COMMUNITY HEALTH PLAN of Washington™ | MEDICARE ADVANTAGE

The power of community

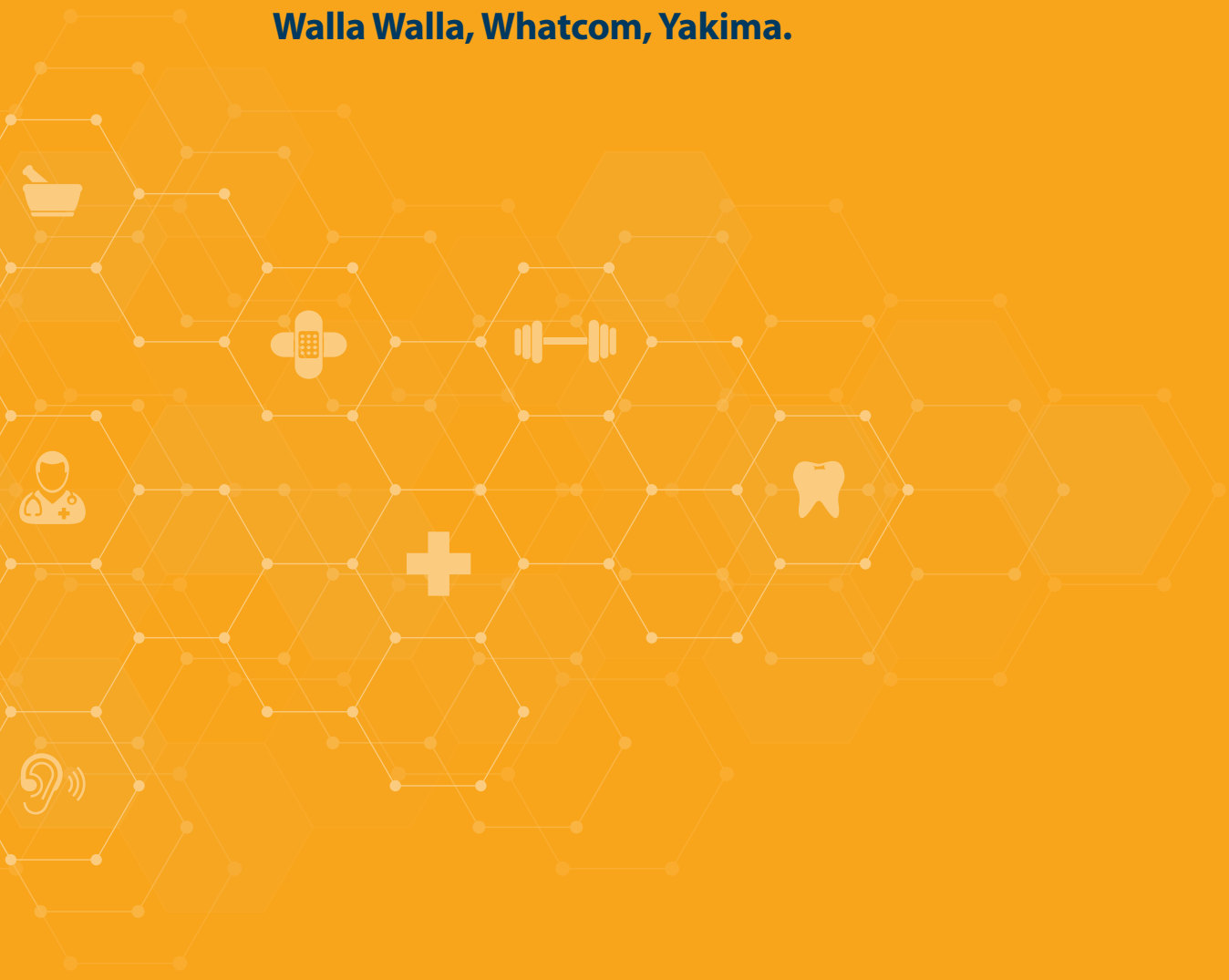
Community Health Plan of Washington Medicare Advantage

HMO Plans: **Plan 2** | **Plan 4** | **Freedom Plan**

2025 Summary of Benefits

CHPW Medicare Advantage Plan 2 (HMO)

Service areas: Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Douglas, Franklin, Grant, Jefferson, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Yakima.



