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)

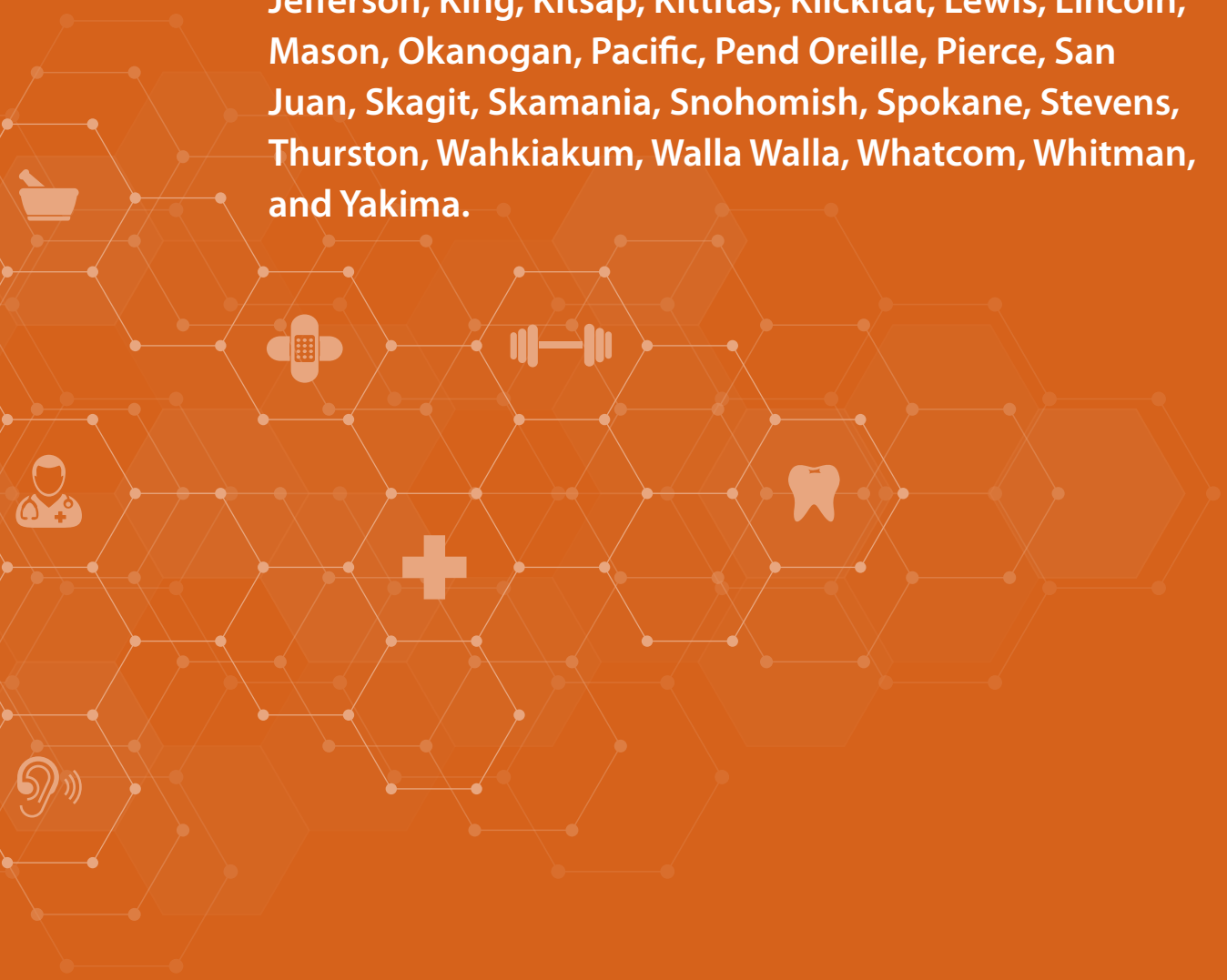
2025 Summary of Benefits

$0 or 20%

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

CHPW Dual Complete (HMO D-SNP)

Service areas: Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, and Yakima.



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

Monthly Plan Premium 	$0* *Your monthly plan premium of $26.20 is paid for as long as you qualify for 100% Low Income Subsidy (“Extra Help”)
Deductible	$0. (Without Apple Health cost-share assistance, deductible of $240 applies for Medicare Part B services. This is the 2024 amount, and may change for 2025. Please contact Customer Service for updated amounts.)
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] 	$0 copay with full Apple Health cost-share assistance. Without full Apple Health cost-share assistance, Part A deductible and copays apply. These are 2024 cost sharing amounts and may change for 2025. Please contact Customer Service for updated amounts. · $1,632 deductible for days 1-60 · $408 copay for days 61 to 90 · $816 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[1,2] 	$0 for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center[1,2] 	You pay $0.

