

# 2021

## Schedule of Benefits

Community Health Network of Washington  
Cascade Select Bronze AI/AN Limited Cost Share Plan



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## Schedule of Benefits

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

### Community Health Network of Washington Cascade Select Bronze

There is no cost sharing with this plan when you receive care from an Indian health care provider. To avoid costs when receiving care outside of a tribal clinic, you must receive a referral.

Deductible and Out-of-Pocket Maximums	For Network Provider, You Pay
<b>Annual Deductible (per Calendar Year)</b>	
Individual	<b>\$6,000</b>
Family	<b>\$12,000</b>
<b>Annual Out-of-Pocket Maximum (per Calendar Year)</b>	
Individual	<b>\$8,550</b>
Family	<b>\$17,100</b>

## 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 [CHNW website](#). You may request a paper copy be mailed to you by calling Customer Service.

### Community Health Network of Washington Cascade Select Bronze

Benefit	For Network Provider, You Pay	
<b>Acupuncture</b> Limited to 12 visits per calendar year. (Unlimited visits for chemical dependency treatment.)	<b>\$50</b>	<b>Copay</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>40%</b>	<b>Coinsurance after Deductible</b>
<b>Anesthesia</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>Autologous Blood Donation/ Blood Transfusion</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>Chemotherapy and Radiation</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>Chemical Dependency (Substance Use Disorder)</b>		
<b>• Inpatient</b> (facility and professional)	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>• Office Visit</b>	<b>\$50 per visit</b>	<b>Copay</b>
<b>• Other Outpatient Professional and Facility Services</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>Diabetes Care Management</b>	<b>You Pay Nothing</b>	
<b>Diabetic Education and Diabetic Nutrition Education</b>		

## Community Health Network of Washington Cascade Select Bronze

Benefit	For Network Provider, You Pay	
• In Office	You Pay Nothing	
Dialysis Services	40%	Coinsurance after Deductible
<b>Durable Medical Equipment</b>		
• Durable Medical Equipment	40%	Coinsurance after Deductible
<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)		
• <b>Emergency Care Services</b> Co-insurance waived if admitted as an inpatient within 24 hours.	40%	Coinsurance after Deductible
• <b>Urgent Care</b>	\$100	Copay
<b>Genetic Services</b>		
• <b>Genetic Services</b> (Testing and associated services)	40%	Coinsurance after Deductible
<b>Habilitation Services</b> Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices.		
• <b>Inpatient</b> (facility and professional) <b>30 days per Calendar Year.</b>	40%	Coinsurance after Deductible
• <b>Outpatient</b> (facility and professional) Includes physical, speech, and occupational therapies. 25 visit maximum for all habilitation therapy services combined per Calendar Year.	40%	Coinsurance after Deductible
<b>Hearing</b>		
• <b>Cochlear Implants</b>	40%	Coinsurance after Deductible

## Community Health Network of Washington Cascade Select Bronze

Benefit	For Network Provider, You Pay	
<b>Home Health Care</b> Limited to 130 visits per Calendar Year.		
• Home Health Care	40%	Coinsurance after Deductible
<b>Hospice</b>		
• Hospice Care	40%	Coinsurance after Deductible
• Respite Care 14 days lifetime maximum	40%	Coinsurance after Deductible
<b>Hospital Inpatient Medical and Surgical Care</b>		
• Inpatient (facility and professional)	40%	Coinsurance after Deductible
• Inpatient professional (surgeon)	40%	Coinsurance after Deductible
• Inpatient professional services (assistant surgeon, radiologist, pathologist)	40%	Coinsurance after Deductible
<b>Hospital Outpatient Surgery and Services</b>		
• Outpatient surgery professional services (surgeon)	40%	Coinsurance after Deductible
• Outpatient surgery professional services (assistant surgeon, radiologist, pathologist)	40%	Coinsurance after Deductible
• Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	40%	Coinsurance after Deductible
<b>Infertility Diagnostic Services</b> Limited benefit, see Infertility Diagnostic Services below for details.	40%	Coinsurance after Deductible

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Benefit	For Network Provider, You Pay	
<b>Infusion Therapy</b> Includes infusion therapy provided in the home.	<i>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).</i>	
<b>Inherited Metabolic Disorder – PKU Services</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>Lab and Radiology Services</b> (non-routine, facility and professional services).		
• <b>Laboratory outpatient and Professional Services</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
• <b>X-Rays and Diagnostic Imaging</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
• <b>Complex Imaging</b> (Such as MRI, CT, PET)	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>Maternity and Newborn Care</b>		
• <b>Delivery and All Inpatient Services for Maternity Care</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
• <b>Prenatal Diagnosis of Congenital Anomalies</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
• <b>Maternity specialty care (global professional fee and all prenatal and postnatal care, except for Preventive Services)</b>	<b>\$50</b>	<b>Copay</b>
• <b>Newborn care</b>	<b>You Pay Nothing</b>	
<b>Mental Health Care</b> Admission to an inpatient facility, residential treatment and partial hospitalization services require Pre- Authorization.		
• <b>Inpatient</b> (facility and professional)	<b>40%</b>	<b>Coinsurance after Deductible</b>
• <b>Mental/Behavioral Health Outpatient Services</b>	<b>\$50</b>	<b>Copay</b>
<b>Prescription Drugs</b>	Administered by Express Scripts, Inc.	



