COMMUNITY HEALTH PLAN of Washington™ | MEDICARE ADVANTAGE

The power of community

Community Health Plan of Washington
Dual Complete (HMO D-SNP) | Dual Select (HMO-D-SNP)

2024 Summary of Benefits

$0 or 20%?

With full Medicaid cost-share assistance, you pay $0 copays for covered services. Without full Medicaid cost-share assistance, you may pay up to 20% for services; the exact amount depends on the level of Medicaid assistance you receive.

Get ***More Than*** Original Medicare

CHPW Dual Complete (HMO D-SNP)

Service areas: Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Douglas, Franklin, Grant, Grays Harbor, Jefferson, King, Kittitas, Kitsap, Lewis, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima.

CHPW Dual Complete (HMO D-SNP)
Summary of Premiums & Benefits

Monthly Plan Premium 	$0* *Your monthly plan premium of $40.60 is paid for as long as you qualify for 100% Low Income Subsidy (“Extra Help”)
Deductible	$0. (Without Medicaid cost-share assistance, deductible of $226 applies for Medicare Part B services. This is the 2023 amount, and may change for 2024. Please contact Customer Service for updated amounts.)
Maximum Out-of-Pocket Responsibility (does not include prescription drugs) 	Your yearly limit(s) in this plan: $8,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost of your Part D prescription drugs.
Inpatient Hospital 	$0 copay with full Medicaid cost-share assistance. Without full Medicaid cost-share assistance, Part A deductible and copays apply. These are 2023 cost sharing amounts and may change for 2024. Please contact Customer Service for updated amounts. · $1,600 deductible for days 1-60 · $400 copay for days 61 to 90 · $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) Each new benefit period begins with a new day 1.
Outpatient Hospital 	$0 for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center 	You pay $0.

CHPW Dual Complete (HMO D-SNP)
Summary of Premiums & Benefits

Doctor Visits[1,2]
(Primary care and Specialists)

$0 for each Medicare-covered primary care provider or specialist visit (including telehealth).

Preventive Care[2]

$0 for preventive services, such as flu shots, and yearly "Wellness" visits.

Any additional preventive services approved by Medicare during the contract year will be covered. Eight counseling calls per year and Nicotine Replacement Therapy of up to 12 weeks are also available. Please call for more details.

Emergency Care

$0 for each Medicare-covered emergency room visit.

Urgently Needed Services

$0 for Medicare-covered urgently-needed care visits.

Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

If additional services are provided, cost sharing may apply. For urgently needed services received outside of the U.S. and its territories, please see "Worldwide emergency/urgent care."

Diagnostic Services/ Labs/Imaging[1]

Diagnostic radiology services *(such as MRIs, CT scans)*:
$0

Lab services:
$0

Diagnostic tests and procedures:
$0

Outpatient X-rays:
$0

Therapeutic radiology services, such as radiation treatment for cancer:
$0

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

Hearing Services[1,2]

Hearing Services:
$0 for Medicare-covered diagnostic hearing exams.

Hearing Services (supplemental):
$0 for one routine hearing exam per year and one hearing aid fitting/evaluation per year. You pay nothing for supplemental hearing aids and supplies, up to the $2,250 benefit limit every calendar year. Limit one per ear per year. You pay for any costs over the plan benefit limit.

Dental Services[1]

$0 copay for supplemental preventive and comprehensive services combined, up to $5,000 per year.

You pay nothing for supplemental preventive and comprehensive services up to $5,000 combined total benefit limit per year. You must use a dentist who is part of Delta Dental of Washington's dental network. To find the most current listing of Delta Dental PPO Plus Premier network dentists, visit DeltaDentalWA.com. Delta Dental Network Providers must submit claims for these dental services to Delta Dental of Washington. You will be responsible for all, or most, services provided by Out of Network dentists.

Vision Services

Vision services:
$0 for the cost for Medicare-covered exams to diagnose and treat diseases and conditions of the eye

Vision services (supplemental):
(Through the Vision Service Plan (VSP) Choice Network)
- $0 for one WellVision exam every year.
- Up to the $500 plan benefit limit, every year for supplemental hardware.

Outside of the VSP Choice network:
- 100% of the cost over the plan benefit limit.

