

2021

Schedule of Benefits

Community Health Network of Washington
Cascade Select Silver Variant 94% 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	\$150
Family	\$300
Annual Out-of-Pocket Maximum (per Calendar Year)	
Individual	\$800
Family	\$1,600

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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.)	\$3	Copay
Ambulance Services	\$75	Copay
Anesthesia	15%	Coinsurance after Deductible
Autologous Blood Donation/ Blood Transfusion	15%	Coinsurance after Deductible
Chemotherapy and Radiation	15%	Coinsurance after Deductible
Chemical Dependency (Substance Use Disorder)		
• Inpatient (facility and professional) You pay no more than 5 copayments per stay.	\$100 per day	Copay after Deductible
• Office Visit	\$3 per visit	Copay
• Other Outpatient Professional and Facility Services	\$3 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	15%	Coinsurance after Deductible
Durable Medical Equipment		
• Durable Medical Equipment	15%	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.	\$150	Copay after Deductible
• Urgent Care	\$15	Copay
Genetic Services		
• Genetic Services (Testing and associated services)	\$5	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.	\$100 per day	Copay after Deductible
• Outpatient (facility and professional) Includes physical, speech, and occupational therapies. 25 visit maximum for all habilitation therapy services combined per Calendar Year.	\$5 per visit	Copay

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Benefit	For Network Provider, You Pay	
Hearing		
• Cochlear Implants	15%	Coinsurance after Deductible
Home Health Care Limited to 130 visits per Calendar Year.		
• Home Health Care	15%	Coinsurance after Deductible
Hospice		
• Hospice Care	15%	Coinsurance after Deductible
• Respite Care 14 days lifetime maximum	15%	Coinsurance after Deductible
Hospital Inpatient Medical and Surgical Care		
• Inpatient (facility and professional) You pay no more than 5 copayments per stay.	\$100 per day	Copay after Deductible
• Inpatient professional (surgeon)	Included with facility copay	Copay after Deductible
• Inpatient professional services (assistant surgeon, radiologist, pathologist)	Included with facility copay	Copay after Deductible
Hospital Outpatient Surgery and Services		
• Outpatient surgery professional services (surgeon)	\$25	Copay after Deductible
• Outpatient surgery professional services (assistant surgeon, radiologist, pathologist)	\$25	Copay after Deductible
• Outpatient Facility Fee (e.g. Ambulatory Surgery Center)	\$100	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.	15%	Coinsurance after Deductible
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	15%	Coinsurance after Deductible
Lab and Radiology Services (non-routine, facility and professional services).		
• Laboratory outpatient and Professional Services	\$5	Copay
• X-Rays and Diagnostic Imaging	\$15	Copay
• Complex Imaging (Such as MRI, CT, PET)	15%	Coinsurance after Deductible
Maternity and Newborn Care		
• Delivery and All Inpatient Services for Maternity Care [You pay no more than 5 copayments per stay.]	\$100 per day	Copay after Deductible
• Prenatal Diagnosis of Congenital Anomalies	\$15	Copay
• Maternity specialty care (global professional fee and all prenatal and postnatal care, except for Preventive Services)	\$3	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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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. 	\$100 per day	Copay after Deductible
<ul style="list-style-type: none"> Mental/Behavioral Health Outpatient Services 	\$3	Copay
Prescription Drugs	Administered by Express Scripts, Inc.	
<ul style="list-style-type: none"> Generic Drugs 	\$3 per 30-day supply \$8.10 per 90-day supply	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 	\$12 per 30-day supply \$32.40 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.
<ul style="list-style-type: none"> Non-Preferred Brand Drugs 	\$35 per 30-day supply	Coverage is limited to a 30-day supply
<ul style="list-style-type: none"> Specialty Drugs (exception: Insulin) 	\$35 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	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	
<p>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.</p>		

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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	\$3	Copay
Professional/Physician Services (office visits)		
• Primary Care Provider (including naturopaths, nurse practitioners, and physician assistants)	\$3 per visit	Copay
• Specialist	\$15 per visit	Copay
• Mental Health and Chemical Dependency Providers	\$3 per visit	Copay
• Reconstructive Surgery	15%	Coinsurance after Deductible
Rehabilitation Therapy		
• Inpatient (facility and professional). 30 days per Calendar Year. You pay no more than 5 copayments per stay.	\$100 per day	Copay

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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>	\$5 per visit	Copay
<p>Skilled Nursing Facility 60 days per Calendar Year. You pay no more than 5 copayments per stay.</p>	\$100 per day	Copay after Deductible
<p>Spinal Manipulations 10 visits per Calendar Year</p>	\$3	Copay
<p>Temporomandibular Joint Disorder Services</p>	15%	Coinsurance after Deductible
<p>Pediatric Vision (under age 19)</p>	Administered by Vision Service Plan (VSP)	
<p>• Routine Vision Screening 1 exam per Calendar Year.</p>	You Pay Nothing	
<p>• Low Vision Evaluation (Comprehensive low vision evaluation every five year)</p>	You Pay Nothing	
<p>• Comprehensive Eye Exam (including dilation as professionally indicated and with refraction) 1 exam per Calendar Year.</p>	You Pay Nothing	
<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>	You Pay Nothing	



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Contact us

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Current Members
1-866-907-1906

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