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Benefit	For Network Provider, You Pay	
• <b>Generic Drugs</b>	\$32 per 30-day supply \$86 per 90-day supply	Prescription drugs are provided up to a 90 day supply at participating retail pharmacies or through mail order.
• <b>Preferred Brand Drugs</b>	40% per 30-day supply 40% per 90-day supply	Coinsurance after deductible. Prescription drugs are provided up to a 90 day supply at participating retail pharmacies or through mail order.
• <b>Non-Preferred Brand Drugs</b>	40% per 30-day supply	Coinsurance after deductible. Coverage is limited to a 30-day supply
• <b>Specialty Drugs</b> (exception: Insulin)	40% per 30-day supply *Enrollee cost sharing for insulin as follows: (1) cap total monthly OOP at \$100 / 30-day supply; (2) insulin is not subject to deductible	Coinsurance after deductible. Coverage is limited to a 30-day supply at specialty pharmacy.
• <b>Contraceptive Drugs &amp; Devices</b>	<b>You Pay Nothing</b>	
<b>Podiatric Care</b> <i>Podiatric Care includes Routine Foot Care, which is covered for diabetics only.</i>	<b>You Pay Nothing</b>	
<p><b>Preventive Care</b> Limits listed below are a guideline only. These limits are not meant to be benefit limitations. 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.</p>		

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Benefit	For Network Provider, You Pay	
<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. See Preventive Care for details. Travel immunizations are not covered.	<b>You Pay Nothing</b>	
<b>Preventive Care</b> Limits listed below are a guideline only. These limits are not meant to be benefit limitations.		<b>You Pay Nothing</b>
<b>Periodic Exams</b> (adult and child)	<b>You Pay Nothing</b>	
<b>Nutritional Counseling</b>	<b>\$50</b>	<b>Copay</b>
<b>Professional/Physician Services</b> (office visits)		
• <b>Primary Care Provider</b> (including naturopaths, nurse practitioners, and physician assistants)	<b>\$50 per visit</b>	<b>Copay</b>
• <b>Specialist</b>	<b>\$100 per visit</b>	<b>Copay after Deductible</b>
• <b>Mental Health and Chemical Dependency Providers</b>	<b>\$50 per visit</b>	<b>Copay</b>
<b>Reconstructive Surgery</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>
<b>Rehabilitation Therapy</b>		
• <b>Inpatient</b> (facility and professional). <b>30 days per Calendar Year.</b>	<b>40%</b>	<b>Coinsurance after Deductible</b>



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Benefit	For Network Provider, You Pay	
<ul style="list-style-type: none"> <li>• <b>Outpatient</b> (facility and professional) Includes physical, speech, and occupational therapies. 25 visit maximum for all rehabilitation therapy services combined per Calendar Year.</li> </ul>	40%	Coinsurance after Deductible
<ul style="list-style-type: none"> <li>• <b>Skilled Nursing Facility</b> 60 days per Calendar Year</li> </ul>	40%	Coinsurance after Deductible
<ul style="list-style-type: none"> <li>• <b>Spinal Manipulations</b> 10 visits per Calendar Year</li> </ul>	\$50	Copay
<ul style="list-style-type: none"> <li>• <b>Temporomandibular Joint Disorder Services</b></li> </ul>	40%	Coinsurance after Deductible
<ul style="list-style-type: none"> <li>• <b>Pediatric Vision</b> (under age 19)</li> </ul>	Administered by Vision Service Plan (VSP)	
<ul style="list-style-type: none"> <li>• <b>Routine Vision Screening</b> 1 exam per Calendar Year.</li> </ul>	You Pay Nothing	
<ul style="list-style-type: none"> <li>• <b>Low Vision Evaluation</b> (Comprehensive low vision evaluation every five year)</li> </ul>	You Pay Nothing	
<ul style="list-style-type: none"> <li>• <b>Comprehensive Eye Exam</b> (including dilation as professionally indicated and with refraction) 1 exam per Calendar Year.</li> </ul>	You Pay Nothing	
<ul style="list-style-type: none"> <li>• <b>Vision Hardware</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.</li> </ul>	You Pay Nothing	



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## Contact us

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