Mental Health Services[1,2] 	**Inpatient visit:** $0 copay with full Medicaid cost-share assistance. Without full Medicaid cost-share assistance, Part A deductible and copays apply. These are 2023 cost sharing amounts and may change for 2024. Please contact Customer Service for updated amounts. · $1,600 deductible for days 1 to 60 for each benefit period · $400 copay for days 61 to 90 for each benefit period · $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) **Outpatient group and/or individual therapy visit (including telehealth):** You pay $0.
Skilled Nursing Facility (SNF)[1,2] 	$0 copay with full Medicaid cost-share assistance. Without full Medicaid cost-share assistance, you pay the following. These are 2023 cost sharing amounts and may change for 2024. Please contact Customer Service for updated amounts. Days 1 to 20: $0 copay per day for each benefit period Days 21 to 100: $200 copay per day for each benefit period Days 101 and beyond: all cost
Physical Therapy 	You pay $0 for Medicare-covered physical therapy services.
Ambulance[1] 	You pay $0 for one-way, Medicare-covered ambulance services.
Transportation 	You pay nothing for up to 40 one-way trips (50-mile limit) to health-related appointments each calendar year.
Medicare Part B Drugs 	You pay $0 for Medicare covered Part B drugs: · Part B drugs such as chemotherapy drugs[1] · Other Part B drugs[1]

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

Medicare Part D Drugs Deductible $0

You may get your drugs at network retail pharmacies and mail order pharmacies.

Retail cost sharing

	Pharmacy	
Tier	30 Day supply	90 Day supply
All Tiers	$0	$0

Preferred Mail Order Cost-Sharing

Tier	90 day supplies
All Tiers	$0

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as at a standard retail pharmacy.

CHPW Dual Complete (HMO D-SNP)
Summary of Other Benefits

Health & Wellbeing 	$0 copay for covered services which include acupuncture, naturopathy, routine chiropractic, massage therapy, and CHPW-recommended wellbeing programs with up to 25 sessions or visits on all service types combined per year. *These services must be performed by a state certified practitioner.*
Telehealth Services 	**We cover telehealth services, including virtual visits with:** · Primary care provider · Specialist · Urgent Care · Individual and group sessions for outpatient mental health, psychiatric, and substance abuse You pay the same as you would for an in-person visit.
Diabetic Supplies/ Diabetes Supplies and Services 	$0 for the cost of Medicare-covered diabetic self-management, diabetes services and supplies. Diabetic medication, such as insulin, injected by syringe is typically covered by your Part D prescription drug coverage.
Durable Medical Equipment [1] 	$0 for Medicare-covered durable medical equipment.

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

Fitness Program 	**$0 copay for the following:** · Home fitness kit (options include activity tracker, videos, and exercise equipment) · Membership at participating fitness center · Online and smartphone fitness app tools
Foot Care[1,2] (podiatry services) 	**Podiatry Services:** $0 of the cost for each Medicare-covered podiatry visit. Covered services include: · Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) · Routine foot care for members with certain medical conditions affecting the lower limbs. **Podiatry Services (supplemental):** $0 of the cost for each supplemental podiatry visit. Our supplemental benefit includes up to four (4) visits per year for non-Medicare covered foot care from a Medicare-approved foot care provider.
Home Health Care[1,2] 	$0 copay for Medicare-covered home health services.
Hospice 	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Community Health Plan of Washington Medicare Advantage.

CHPW Dual Complete (HMO D-SNP)
Summary of Other Benefits

Meals When You Need It Most	You pay nothing for covered meals up to the maximum benefit. Benefit includes 28 meals post discharge from each hospital or skilled nursing facility admission. Also available with a positive COVID-19 diagnosis. Meal program limited to 6 instances per calendar year.	
Outpatient Substance Abuse[1,2]	**Group therapy visit:** $0	**Individual therapy visit:** $0
Over-the-Counter (OTC) & Grocery	$100 every month to spend on covered grocery and OTC items.	
Prosthetic Devices[1] (Braces, artificial limbs, etc.)	**Medicare-covered:**	
	Prosthetic Devices You pay $0 for Medicare-covered prosthetic devices	**Medical Supplies** You pay $0 for Medicare-covered medical supplies
Renal Dialysis[1]	$0	
Worldwide Emergency/ Urgent Care	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000. This plan covers supplemental emergency services, urgent services, and emergency transportation received outside of the U.S. and its territories up to a plan coverage limit.	
Family on Demand	Family on Demand, offered by CHPW through Papa Pals, pairs you with members of your community for an extra pair of hands, a shoulder to lean on, and a listening ear. You get 60 hours of Family on Demand per year–for help with errands or meal prep, simple tech support, or just a little company.	

