

2021

Schedule of Benefits

Community Health Network of Washington
Cascade Select Gold AI/AN Zero 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 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.	<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>
Inherited Metabolic Disorder – PKU Services	You Pay Nothing
Lab and Radiology Services (non-routine, facility and professional services).	
<ul style="list-style-type: none"> • Laboratory outpatient and Professional Services 	You Pay Nothing
<ul style="list-style-type: none"> • X-Rays and Diagnostic Imaging 	You Pay Nothing
<ul style="list-style-type: none"> • Complex Imaging (Such as MRI, CT, PET) 	You Pay Nothing
Maternity and Newborn Care	
<ul style="list-style-type: none"> • Delivery and All Inpatient Services for Maternity Care 	You Pay Nothing
<ul style="list-style-type: none"> • Prenatal Diagnosis of Congenital Anomalies 	You Pay Nothing
<ul style="list-style-type: none"> • Maternity specialty care (global professional fee and all prenatal and postnatal care, except for Preventive Services) 	You Pay Nothing
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> Inpatient (facility and professional) You pay no more than 5 copayments per stay. 	You Pay Nothing	
<ul style="list-style-type: none"> Mental/Behavioral Health Outpatient Services 	You Pay Nothing	
Prescription Drugs	Administered by Express Scripts, Inc.	
<ul style="list-style-type: none"> Generic Drugs 	You Pay Nothing	Prescription drugs are provided up to a 90 day supply at participating retail pharmacies or through mail order.
<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Non-Preferred Brand Drugs 	You Pay Nothing	Coverage is limited to a 30-day supply
<ul style="list-style-type: none"> Specialty Drugs (exception: Insulin) 	You Pay Nothing	Coverage is limited to a 30-day supply at specialty pharmacy.
<ul style="list-style-type: none"> Contraceptive Drugs & Devices 	You Pay Nothing	
Podiatric Care <i>Podiatric Care includes Routine Foot Care, which is covered for diabetics only.</i>	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)	
<ul style="list-style-type: none"> • Primary Care Provider (including naturopaths, nurse practitioners, and physician assistants) 	You Pay Nothing
<ul style="list-style-type: none"> • Specialist 	You Pay Nothing
<ul style="list-style-type: none"> • Mental Health and Chemical Dependency Providers 	You Pay Nothing
Reconstructive Surgery	You Pay Nothing
Rehabilitation Therapy	
<ul style="list-style-type: none"> • 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
<p>• Outpatient (facility and professional) Includes physical, speech, and occupational therapies. 25 visit maximum for all rehabilitation therapy services combined per Calendar Year.</p>	<p>You Pay Nothing</p>
<p>Skilled Nursing Facility 60 days per Calendar Year. You pay no more than 5 copayments per stay.</p>	<p>You Pay Nothing</p>
<p>Spinal Manipulations 10 visits per Calendar Year</p>	<p>You Pay Nothing</p>
<p>Temporomandibular Joint Disorder Services</p>	<p>You Pay Nothing</p>
<p>• Routine Vision Screening 1 exam per Calendar Year.</p>	<p>You Pay Nothing</p>
<p>• Low Vision Evaluation (Comprehensive low vision evaluation every five year)</p>	<p>You Pay Nothing</p>
<p>• Comprehensive Eye Exam (including dilation as professionally indicated and with refraction) 1 exam per Calendar Year.</p>	<p>You Pay Nothing</p>
<p>• 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.</p>	<p>You Pay Nothing</p>



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