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

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

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

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

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

Diagnostic tests and procedures:
$0

Outpatient X-rays:
$0

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

$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 in Acute Care Facility[1,2] 	**Inpatient visit:** $0 copay with full Apple Health cost-share assistance. Without full Apple Health cost-share assistance, Part A deductible and copays apply. These are 2024 cost sharing amounts and may change for 2025. Please contact Customer Service for updated amounts. · $1,632 deductible for days 1 to 60 for each benefit period · $408 copay for days 61 to 90 for each benefit period · $816 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 with full Apple Health cost-share assistance.
Skilled Nursing Facility (SNF)[1,2] 	$0 copay with full Apple Health cost-share assistance. Without full Apple Health cost-share assistance, you pay the following. These are 2024 cost sharing amounts and may change for 2025. Please contact Customer Service for updated amounts. Days 1 to 20: $0 copay per day for each benefit period Days 21 to 100: $204 copay per day for each benefit period Days 101 and beyond: all cost
Physical Therapy[1,2] 	You pay $0 for Medicare-covered physical therapy services.
Ambulance[1] 	You pay $0 for one-way, Medicare-covered ambulance services.
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.
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]

Medicare Part D Drugs Deductible $0

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.

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. 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] 	$0 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[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.	

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 Dual Complete. You can view the Evidence of Coverage for CHPW Dual Complete at medicare.chpw.org/eoc2025 or call 1-800-944-1247 (TTY: 711) to request a copy.

What Apple Health (Medicaid) covers

The benefits described below are covered by 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 Apple Health eligibility.

Benefit	CHPW Dual Complete	Apple Health (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	Apple Health (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 27 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

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

Benefit	CHPW Dual Complete	Apple Health (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.*

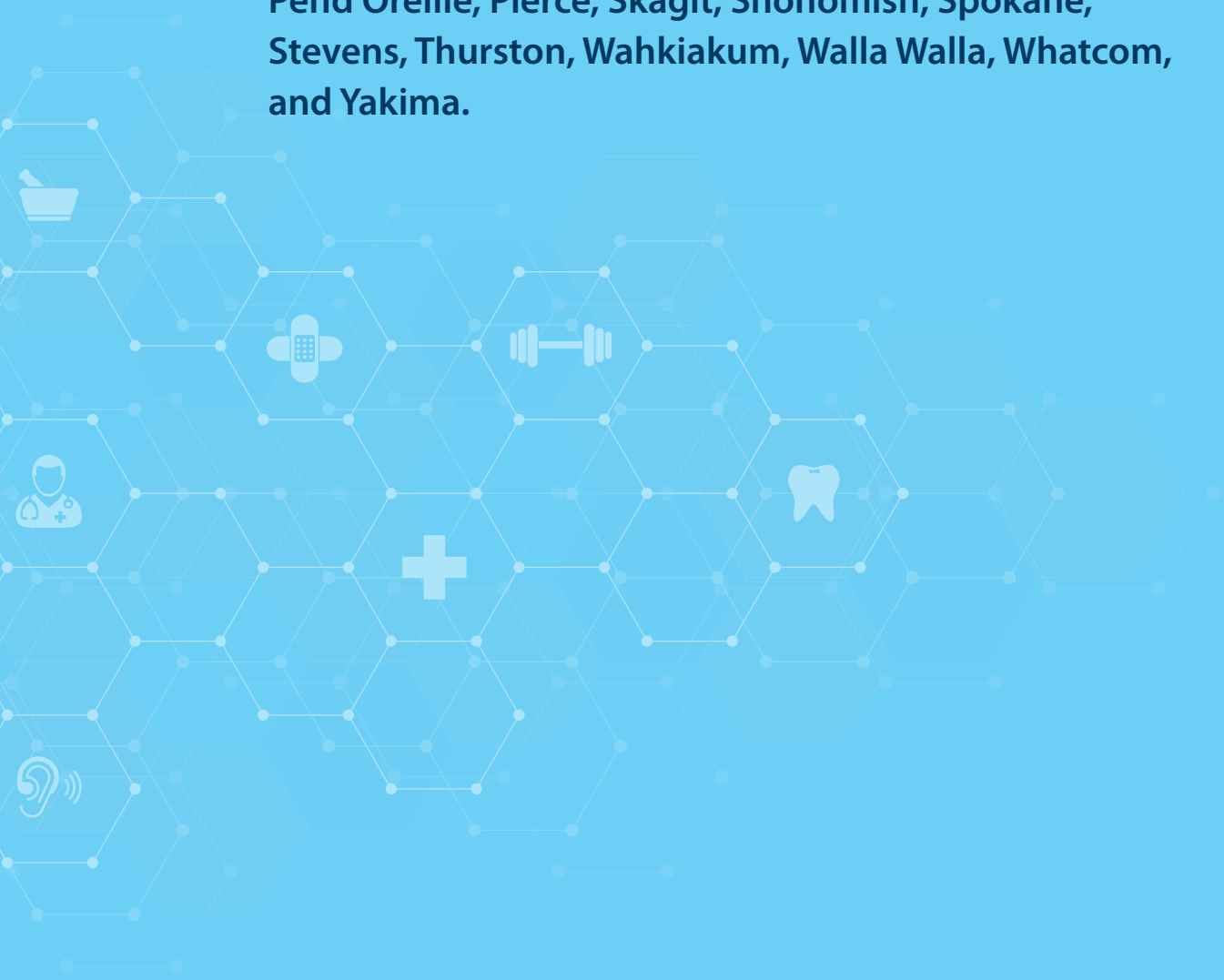
CHPW Dual Complete (HMO D-SNP)
Summary of Other Benefits

