after the deductible		BPT 8.24.20
Nutritional Counseling	$0 copay	Not limited to diabetic condition.	2026: Changed to $0 copay from $1 and $5.00 copay. *Removed limit to diabetic dx. *Removed from 2 visits, $1 copay shared list.
Nurse Advice Line	0% cost share	24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006	EOC
Obesity counseling, Weight Loss and Weight Management	15% coinsurance after deductible	Weight loss and weight management therapies are covered for children aged 6 and older who qualify as obese and adult members and children age 6 and older with a documented body mass index (BMI) of 30 kg/m2 or higher, when provided by an In-Network provider. The following multicomponent behavioral interventions are covered by the plan: •High intensity group and individual counseling sessions (12-26 sessions within a year), •Behavioral management activities, such as weight-loss goals, •Improving diet or nutrition and increasing physical activity, •Addressing barriers to change, •Self-monitoring, and •Strategizing how to maintain lifestyle changes. Not covered by this plan: •Exercise programs or use of exercise equipment, •Weight-loss diet supplements, such as Optifast liquid protein meals, NutriSystems pre-packaged foods, Medifast foods, phytotherapy, •Jenny Craig, Weight Watchers, Diet Center, Zone diet or other similar programs. •Bariatric Surgery	2025: Added Bariatric Surgery for clarification. No change in benefit. If not called out in PBT, default is 30% after deductible.
Organ (Living, Donor) Donation (Transplant)	Cost share determined by service: Inpatient hospital copays, anesthesia, etc.	Refer to prior authorization list. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Each time a member is admitted for a new inpatient stay the copay will apply.	confirm cost share

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Out of Pocket Max. Per Year, MOOP, Individual, includes pharmacy	$2400.00 includes copays including pharmacy and all services applied to deductibles for in-network services.		2026 - changed to $2400.00 from $1900.00 2025 - changed to $1900.00 from $1200.00 2023 - changed to $1200.00 from $800.00
Out of Pocket Max. Per Year, MOOP, Family, includes pharmacy	$4800.00 includes copays including pharmacy and all services applied to deductibles for in-network services.		2026 - changed to $4800.00 from $3800.00 2025 - changed to $3800.00 from $2400.00 2023 - changed to $2400.00 from $1600.00
Orthotics	15% coinsurance after deductible	Refer to prior authorization list. This benefit does not cover off-the-shelf shoe inserts or orthopedic shoes.	If not called out in PBT, default is 15% after deductible.
Outpatient Lab and Pathology	$5.00 copay Genetic Test - See Genetic Testing	Refer to prior authorization list. • One copay when technical component and professional component are performed by the same provider. • Separate copays when the components are performed by separate providers. • No pathology copay when inpatient	11.8.21 - Changed, genetic tests now included in lab copay. Genetic test no longer coinsurance, subject to the deductible. Added no copay when inpatient for pathology.11.8.21 - Changed, genetic tests now included in lab copay. Genetic test no longer coinsurance, subject to the deductible. Added no professional copay if inpatient for pathology.
Outpatient X-ray, Radiology (does not include scans)	$15.00 Copay	surgeon	Per meeting & BPT 8.24.20
Outpatient diagnostic, Complex imaging,scans, includes, MRI, CT scan, PET scan	15% after deductible	Refer to prior authorization list.	2025: Added wording, 'complex' for clarification – No change in benefit 2023 - No change
Outpatient hospital (facility)	15% coinsurance after deductible. Or $100.00 Outpatient Hospital Facility Surgery Copay after deductible (Same as ASC)	Refer to prior authorization list. • Includes Sleep Studies • Prior Authorization is required for certain outpatient surgery/procedures. • Professional fees are separate from the facility fees.	2026: Clarification, no change, cost share same as outpatient hospital. 2024: Added Surgery Copay
Outpatient Professional, Physician and Surgical services (surgeon, asst. surgeon, midwife/midwives, radiologist, pathologist)	$25.00 copay not subject to the deductible Other 15% after deductible	• Prior Authorization is required for certain outpatient surgery/procedures.	2025: Not subject to the deductible. Added midwife/midwives, radiologist, pathologist 11.8.21 - No Change BPT 8.24.20
Outpatient mental health visits (professional)	*$1.00 copay for E & M service, deductible does not apply. • Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply *Other services 20% coinsurance after the deductible	2026: 2 visit limit, $1 copay does not apply. Refer to the prior authorization list.	2026 reduced to $1.00 from $5.00. Removed Shared $1, 2 visit limits. No longer applied.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Outpatient rehabilitation services (physical (PT), speech (ST), occupational therapy (OT)	$5.00 copay	*25 combined visit limit per calendar year. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 25 visits. * Limit does not apply to these services with a behavioral health (mental health) diagnosis	2026 Clarification: No Change. Added wording, does not apply to these services with a behavioral health (mental health) diagnosis
Outpatient substance disuse, SUD, chemical dependency visits (professional)	$1.00 copay not subject to the deductible	2 visit limit, $1 copay does not apply. Refer to prior authorization list. Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.	2026 reduced to $1.00 from $5.00. Removed Shared $1, 2 visit limits. No longer applied.