CHPW Medicare Advantage Plan 2 (HMO)
Summary of Premiums & Benefits

Monthly Plan Premium	$0 - $23.10 (exact amount depends on level of Extra Help) In addition, you must keep paying your Medicare Part B Premium.
Deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: $9,350 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 in Acute Care Facility[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. · $500 copay per day for days 1 through 4 for each benefit period · $0 copay days 5 through 90 for each benefit period Each new benefit period begins with a new day 1
Outpatient Hospital[1,2]	$365 copay for Medicare-covered outpatient hospital observation services. $365 copay for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center[1,2]	$365 copay

CHPW Medicare Advantage Plan 2 (HMO)
Summary of Premiums & Benefits

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

Primary care physician visit*:
$0 copay

Specialist visit*:
$50 copay

The most recent list of our primary care providers and specialists is available on our website at medicare.chpw.org/find-a-doctor.

*Including telehealth visits

Preventive Care[2]

$0 copay 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

$100 copay

If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See "Inpatient Hospital Care" section of this booklet for other costs.

Urgently Needed Services

$40 copay 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)*: 20% of the cost **Lab services:** $0 copay **Diagnostic tests and procedures:** 20% of the cost **Outpatient X-rays:** $15 copay **Therapeutic radiology services, such as radiation treatment for cancer:** 20% of the cost
Hearing Services[1,2] 	Medicare-covered diagnostic hearing exams: 20% of the cost Routine hearing exams and hearing aids are not covered.
Dental Services (Supplemental) 	$0 copay for unlimited supplemental preventive services. $0 copay for supplemental comprehensive services, up to $500 per year. You pay nothing for unlimited preventive services. You also pay nothing for supplemental comprehensive services, up to a $500 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:** 20% of the cost for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. **Vision services (supplemental):** Not covered

Mental Health Services in Acute Care Facility[1,2] 	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For Medicare-covered inpatient psychiatric hospital stays: · $350 copay per day for days 1 through 5 · $0 copay per day for days 6 through 90 · $0 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):** $40 copay *If additional services are provided, cost sharing may apply.*
Skilled Nursing Facility (SNF)1,2 	Our plan covers up to 100 days in a SNF. · $0 copay per day for days 1 through 20 for each benefit period · $200 copay per day for days 21 through 100 for each benefit period
Physical Therapy[1,2] 	$45 copay for each Medicare covered outpatient visit
Ambulance[1] 	$350 copay for one-way, Medicare-covered ambulance benefits.
Medicare Part B Drugs 	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost *For part D drug coverage please see the next section.*

Medicare Part D Drugs Deductible No Deductible

You may get your drugs at network retail pharmacies and mail order pharmacies. To get the most complete and current information about which drugs are covered, visit medicare.chpw.org/formulary.

Initial Coverage	You pay the cost share for Tier 1, Tier 2, Tier 3, Tier 4, and Tier 5 Part D prescription drugs until your yearly drug costs reach $2,000. Total yearly drug costs are the total drug cost paid by you and Part D plan.
Catastrophic Coverage	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the year. During this payment stage, you pay nothing for your covered Part D drugs.

Retail cost sharing	Preferred Pharmacy		Standard Pharmacy	
Tier	30 Day supply	90 Day supply	30 Day supply	90 Day supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$10 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$37 copay	$110 copay	$47 copay	$140 copay
Tier 4: Non-preferred Drug	50% of the cost	50% of the cost	50% of the cost	50% of the cost
Tier 5: Speciality Tier	33% of the cost	Not covered	33% of the cost	Not covered

Preferred Mail Order Cost-Sharing

Tier	**90 Day supply**
Tier 1: Preferred Generic	$0 copay
Tier 2: Generic	$20 copay
Tier 3: Preferred Brand	$110 copay
Tier 4: Non-preferred Drug	50% of the cost
Tier 5: Specialty Tier	Not covered

Note: Depending on your level of "Extra Help" subsidy, your pharmacy cost-shares may be reduced

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.

