2021

Schedule of Benefits

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

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CS_MK_037_2021_Gold_AIAN_Zero_Cost_SB_M

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Schedule of Benefits

Your Provider Network is: CHPW Cascade Care Affiliate Network

Community Health Network of Washington Cascade Select Gold Zero Cost Share Plan Variation

Deductible and Out-of- Pocket Maximums	For Network Provider, You Pay
Annual Deductible (per Calendar Year)	
Individual	**Not Applicable**
Family	**Not Applicable**
Annual Out-of-Pocket Maximum (per Calendar Year)	
Individual	**Not Applicable**
Family	**Not Applicable**

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.

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Benefit	For Network Provider, You Pay
Acupuncture Limited to 12 visits per calendar year. (Unlimited visits for chemical dependency treatment.)	**You Pay Nothing**
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)	**You Pay Nothing**
Anesthesia	**You Pay Nothing**
Autologous Blood Donation/ Blood Transfusion	**You Pay Nothing**
Chemotherapy and Radiation	**You Pay Nothing**
Chemical Dependency (Substance Use Disorder)	
• **Inpatient** (facility and professional)	**You Pay Nothing**
• **Office Visit**	**You Pay Nothing**
• **Other Outpatient Professional and Facility Services**	**You Pay Nothing**

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Benefit	For Network Provider, You Pay	
Diabetes Care Management	**You Pay Nothing**	
Diabetic Education and Diabetic Nutrition Education		
• **In Office**	**You Pay Nothing**	
Dialysis Services	**You Pay Nothing**	
Durable Medical Equipment		
• **Durable Medical Equipment**	**You Pay Nothing**	
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** Co-insurance waived if admitted as an inpatient within 24 hours.	**You Pay Nothing**	
• **Urgent Care**	**You Pay Nothing**	
Genetic Services		
• **Genetic Services** (Testing and associated services)	**You Pay Nothing**	
Habilitation Services Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices.		
• **Inpatient** (facility and professional) 30 days per Calendar Year.	**You Pay Nothing**	
• **Outpatient** (facility and professional) Includes physical, speech, and occupational therapies. 25 visit maximum for all habilitation therapy services combined per Calendar Year.	**You Pay Nothing**	
Hearing		

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Benefit	For Network Provider, You Pay
• **Cochlear Implants**	**You Pay Nothing**
Home Health Care Limited to 130 visits per Calendar Year.	
• **Home Health Care**	**You Pay Nothing**
Hospice	
• **Hospice Care**	**You Pay Nothing**
• **Respite Care** 14 days lifetime maximum	**You Pay Nothing**
Hospital Inpatient Medical and Surgical Care	
• **Inpatient** (facility and professional) You pay no more than 5 copayments per stay.	**You Pay Nothing**
• **Inpatient professional** (surgeon)	**You Pay Nothing**
• **Inpatient professional services** (assistant surgeon, radiologist, pathologist)	**You Pay Nothing**
Hospital Outpatient Surgery and Services	
• **Outpatient surgery professional services** (surgeon)	**You Pay Nothing**
• **Outpatient surgery professional services** (assistant surgeon, radiologist, pathologist)	**You Pay Nothing**
• **Outpatient Facility Fee** (e.g. Ambulatory Surgery Center)	**You Pay Nothing**

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Benefit	For Network Provider, You Pay
Infertility Diagnostic Services Limited benefit, see Infertility Diagnostic Services below for details.	**You Pay Nothing**
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	**You Pay Nothing**
Lab and Radiology Services (non-routine, facility and professional services).	
• **Laboratory outpatient and Professional Services**	**You Pay Nothing**
• **X-Rays and Diagnostic Imaging**	**You Pay Nothing**
• **Complex Imaging** (Such as MRI, CT, PET)	**You Pay Nothing**
Maternity and Newborn Care	
• **Delivery and All Inpatient Services for Maternity Care**	**You Pay Nothing**
• **Prenatal Diagnosis of Congenital Anomalies**	**You Pay Nothing**
• **Maternity specialty care (global professional fee and all prenatal and postnatal care, except for Preventive Services)**	**You Pay Nothing**
• **Newborn care**	**You Pay Nothing**
Mental Health Care Admission to an inpatient facility, residential treatment and partial hospitalization services require Pre- Authorization.	

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Benefit	For Network Provider, You Pay	
• **Inpatient** (facility and professional) You pay no more than 5 copayments per stay.	**You Pay Nothing**	
• **Mental/Behavioral Health Outpatient Services**	**You Pay Nothing**	
Prescription Drugs	Administered by Express Scripts, Inc.	
• **Generic Drugs**	**You Pay Nothing**	Prescription drugs are provided up to a 90 day supply at participating retail pharmacies or through mail order.
• **Preferred Brand Drugs**	**You Pay Nothing**	Coinsurance after deductible. Prescription drugs are provided up to a 90 day supply at participating retail pharmacies or through mail order.
• **Non-Preferred Brand Drugs**	**You Pay Nothing**	Coverage is limited to a 30-day supply
• **Specialty Drugs** (exception: Insulin)	**You Pay Nothing**	Coverage is limited to a 30-day supply at specialty pharmacy.
• **Contraceptive Drugs & Devices**	**You Pay Nothing**	
Podiatric Care *Podiatric Care includes Routine Foot Care, which is covered for diabetics only.*	**You Pay Nothing**	
Preventive Care 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.		

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Benefit	For Network Provider, You Pay
Immunizations 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.	**You Pay Nothing**
Preventive Care 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	**You Pay Nothing**
Professional/Physician Services (office visits)	
• **Primary Care Provider** (including naturopaths, nurse practitioners, and physician assistants)	**You Pay Nothing**
• **Specialist**	**You Pay Nothing**
• **Mental Health and Chemical Dependency Providers**	**You Pay Nothing**
Reconstructive Surgery	**You Pay Nothing**
Rehabilitation Therapy	
• **Inpatient** (facility and professional). 30 days per Calendar Year. You pay no more than 5 copayments per stay.	**You Pay Nothing**

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Benefit	For Network Provider, You Pay
• **Outpatient** (facility and professional) Includes physical, speech, and occupational therapies. 25 visit maximum for all rehabilitation therapy services combined per Calendar Year.	**You Pay Nothing**
Skilled Nursing Facility 60 days per Calendar Year. You pay no more than 5 copayments per stay.	**You Pay Nothing**
Spinal Manipulations 10 visits per Calendar Year	**You Pay Nothing**
Temporomandibular Joint Disorder Services	**You Pay Nothing**
• **Routine Vision Screening** 1 exam per Calendar Year.	**You Pay Nothing**
• **Low Vision Evaluation** (Comprehensive low vision evaluation every five year)	**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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Contact us

Prospective Members
1-833-993-0181

Current Members
1-866-907-1906

TTY Relay: Dial 711

8:00 a.m. to 5:00 p.m.
Monday through Friday

1111 3rd Ave, Suite 400
Seattle, WA 98101-3207

cascadeselect.org