Spinal Manipulations (not Chiropractors)	15% after deductible	See separate benefit for Chiropractors.	2023 - Clarified the difference between spinal manipulations from Chiropractors and other providers.
Surgery, ambulatory surgical centers (ASC)	$100.00 facility copay after the deductible. Copay cannot exceed the actual cost of the service. For example if the service is $50.00 the copay will be $50.00.	Refer to prior authorization list. • Prior Authorization is required for certain outpatient surgery/procedures. • Professional fees are separate from the facility fees.	BPT 8.24.20
Over the Counter (OTC) medication/pharmacy	NOT COVERED except FDA approved, FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides. OTC Covid Tests are not covered. See Pharmacy.		EOC
Partial hospitalization service intensive outpatient mental health services (facility)	*$1.00 copay for E & M service, deductible does not apply. • Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply *Other services 20% coinsurance after the deductible	2026: 2 visit limit, $1 copay does not apply.	2026 reduced to $1.00 from $5.00. Removed Shared $1, 2 visit limits. No longer applied.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Outpatient substance disuse, SUD, chemical dependency (facility)	$1.00 copay not subject to the deductible	2 visit limit, $1 copay does not apply. Refer to prior authorization list. Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.	2026 reduced to $1.00 from $5.00. Removed Shared $1, 2 visit limits. No longer applied.
Physical Exam, Periodic Exam, Annual Exam, Screenings, Preventive	$0 Cost Share		BPT 8.24.20
Primary Care Physician (PCP) office visits	*$1.00 copay for E & M service, deductible does not apply. • Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply *Other services 20% coinsurance after the deductible	2026: 2 visit limit, $1 copay no longer applies.	2026 reduced to $1.00 from $5.00. Removed Shared $1, 2 visit limits. No longer applied. 2024: 2 visits at $1 copay, after which regular copay applies. These visits apply to a combination of benefits, PCP visit and Nutritional Counseling Visit and Prenatal Congenital Anomalies Office Visit. For example, a PCP on one day and Nutritional Counseling on separate day ,the 2 visit, $1.00 copay is maxed
Podiatry Services (Routine Foot Care)	$0 Cost share	Not limited to diabetic condition.	2026: Removed diabetics only to Medically necessary. Not limited to diabetic related dx Still $0 copay
Podiatry Services (Foot Care) Medical Covered	$0 Cost share		2026: Changed to $0 copay from 15% (2026 Same as routine)
Prescription drugs, pharmacy	Not subject to the deductible: • Asthma inhalers/ epinephrine auto injectors/EpiPen -$35.00, 30-day Supply • Insulin, $35, 30-day supply • Generic, $5, 30-day supply • Generic, $13.50-90 day supply • Preferred, $12.00, 30-day supply • Preferred, $32.40, 90 day supply • Non-Preferred, $35.00 copay 30-day supply. Limited to 30-day supply. • Specialty Rx $35.00 copay 30-day supply. Limited to 30-day supply.	• Immunizations administered by pharmacists in a pharmacy must be submitted as a professional claim (HCFA). • Not covered: Over the counter (OTC) except FDA approved, FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides. • OTC Covid Tests are not covered.	2025: New: Asthma inhalers/ epinephrine auto injectors/EpiPen -$35.00, 30-day Supply 2023 changes from Summary of Benefits (SOB) • Generic $5 copay for 30-day supply from $3.00 90-day supply $13.50 from $8.10, not subject to the deductible. • Insulin, Limit 1-month/30 supply, cost share $35.00 from no more than $100.00, not subject to the deductible.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Prostate cancer screening exams (PSA)	$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. For men over age 50: • Every 12 months: Digital rectal exam • Every 12 months PSA test	BPT 8.24.20