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. To get the most complete and current information about telehealth services, visit medicare.chpw.org/virtualcare.
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] 	20% of the cost for Medicare-covered durable medical equipment.
Transportation[1] 	You pay nothing for up to 20 one-way trips (40-mile limit) to health-related appointments each calendar year. Prior authorization is required for trips over 40 miles.

Fitness Program 	**$0 copay for the following:** · Home fitness kit (options include activity tracker, videos, and exercise equipment) · Membership at a participating fitness center · Online and smartphone fitness app tools
Foot Care[2] (podiatry services) 	**Podiatry Services:** $0 copay 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 visits.
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.

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:** 20% of the cost	**Individual therapy visit:** 20% of the cost
Prosthetic Devices[1] (Braces, artificial limbs, etc.) 	**Medicare-covered:** **Prosthetic Devices** 20% of the cost	**Medical Supplies** 20% of the cost
Renal Dialysis[1] 	20% of the cost	
Worldwide Emergency/ Urgent Care 	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000 per year. 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. This does not apply to the Maximum Out-of-Pocket responsibility.	

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-944-1247 (TTY: 711). For general definitions of common terms, such as maximum out-of-pocket amount, balance billing, coinsurance, copayment, deductible, network provider, or other terms, see Chapter 12 of the Evidence of Coverage for CHPW Medicare Advantage Plan 2. You can view the Evidence of Coverage for CHPW Medicare Advantage Plan 2 at medicare.chpw.org/eoc2025 or call 1-800-944-1247 (TTY: 711) to request a copy.

CHPW Medicare Advantage Plan 4 (HMO)

Service Areas: Adams, Chelan, Clark, Cowlitz, Douglas, Grant, King, Kitsap, Lewis, Okanogan, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, and Yakima.

CHPW Medicare Advantage Plan 4 (HMO)
Summary of Premiums & Benefits

Monthly Plan Premium 	$107 per month In addition, you must keep paying your Medicare Part B Premium.
Deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs) 	Your yearly limit(s) in this plan: $9,350 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 in Acute Care Facility[1,2] 	Our plan covers an unlimited number of days for an inpatient hospital stay. · $500 copay per day for days 1 through 4 for each benefit period · $0 copay days 5 through 90 for each benefit period Each new benefit period begins with a new day 1
Outpatient Hospital[1,2] 	$325 copay for Medicare-covered outpatient hospital observation services. $325 copay for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center[1,2] 	$325 copay

Doctor Visits[1,2] (Primary care and Specialists) 	**Primary care physician visit*:** $0 copay **Specialist visit*:** $40 copay The most recent list of our primary care providers and specialists is available on our website at medicare.chpw.org/find-a-doctor. *Including telehealth visits
Preventive Care[2] 	$0 copay 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 	$100 copay If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services 	$0 copay 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)*: 20% of the cost **Lab services:** $0 copay **Therapeutic radiology services, such as radiation treatment for cancer:** 20% of the cost	**Diagnostic tests and procedures:** 20% of the cost **Outpatient X-rays:** $15 copay
Hearing Services[1,2] 	Medicare-covered diagnostic hearing exams: $20 copay Routine hearing exams and hearing aids are not covered.	
Dental Services (Supplemental) 	$0 copay for unlimited supplemental preventive services. $0 copay for supplemental comprehensive services, up to $500 per year. You pay nothing for unlimited preventive services. You also pay nothing for supplemental comprehensive services, up to a $500 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:** $40 copay 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 copay for one WellVision exam every year · Up to $150 benefit limit every two years for supplemental vision hardware. **Outside of the VSP Choice network:** · 100% of the cost over the plan benefit limit.	

