All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	Not Covered	None
	Specialist visit	No Charge	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Requires preauthorization for certain services. Failure to obtain an authorization may result in denial of benefits. *See Section 3(g)
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.communityhealthchoice.org/wp-content/uploads/2022/04/formulary-2023.pdf	Generic drugs	No Charge	Not Covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Please refer to formulary for cost share tiers. Tier 1 includes preferred generics and some lower cost brand products. *See Section 3(n).
	Preferred brand drugs	No Charge	Not Covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Preauthorization may be required for a branded medication when the generic equivalent is preferred on the formulary. Failure to obtain preauthorization to show medical necessity may increase your costs. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost

* For more information about limitations and exceptions, see the plan or policy document https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf

* For more information about limitations and exceptions, see the plan or policy document

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				may result in denial of benefits.
If you are pregnant	Office visits	No Charge	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. *See section 3(I)
	Childbirth/delivery professional services	No Charge	Not Covered	
	Childbirth/delivery facility			

* For more information about limitations and exceptions, see the plan or policy document https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Children's glasses	No Charge	Not Covered	For select frames, standard lenses, and contact lenses only, for children 18 years old and younger. Limited to plan requirements. *See Section 3(w)
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan

* For more information about limitations and exceptions, see the plan or policy document https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-315-5386

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-315-5386

Chinese ( ): , 1-855-315--

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this