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

What Medicaid covers

The benefits described below are covered by Medicaid (Apple Health). The benefits described in Covered-Medical and Hospital Benefits Section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what Apple Health covers. What you pay for covered services may depend on your level of Medicaid eligibility.

Benefit	CHPW Dual Complete	Medicaid*
INPATIENT CARE		
Inpatient Hospital Care (includes Substance Abuse and Rehabilitation)	✓ Covered	Covered
Inpatient Mental Health Care	✓ Covered	Covered
Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	✓ Covered	Covered
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	✓ Covered	Covered
Hospice	✓ Covered	Covered
OUTPATIENT CARE		
Doctor Office Visits	✓ Covered	Covered
Chiropractic Services	✓ Covered	20 and under - Covered 21 and over - Not Covered
Podiatry Services	✓ Covered	Covered for medically necessary procedures
Outpatient Mental Health Care	✓ Covered	Covered

** This list is provided for general information only and does not guarantee that the services will actually be covered.*

CHPW Dual Complete (HMO D-SNP)
Summary of Other Benefits

Benefit	CHPW Dual Complete	Medicaid*
OUTPATIENT CARE *(continued)*		
Outpatient Substance Abuse Care	✓ Covered	Covered with restrictions
Outpatient Services	✓ Covered	Covered
Ambulance Services (medically necessary ambulance services)	✓ Covered	Covered with restrictions
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care)	✓ Covered	Covered
Urgently Needed Services (This is not emergency care, and in most cases, is out of the service area. See page 3 for more details.)	✓ Covered	Covered
Outpatient Rehabilitation Services (Occupational Therapy physical therapy, Speech and language therapy.)	✓ Covered	Covered with limitations
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	✓ Covered	Covered
Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	✓ Covered	Covered
Diabetes Programs and Supplies	✓ Covered	Covered
Cardiac and Pulmonary Rehabilitation Services	✓ Covered	Covered

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

Benefit	CHPW Dual Complete	Medicaid*
PREVENTIVE SERVICES		
Preventive Services: • Abdominal aortic aneurysm • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening • Cardiovascular disease • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression Screening • Diabetes Screenings • HIV screening • Medicare Diabetes Prevention Program • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling • Vaccines including COVID-19, Flu, Hepatitis B and Pneumococal shots • "Welcome to Medicare" preventive visit • Yearly "Wellness" Visit	✓ Covered plus Nicotine Replacement Therapy and counseling	Covered with limitations

** This list is provided for general information only and does not guarantee that the services will actually be covered.*

CHPW Dual Complete (HMO D-SNP)
Summary of Other Benefits

Benefit	CHPW Dual Complete	Medicaid*
PRESCRIPTION DRUG BENEFITS		
Outpatient Prescription Drugs	✓ Covered	Covered with restrictions
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
Dental Services	✓ Covered	Not covered
Hearing Services	✓ Covered - Hearing Exam and Hearing Aid device	Covered - Hearing exam only
Vision Services	✓ Covered plus additional hardware benefit	Covered
Fitness Program	✓ Covered	Not covered
Over-the-counter (OTC) & Grocery	✓ Covered	Not covered
Non-emergency Medical Transportation (NEMT)	✓ Covered	Covered
Health & Wellbeing	✓ Covered	Not covered

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CHPW Dual Select (HMO D-SNP)

Service areas: Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Douglas, Franklin, Grant, Grays Harbor, Jefferson, King, Kittitas, Kitsap, Lewis, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima.

CHPW Dual Select (HMO D-SNP)
Summary of Premiums & Benefits

Monthly Plan Premium	$0 - $40.60 (exact amount depends on level of Extra Help)
Deductible	Without Medicaid cost-share assistance, deductible of $226 applies for Medicare Part B services. This is the 2023 amount, and may change for 2024. Please contact Customer Service for updated amounts.
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: $8,850 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your share of the cost of your Part D prescription drugs.
Inpatient Hospital	Without full Medicaid cost-share assistance, Part A deductible and copays apply. These are 2023 cost sharing amounts and may change for 2024. Please contact Customer Service for updated amounts. · $1,600 deductible for days 1-60 · $400 copay for days 61 to 90 · $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) Each new benefit period begins with a new day 1.
Outpatient Hospital	$0 or 20% for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center	You pay $0 or 20%.

