2021

Schedule of Benefits

Community Health Network of Washington
Cascade Select Gold Plan

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Schedule of Benefits

Your Provider Network is: CHPW Cascade Care Affiliate Network

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Deductible and Out-of- Pocket Maximums	For Network Provider, You Pay
Annual Deductible (per Calendar Year)	
Individual	**$500**
Family	**$1,000**
Annual Out-of-Pocket Maximum (per Calendar Year)	
Individual	**$5,250**
Family	**$10,500**

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.)	**$15**	**Copay**
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)	**$375**	**Copay**
Anesthesia	**20%**	**Coinsurance after Deductible**
Autologous Blood Donation/ Blood Transfusion	**20%**	**Coinsurance after Deductible**
Chemotherapy and Radiation	**20%**	**Coinsurance after Deductible**
Chemical Dependency (Substance Use Disorder)		
• **Inpatient** (facility and professional) You pay no more than 5 copayments per stay.	**$525 per day**	**Copay**
• **Office Visit**	**$15 per visit**	**Copay**
• **Other Outpatient Professional and Facility Services**	**$15 per visit**	**Copay**

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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	**20%**	**Coinsurance after Deductible**
Durable Medical Equipment		
• **Durable Medical Equipment**	**20%**	**Coinsurance after Deductible**
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.	**$450**	**Coinsurance after Deductible**
• **Urgent Care**	**$35**	**Copay**
Genetic Services		
• **Genetic Services** (Testing and associated services)	**$20**	**Copay**
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 no more than 5 copayments per stay.	**$525* Included with Inpatient Copay**	**Copay**
• **Outpatient** (facility and professional) Includes physical, speech, and occupational therapies. 25 visit maximum for all habilitation therapy services combined per Calendar Year.	**$25 per visit**	**Copay**

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Benefit	For Network Provider, You Pay	
Hearing		
• **Cochlear Implants**	**20%**	**Coinsurance after Deductible**
Home Health Care Limited to 130 visits per Calendar Year.		
• **Home Health Care**	**20%**	**Coinsurance after Deductible**
Hospice		
• **Hospice Care**	**20%**	**Coinsurance after Deductible**
• **Respite Care** 14 days lifetime maximum	**20%**	**Coinsurance after Deductible**
Hospital Inpatient Medical and Surgical Care		
• **Inpatient** (facility and professional) You pay no more than 5 copayments per stay.	**$525 per day**	**Copay**
• **Inpatient professional** (surgeon)	**Included with facility copay**	**Copay**
• **Inpatient professional services** (assistant surgeon, radiologist, pathologist)	**Included with facility copay**	**Copay**
Hospital Outpatient Surgery and Services		
• **Outpatient surgery professional services** (surgeon)	**$75**	**Copay after Deductible**
• **Outpatient surgery professional services** (assistant surgeon, radiologist, pathologist)	**$75**	**Copay after Deductible**
• **Outpatient Facility Fee** (e.g. Ambulatory Surgery Center)	**$350**	**Copay after Deductible**

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Benefit	For Network Provider, You Pay	
Infertility Diagnostic Services Limited benefit, see Infertility Diagnostic Services below for details.	**20%**	**Coinsurance after Deductible**
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	**20%**	**Coinsurance after Deductible**
Lab and Radiology Services (non-routine, facility and professional services).		
• **Laboratory outpatient and Professional Services**	**$20**	**Copay**
• **X-Rays and Diagnostic Imaging**	**$30**	**Copay**
• **Complex Imaging** (Such as MRI, CT, PET)	**$300**	**Copay**
Maternity and Newborn Care		
• **Delivery and All Inpatient Services for Maternity Care**	**$525 per day**	**Copay**
• **Prenatal Diagnosis of Congenital Anomalies**	**$30**	**Copay**
• **Maternity specialty care (global professional fee and all prenatal and postnatal care, except for Preventive Services)**	**$15**	**Copay**
• **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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• **Inpatient** (facility and professional) You pay no more than 5 copayments per stay.	**$525 per day**	**Copay**
• **Mental/Behavioral Health Outpatient Services**	**$15**	**Copay**
Prescription Drugs	Administered by Express Scripts, Inc.	
• **Generic Drugs**	$10 per 30-day supply $27 per 90-day supply	Prescription drugs are provided up to a 90 day supply at participating retail pharmacies or through mail order.
• **Preferred Brand Drugs**	$60 per 30-day supply $162 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.
• **Non-Preferred Brand Drugs**	$100 per 30-day supply	Coverage is limited to a 30-day supply
• **Specialty Drugs** (exception: Insulin)	$100 *Enrollee cost sharing for insulin as follows: (1) cap total monthly OOP at $100 / 30-day supply; (2) insulin is not subject to deductible	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	**$15**	**Copay**
Professional/Physician Services (office visits)		
• **Primary Care Provider** (including naturopaths, nurse practitioners, and physician assistants)	**$15 per visit**	**Copay**
• **Specialist**	**$40 per visit**	**Copay**
• **Mental Health and Chemical Dependency Providers**	**$15 per visit**	**Copay**
Reconstructive Surgery	**20%**	**Coinsurance after Deductible**
Rehabilitation Therapy		
• **Inpatient** (facility and professional). 30 days per Calendar Year. You pay no more than 5 copayments per stay.	**$525 per day**	**Copay**

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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.	**$25 per visit**	**Copay**
Skilled Nursing Facility 60 days per Calendar Year. You pay no more than 5 copayments per stay.	**$350 per day**	**Copay after Deductible**
Spinal Manipulations 10 visits per Calendar Year	**$15**	**Copay**
Temporomandibular Joint Disorder Services	**20%**	**Coinsurance after Deductible**
Pediatric Vision (under age 19)	Administered by Vision Service Plan (VSP)	
• **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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