Benefit	CHPW Dual Complete	Apple Health (Medicaid)*
PRESCRIPTION DRUG BENEFITS		
Outpatient Prescription Drugs	✓ Covered	Covered with restrictions
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
Dental Services	✓ Covered	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

** 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)

Service areas: Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Douglas, Franklin, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, 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 - $26.20 (exact amount depends on level of Extra Help)
Deductible	Without Apple Health (Medicaid) cost-share assistance, deductible of $240 applies for Medicare Part B services. This is the 2024 amount, and may change for 2025. Please contact Customer Service for updated amounts.
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]	Without full Apple Health cost-share assistance, Part A deductible and copays apply. These are 2024 cost sharing amounts and may change for 2025. Please contact Customer Service for updated amounts. · $1,632 deductible for days 1-60 · $408 copay for days 61 to 90 · $816 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[1,2]	$0 or 20% for Medicare-covered outpatient hospital surgery and other services.
Ambulatory Surgery Center[1,2]	You pay $0 or 20%.

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

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

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

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

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%; $110 limit, for each Medicare-covered emergency room visit.

Urgently Needed Services

$0 or 20%; $45 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%

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 	$0 copay for supplemental preventive and comprehensive services combined, up to $750 per year. You pay nothing for supplemental preventive and comprehensive services up to $750 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 in Acute Care Facility [1,2] 	**Inpatient visit:** Without full Apple Health cost-share assistance, Part A deductible and copays apply. These are 2024 cost sharing amounts and may change for 2025. Please contact Customer Service for updated amounts. · $1,632 deductible for days 1 to 60 for each benefit period · $408 copay for days 61 to 90 for each benefit period · $816 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% with full Apple Health cost-share assistance.
Skilled Nursing Facility (SNF)[1,2] 	Without full Apple Health cost-share assistance, you pay the following. This is the 2024 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: $204 copay per day for each benefit period Days 101 and beyond: all cost
Transportation[1] 	You pay nothing for up to 32 one-way trips (40-mile limit) to health-related appointments each calendar year. Prior authorization is required for trips over 40 miles.
Physical Therapy[1,2] 	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]

Medicare Part D Drugs Deductible $0 - $590 Depending on "Extra Help"

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.

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. To get the most complete and current information about telehealth services, visit medicare.chpw.org/virtualcare.
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[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.	

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 Dual Select. You can view the Evidence of Coverage for CHPW Dual Select at medicare.chpw.org/eoc2025 or call 1-800-944-1247 (TTY: 711) to request a copy.

What Apple Health (Medicaid) covers

The benefits described below are covered by 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 Apple Health eligibility.

Benefit	CHPW Dual Select	Apple Health (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.*

Benefit	CHPW Dual Select	Apple Health (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 41 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

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

Benefit	CHPW Dual Select	Apple Health (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	Apple Health (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.*

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
of Washington™
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