Mental Health Services in Acute Care Facility[1,2] 	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For Medicare-covered inpatient psychiatric hospital stays: · $175 copay per day for days 1 through 10 · $0 copay per day for days 11 through 90 · $0 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):** $30 copay *If additional services are provided, cost sharing may apply.*
Skilled Nursing Facility (SNF)[1,2] 	Our plan covers up to 100 days in a SNF. · $0 copay per day for days 1 through 20 for each benefit period · $200 copay per day for days 21 through 100 for each benefit period
Physical Therapy[1,2] 	$30 copay for outpatient services
Ambulance[1] 	$325 copay for one-way, Medicare-covered ambulance benefits.
Medicare Part B Drugs 	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost *For part D drug coverage please see the next section.*

Medicare Part D Drugs Deductible No Deductible

You may get your drugs at network retail pharmacies and mail order pharmacies. To get the most complete and current information about which drugs are covered, visit medicare.chpw.org/formulary.

Initial Coverage	You pay the cost share for Tier 1, Tier 2, Tier 3, Tier 4, and Tier 5 Part D prescription drugs until your yearly drug costs reach $2,000. Total yearly drug costs are the total drug cost paid by you and Part D plan.
Catastrophic Coverage	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the year. During this payment stage, you pay nothing for your covered Part D drugs.

Retail cost sharing	Preferred Pharmacy		Standard Pharmacy	
Tier	30 Day supply	90 Day supply	30 Day supply	90 Day supply
Tier 1: Preferred Generic	$0 copay	$0 copay	$10 copay	$20 copay
Tier 2: Generic	$10 copay	$20 copay	$20 copay	$40 copay
Tier 3: Preferred Brand	$37 copay	$110 copay	$47 copay	$140 copay
Tier 4: Non-preferred Drug	50% of the cost	50% of the cost	50% of the cost	50% of the cost
Tier 5: Speciality Tier	33% of the cost	Not covered	33% of the cost	Not covered

Preferred Mail Order Cost-Sharing

Tier	**90 Day supply**
Tier 1: Preferred Generic	$0 copay
Tier 2: Generic	$20 copay
Tier 3: Preferred Brand	$110 copay
Tier 4: Non-preferred Drug	50% of the cost
Tier 5: Specialty Tier	Not covered

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.

Health & Wellbeing 	$0 copay for covered services which include acupuncture, naturopathy, and routine chiropractic with up to 12 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. To get the most complete and current information about telehealth services, visit medicare.chpw.org/virtualcare.
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] 	20% of the cost 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 a participating fitness center · Online and smartphone fitness app tools

Foot Care[2] (podiatry services) 	**Podiatry Services:** $0 copay 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 copay 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 visits.
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.
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:** 20% of the cost	**Individual therapy visit:** 20% of the cost
Prosthetic Devices[1] (Braces, artificial limbs, etc.) 	**Medicare-covered:** **Prosthetic Devices** 20% of the cost	**Medical Supplies** 20% of the cost
Renal Dialysis[1] 	20% of the cost	
Worldwide Emergency/ Urgent Care 	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000 per year. 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. This does not apply to the Maximum Out-of-Pocket responsibility.	

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-944-1247 (TTY: 711). For general definitions of common terms, such as maximum out-of-pocket amount, balance billing, coinsurance, copayment, deductible, network provider, or other terms, see Chapter 12 of the Evidence of Coverage for CHPW Medicare Advantage Plan 4. You can view the Evidence of Coverage for CHPW Medicare Advantage Plan 4 at medicare.chpw.org/eoc2025 or call 1-800-944-1247 (TTY: 711) to request a copy.

CHPW Medicare Advantage Freedom Plan (HMO)

Service areas: Clark, Cowlitz, King, Kitsap, Pierce, Snohomish, Spokane, Thurston.