Doctor Visits[1,2]
(Primary care and Specialists)

$0 or 20% for each Medicare-covered primary care provider or specialist visit (including telehealth).

Preventive Care[2]

$0 for preventive services, such as flu shots, and yearly "Wellness" visits.

Any additional preventive services approved by Medicare during the contract year will be covered. Eight counseling calls per year and Nicotine Replacement Therapy of up to 12 weeks are also available. Please call for more details.

Emergency Care

$0 or 20%; $100 limit, for each Medicare-covered emergency room visit.

Urgently Needed Services

$0 or 20%; $55 limit, for Medicare-covered urgently-needed care visits.

Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

If additional services are provided, cost sharing may apply. For urgently needed services received outside of the U.S. and its territories, please see "Worldwide emergency/urgent care."

Diagnostic Services/ Labs/Imaging[1]

Diagnostic radiology services *(such as MRIs, CT scans)*:
$0 or 20%

Lab services:
$0 or 20%

Diagnostic tests and procedures:
$0 or 20%

Outpatient X-rays:
$0 or 20%

Therapeutic radiology services, such as radiation treatment for cancer:
$0 or 20%

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

Hearing Services[1,2] 	**Hearing Services:** $0 or 20% for Medicare-covered diagnostic hearing exams. **Hearing Services (supplemental):** $0 for one routine hearing exam per year and one hearing aid fitting/evaluation per year. You pay nothing for supplemental hearing aids and supplies, up to the $2,250 benefit limit every calendar year. Limit one per ear per year. You pay for any costs over the plan benefit limit.
Dental Services[1] 	$0 copay for supplemental preventive and comprehensive services combined, up to $500 per year. You pay nothing for supplemental preventive and comprehensive services up to $500 combined total benefit limit per year. You must use a dentist who is part of Delta Dental of Washington's dental network. To find the most current listing of Delta Dental PPO Plus Premier network dentists, visit DeltaDentalWA.com. Delta Dental Network Providers must submit claims for these dental services to Delta Dental of Washington. You will be responsible for all, or most, services provided by Out of Network dentists.
Vision Services 	**Vision services:** $0 or 20% for the cost for Medicare-covered exams to diagnose and treat diseases and conditions of the eye **Vision services (supplemental):** *(Through the Vision Service Plan (VSP) Choice Network)* • $0 for one WellVision exam every year. • Up to the $500 plan benefit limit, every year for supplemental hardware. **Outside of the VSP Choice network:** • 100% of the cost over the plan benefit limit.

Mental Health Services[1,2] 	**Inpatient visit:** Without full Medicaid cost-share assistance, Part A deductible and copays apply. These are 2023 cost sharing amounts and may change for 2024. Please contact Customer Service for updated amounts. · $1,600 deductible for days 1 to 60 for each benefit period · $400 copay for days 61 to 90 for each benefit period · $800 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) **Outpatient group and/or individual therapy visit (including telehealth):** You pay $0 or 20%.
Skilled Nursing Facility (SNF)[1,2] 	Without full Medicaid cost-share assistance, you pay the following. This is the 2023 amount, which changes every year. Please contact Customer Service for updated amounts. Days 1 to 20: $0 copay per day for each benefit period Days 21 to 100: $200 copay per day for each benefit period Days 101 and beyond: all cost
Physical Therapy 	You pay $0 or 20% for Medicare-covered physical therapy services.
Ambulance[1] 	You pay $0 or 20% for one-way, Medicare-covered ambulance services.
Medicare Part B Drugs 	You pay $0 or 20% for Medicare covered Part B drugs: · Part B drugs such as chemotherapy drugs[1] · Other Part B drugs[1]

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

Medicare Part D Drugs Deductible $0 - $545 Depending on "Extra Help"

You may get your drugs at network retail pharmacies and mail order pharmacies.

Retail cost sharing

	Pharmacy	
Tier	30 Day supply	90 Day supply
All Tiers	$0	$0

Preferred Mail Order Cost-Sharing

Tier	90 day supplies
All Tiers	$0

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as at a standard retail pharmacy.