Prosthetic devices and related supplies	15% coinsurance after deductible	Refer to prior authorization list. Prior Authorization required if purchase is $500.00 or more or rental is $500.00 per month or more Prosthetic/Orthopedic Shoes that are part of a leg brace are covered and included in the cost of the leg brace.	BPT 8.24.20
Pulmonary rehabilitation services	15% coinsurance after deductible	*Refer to prior authorization list.* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	07/14/23 – Added Prior Authorization
Reconstructive Surgery	Cost share determined by service: Inpatient hospital copays, outpatient facility fees, surgeon, anesthesia, etc. Other - 15% after deductible	Refer to prior authorization list. Covered because of an accidental injury or to improve a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.	BPT 8.24.20
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	$0 copay		BPT 8.24.20
Skilled nursing inpatient facility (SNF) care	Days: 1-5 - $100.00.00 per day after the deductible. No more than 5 days of copayments per stay. Professional: All inpatient professional services 15% coinsurance after the deductible.	Refer to prior authorization list. Coverage is limited to 60 inpatient days per year • Nursing Facility services are covered when provided as an alternative to hospitalization and prescribed by your Provider. • Room and board is limited to a semi-private room, except when a private room is determined to be Medically Necessary. • Care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome, including services provided by a licensed behavioral health Provider for a covered diagnosis. Not Covered: Maintenance and Custodial Care are not covered.	11.8.21 - Added Cost Shares for inpatient professional services. 06.11.21 - Changed cost shares from per day to a limit of 5 per stay. BPT 8.24.20
Smoking and tobacco use cessation	0% Coinsurance with Alere Or 15% Coinsurance other providers	0% Coinsurance with through Alere Quit-for-Life smoking cessation program. 15% Coinsurance if not Alere Quit-for-Life smoking cessation program	11.8.21 -Added coinsurance if not Alere Quit-for-Life smoking cessation program.

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Sterilization Reversal	Not Covered	Not Covered reversal of surgical sterilization, including any direct or indirect complications thereof.	EOC
Specialist Care/Services	*$15.00 for E & M (visit) only. Deductible does not apply. * Separate copay for facility clinic visit * Separate copay for lab and x-ray services * Separate cost shares for additional services may apply	• SPECIALIST COPAY DOES NOT APPLY TO THE FOLLOWING, SEE RELATED BENEFIT IN THIS GRID: •Acupuncture Visits - new 2026 •Chiropractic Care Visits - new 2026 •Hearing Exams Office Visits - new 2026 •Mental/Behavioral Health Outpatient Services •Other Practitioner Office Visits Naturopaths, Nurse practioner, Physician Assistant when not PCP •Prenatal and Post Natal Care related to Prenatal Congenital Anomalies •PCP •Substance Use Disorder Outpatient Services	2026: $15 copay changed to not subject to the deductible, from 'after the deductible'. Added: Hearing exam, Acupuncture and chiropractor to the DOES NOT APPLY list. 2025: Clarified wording. No Change in benefit. 2024: Added: Not Prenatal Congenital Anomalies Office Visits. See 'Prenatal Congenital Anomalies Office Visits in this grid.
Telemedicine, Telehealth (Virtual care)	Professional cost shares same as in person visits. Other services 15% afer deductible.		2025: Added for clarification, Other services 15% after deductible. No change in benefits.
Transplant Evaluation/Work-Up	Cost share determined by service: Office Visit, Specialist, Lab, etc.	Refer to prior authorization list.	
Transplant	Cost share determined by service: Inpatient hospital copays, anesthesia, etc.	Corneal transplant does not require prior authorization (PA), other transplants do require PA. All admissions, planned and urgent, require notification within 24 hrs. or next business day.	Per Justin, following Medicare PA requirements for Medicare covered services. Question out for clarification of reimbursement.