CHPW Medicare Advantage Freedom Plan (HMO)
Summary of Premiums & Benefits

Monthly Plan Premium	$0 per month In addition, you must keep paying your Medicare Part B Premium.
Deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	Your yearly limit(s) in this plan: $9,350 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.
Inpatient Hospital in Acute Care Facility[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. · $500 copay per day for days 1 through 4 for each benefit period · $0 copay days 5 through 90 for each benefit period Each new benefit period begins with a new day 1
Outpatient Hospital[1,2]	$250 copay for Medicare-covered outpatient hospital observation services. $250 copay for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center[1,2]	$250 copay

Doctor Visits[1,2] (Primary care and Specialists) 	**Primary care physician visit*:** $0 copay **Specialist visit*:** $40 copay The most recent list of our primary care providers and specialists is available on our website at medicare.chpw.org/find-a-doctor. *Including telehealth visits
Preventive Care[2] 	$0 copay 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 	$100 copay If you are admitted to the hospital within 24 hours, you pay the inpatient hospital copay instead of the Emergency copay. See "Inpatient Hospital Care" section of this booklet for other costs.
Urgently Needed Services 	$0 copay 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)*:
20% of the cost

Lab services:
$0 copay

Diagnostic tests and procedures:
20% of the cost

Outpatient X-rays:
$15 copay

Therapeutic radiology services, such as radiation treatment for cancer:
20% of the cost

Hearing Services[1,2]

Medicare-covered diagnostic hearing exams:
$20 copay

Routine hearing exams and hearing aids are not covered.

Dental Services
(Supplemental)

$0 copay for unlimited supplemental preventive services. $0 copay for supplemental comprehensive services, up to $500 per year.

You pay nothing for unlimited preventive services. You also pay nothing for supplemental comprehensive services, up to a $500 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:
$40 copay 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 copay for one WellVision exam every year
- Up to $150 benefit limit every two years for supplemental vision hardware.

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

Mental Health Services in Acute Care Facility[1,2] 	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. For Medicare-covered inpatient psychiatric hospital stays: · $175 copay per day for days 1 through 10 · $0 copay per day for days 11 through 90 · $0 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):** $30 copay *If additional services are provided, cost sharing may apply.*
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Physical Therapy[1,2] 	$30 copay for outpatient services
Ambulance[1] 	$300 copay for one-way, Medicare-covered ambulance benefits.
Medicare Part B Drugs 	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost *For part D drug coverage please see the next section.*
Medicare Part D Drugs	This plan does not cover Part D prescription drugs

Health & Wellbeing 	$0 copay for covered services which include acupuncture, naturopathy, and routine chiropractic with up to 12 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. To get the most complete and current information about telehealth services, visit medicare.chpw.org/virtualcare.
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] 	20% of the cost 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 a participating fitness center · Online and smartphone fitness app tools

Foot Care[2] (podiatry services) 	**Podiatry Services:** $0 copay 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 visits.	
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.	
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:** 20% of the cost	**Individual therapy visit:** 20% of the cost

Prosthetic Devices[1] (Braces, artificial limbs, etc.) 	**Medicare-covered:** **Prosthetic Devices** 20% of the cost **Medical Supplies** 20% of the cost
Renal Dialysis[1] 	20% of the cost
Worldwide Emergency/ Urgent Care 	20% of the cost for Worldwide emergency/urgent care up to the coverage limit of $25,000 per year. 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. This does not apply to the Maximum Out-of-Pocket responsibility.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-944-1247 (TTY: 711). For general definitions of common terms, such as maximum out-of-pocket amount, balance billing, coinsurance, copayment, deductible, network provider, or other terms, see Chapter 12 of the Evidence of Coverage for CHPW Medicare Advantage Freedom Plan. You can view the Evidence of Coverage for CHPW Medicare Advantage Freedom Plan at medicare.chpw.org/eoc2025 or call 1-800-944-1247 (TTY: 711) to request a copy.

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 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 206-652-7010, 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 https://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Insert | Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-942-0247 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-942-0247 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-942-0247 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-942-0247 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-942-0247 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-942-0247 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-942-0247 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-942-0247 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-942-0247 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-942-0247 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-942-0247 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-942-0247 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-942-0247 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-942-0247 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-942-0247 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-942-0247 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-942-0247 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Web:
medicare.chpw.org

Mailing Address:
Community Health Plan
of Washington
1111 3rd Ave, Suite 400
Seattle, WA 98101-3207

Prospective Members:
1-800-944-1247

Current Members:
1-800-942-0247

TTY: 711

8:00 a.m. to 8:00 p.m.
7 days a week

COMMUNITY HEALTH PLAN
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