CHPW Dual Select (HMO D-SNP)
Summary of Other Benefits

Health & Wellbeing 	$0 copay for covered services which include acupuncture, naturopathy, routine chiropractic, massage therapy, and CHPW-recommended wellbeing programs with up to 25 sessions or visits on all service types combined per year. *These services must be performed by a state certified practitioner.*
Telehealth Services 	**We cover telehealth services, including virtual visits with:** · Primary care provider · Specialist · Urgent Care · Individual and group sessions for outpatient mental health, psychiatric, and substance abuse You pay the same as you would for an in-person visit.
Diabetic Supplies/ Diabetes Supplies and Services 	$0 or 20% for the cost of Medicare-covered diabetic self-management, diabetes services and supplies. Diabetic medication, such as insulin, injected by syringe is typically covered by your Part D prescription drug coverage.
Durable Medical Equipment [1] 	$0 or 20% for Medicare-covered durable medical equipment.

Fitness Program 	**$0 copay for the following:** · Home fitness kit (options include activity tracker, videos, and exercise equipment) · Membership at participating fitness center · Online and smartphone fitness app tools
Foot Care[1,2] (podiatry services) 	**Podiatry Services:** $0 or 20% of the cost for each Medicare-covered podiatry visit. Covered services include: · Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) · Routine foot care for members with certain medical conditions affecting the lower limbs. **Podiatry Services (supplemental):** $0 of the cost for each supplemental podiatry visit. Our supplemental benefit includes up to four (4) visits per year for non-Medicare covered foot care from a Medicare-approved foot care provider.
Home Health Care[1,2] 	$0 copay for Medicare-covered home health services.
Hospice 	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Community Health Plan of Washington Medicare Advantage.

CHPW Dual Select (HMO D-SNP)
Summary of Other Benefits

Meals When You Need It Most 	You pay nothing for covered meals up to the maximum benefit. Benefit includes 28 meals post discharge from each hospital or skilled nursing facility admission. Also available with a positive COVID-19 diagnosis. Meal program limited to 6 instances per calendar year.	
Outpatient Substance Abuse[1,2] 	**Group therapy visit:** $0 or 20%	**Individual therapy visit:** $0 or 20%
Prosthetic Devices[1] (Braces, artificial limbs, etc.) 	**Medicare-covered:** **Prosthetic Devices** You pay $0 or 20% for Medicare-covered prosthetic devices	**Medical Supplies** You pay $0 or 20% for Medicare-covered medical supplies
Renal Dialysis[1] 	$0 or 20%	
Worldwide Emergency/ Urgent Care 	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000. This plan covers supplemental emergency services, urgent services, and emergency transportation received outside of the U.S. and its territories up to a plan coverage limit.	
Family on Demand 	Family on Demand, offered by CHPW through Papa Pals, pairs you with members of your community for an extra pair of hands, a shoulder to lean on, and a listening ear. You get 60 hours of Family on Demand per year--for help with errands or meal prep, simple tech support, or just a little company.	

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

What Medicaid covers

The benefits described below are covered by Medicaid (Apple Health). The benefits described in Covered-Medical and Hospital Benefits Section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what Apple Health covers. What you pay for covered services may depend on your level of Medicaid eligibility.

Benefit	CHPW Dual Select	Medicaid*
INPATIENT CARE		
Inpatient Hospital Care (includes Substance Abuse and Rehabilitation)	✓ Covered	Covered
Inpatient Mental Health Care	✓ Covered	Covered
Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	✓ Covered	Covered
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	✓ Covered	Covered
Hospice	✓ Covered	Covered
OUTPATIENT CARE		
Doctor Office Visits	✓ Covered	Covered
Chiropractic Services	✓ Covered	20 and under - Covered 21 and over - Not Covered
Podiatry Services	✓ Covered	Covered for medically necessary procedures
Outpatient Mental Health Care	✓ Covered	Covered

** This list is provided for general information only and does not guarantee that the services will actually be covered.*