Transportation Non-emergency	Not covered	For emergency see Ambulance	EOC
Unlisted Codes with Charge Greater Than $250.00		Refer to prior authorization list. Unlisted codes is the actual, AMA description of the service. Medical necessity documentation and pricing must be submitted with the request. Example: 43499, Unlisted procedure, esophagus.	Following Medicare and Medicaid PA requirements
Urgently, Urgent needed care, in area, Participating and Non-participating providers	$15.00 Copay Not Subject to the deductible.	Out-of-area, urgent care is not covered. Out-of-area care is covered under the Emergency Care (ER) benefit and subject to the Emergency Care copay.	2024: Clarified out of area not covered. Added Non-Par providers (eff. 09/08/22). BPT 8.24.20
Wig (Covered under DME)	15% coinsurance after deductible	Must be medically necessary. Prior Authorization required if purchase exceeds $500.00	Cost share Appendix B EOC
Lung Cancer Screening	$0 Cost Share	Limited to ages 55 through 80, once per year.	BPT 8.24.20
Out-of-Area, Emergency Care Only	$150.00 facility copay and 15% coinsurance for professional services after deductible for out of network, out of area. Copay cannot exceed the actual cost of the service. For example if the service is $50.00 the copay will be $50.00.	Emergency Care Out of network,same as in-network cost shares. Professional fees and other services are separate from the facility fees, the 20% coinsurance subject to deductible or other copays may apply. Emergency Room copay waived if admitted inpatient within 24 hours.	11.8.21 - No change BPT 8.24.20

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Temporomandibular Joint Disorders, TMJ	Cost share determined by service, e.g. outpatient hospital copay, specialist visit, surgery, etc.		BPT 8.24.20
Maternity, OB Care, Prenatal, Postnatal, pregnancy	Cost share determined by service: Inpatient hospital copays, anesthesia, postnatal care, etc.	• Global OB physician care (prenatal, delivery and postpartum care) 0% cost share. • Inpatient hospital facility copays. $100.00 per day. No more than 5 days of copayments per stay. • Birthing Center facility fee $100.00 Copay after deductible • Professional fee in Birthing Center 0% cost share • Postnatal Care includes lactation support and counseling is $5.00 copay for E & M service and 15% coinsurance for other services.	2023 - Changed, Postnatal Care includes lactation support and counseling is $5.00 copay for E & M service not subject to the deductible and 15% coinsurance for other services subject to the deductible from $30.00. 11.8.21 Changed Birthing Center Facility from $100 per day after deductible to $100.00 Copay After Deductible. Changed cost share to $0 for Global OB. Changed cost share to $0 for professional fee in Birthing Center.
Well Baby, Newborn, preventive, donor milk	$0 Cost Share	Effective 1/1/2026: Donor Human Milk is covered when inpatient under Newborn Care.	New 2026: Donor Human Milk is covered when inpatient under Newborn Care.
Radiation	15% coinsurance after deductible		BPT 8.24.20
Transgender Treatment and Surgery		Refer to prior authorization list.	
Massage Therapy	Not Covered	Not Covered	Added to grid 11.29.21
Other Practitioner, includes naturopath, nurse practitioner or physician assistant (not PCP)	*$1.00 copay for E & M service, deductible does not apply. • Copay applies to E & M (visit) only • Separate copay for lab and x-ray services • Separate cost shares for additional services may apply *Other services 20% coinsurance after the deductible	2026: 2 visit limit, $1 copay does not apply.	2026 reduced copay to $1.00 from $5.00. Removed Shared $1, 2 visit limits. No longer applied. 2025: *2 visits at $1 copay, after which regular copay applies 2024: Corrected to Deductible does not apply.
Gender Affirming Care	Cost share determined by related service, e.g. PCP visit, outpatient hospital copay, specialist visit, surgery, etc.	Gender Affirming Care includes health care services prescribed to treat any condition related to gender identity, e.g. PCP visits, specialty care Rx, surgical services, etc.	New 2023 Added to Grid
Breast Pump and Related Supplies (DME)	No Cost Shares	All DME with a purchase price greater than $500.00 or rental of $200.00 per month allowed amount requires prior authorization.	2024: Added to Grid
Prenatal Congenital Anomalies Office Visits	$1.00 copay for E & M service, not subject to the deductible. Other services 20% coinsurance after the deductible.	2 visit limit for $1.00 copay does not apply.	2026 reduced copay to $1.00 from $10.00. Removed Shared $1, 2 visit limits. No longer applied.
SLEEP STUDIES	15% coinsurance after deductible	Refer to prior authorization list.	2026: No change. Cost share same as outpatient hospital. 2024: Added to Grid

COMMUNITY HEALTH PLAN of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Benefit or Service	Member Cost Share	Additional Information	
Surrogacy, surrogate mother, surrogate pregnancy	NOT COVERED	Surrogacy, surrogate mother, surrogate pregnancy, an assisted reproduction process, resulting in pregnancy of a child intended for other parents.	2026: Not Covered. Added to the grid.