CHPW Dual Select (HMO D-SNP)
Summary of Other Benefits

Benefit	CHPW Dual Select	Medicaid*
OUTPATIENT CARE *(continued)*		
Outpatient Substance Abuse Care	✓ Covered	Covered with restrictions
Outpatient Services	✓ Covered	Covered
Ambulance Services (medically necessary ambulance services)	✓ Covered	Covered with restrictions
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care)	✓ Covered	Covered
Urgently Needed Services (This is not emergency care, and in most cases, is out of the service area. See page 17 for more details.)	✓ Covered	Covered
Outpatient Rehabilitation Services (Occupational Therapy physical therapy, Speech and language therapy.)	✓ Covered	Covered with limitations
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	✓ Covered	Covered
Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	✓ Covered	Covered
Diabetes Programs and Supplies	✓ Covered	Covered
Cardiac and Pulmonary Rehabilitation Services	✓ Covered	Covered

Services with a 1 may require prior authorization. Services with a 2 may require a referral from your doctor.

Benefit	CHPW Dual Select	Medicaid*
PREVENTIVE SERVICES		
Preventive Services: • Abdominal aortic aneurysm • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening • Cardiovascular disease • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings • Depression Screening • Diabetes Screenings • HIV screening • Medicare Diabetes Prevention Program • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling • Vaccines including COVID-19, Flu, Hepatitis B and Pneumococal shots • "Welcome to Medicare" preventive visit • Yearly "Wellness" Visit	✓ Covered plus Nicotine Replacement Therapy and counseling	Covered with limitations

** This list is provided for general information only and does not guarantee that the services will actually be covered.*

CHPW Dual Select (HMO D-SNP)
Summary of Other Benefits

Benefit	CHPW Dual Select	Medicaid*
PRESCRIPTION DRUG BENEFITS		
Outpatient Prescription Drugs	✓ Covered	Covered with restrictions
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
Dental Services	✓ Covered	Not covered
Hearing Services	✓ Covered - Hearing Exam and Hearing Aid device	Covered - Hearing exam only
Vision Services	✓ Covered plus additional hardware benefit	Covered
Fitness Program	✓ Covered	Not covered
Non-emergency Medical Transportation (NEMT)	✓ Covered	Covered
Health & Wellbeing	✓ Covered	Not covered

** This list is provided for general information only and does not guarantee that the services will actually be covered.*

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Non-Discrimination Notice

Community Health Plan of Washington complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Plan of Washington does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Under Washington law, people have a right to be free from discrimination because of race, creed, color, national origin, sex, veteran or military status, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a person with a disability.

Community Health Plan of Washington:

- Provides free assistance and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Customer Service (1-800-942-0247).

If you believe that Community Health Plan of Washington has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Appeals and Grievances Department, by mail at 1111 3rd Avenue, Suite 400, Seattle WA 98101, by phone at 1-800-942-0247 (TTY: 711), by fax at 206-613-8984, or by email at appealsgrievances@chpw.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievances Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language, at no additional cost.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-942-0247 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-942-0247 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-942-0247 (TTY: 711).

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-942-0247 (TTY: 711)。

Af Soomaali (Somali) DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqadda, oo lacag la'aan ah, ayaa laguu heli karaa adiga. Wac 1-800-942-0247. (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-942-0247 (телетайп: 711).

(Arabic) العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-942-0247 (طابعة هاتفية :711).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-942-0247 (መስማት ለተሳናቸው: 711).

توجه برای دری (Dari) اگر به زبان دری صحبت می کنید، خدمات مساعدت زبان، طور رایگان برای شما موجود می باشد. با شماره(711 :TTY) 1-800-942-0247 تماس بگیرید.

ትግርኛ (Tigrinya) ምልክታ፡ ትግርኛ ትዛረብ ተኸይንካ ኣገልግሎት ሓገዝ ቋንቋ ንዓኻ ብናጻ ይርከብ። ደውል 1-800-942-0247 (TTY: 711)።

ဗမာ (Burmese) သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-800-942-0247 (TTY: 711) သုိ႔ ေခၚဆိုပါ။

ਪੰਜਾਬੀ (Panjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-942-0247 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-800-942-0247 (TTY: 711) 번으로 전화해 주십시오.

(Farsi) فارسی توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-942-0247 (TTY: 711) تماس بگیرید.

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-942-0247 (телетайп: 711).

ភាសាខ្មែរ (Khmer) កត់ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាមិនគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរសព្ទមកលេខ 1-800-942-0247 (TTY: 711)។

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