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

			20% coinsurance after deductible	*See preauthorization schedule attached to your plan document.
	Generic drugs			
_____ _____	Non-preferred brand drugs			
	Specialty drugs			
	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	20% coinsurance after deductible	Services at out-of-network ambulatory surgical facilities 20% coinsurance.
	Physician/surgeon fees	No charge after deductible	20% coinsurance after deductible	*See preauthorization schedule attached to your plan document.
	Emergency room care	$200 copayment/service	$200 copayment/service	Deductible does not apply. Copayment waived if admitted inpatient.

	Emergency medical transportation	No charge after deductible	No charge after deductible	None
	Urgent care	$45 copayment/service	20% coinsurance after deductible	Deductible does not apply for services at in-network providers.

*For more information about preauthorization, see the requirements document at https://www.capbluecross.com/preauthorization.

			Depending on the type of services, a copayment, coinsurance, or deductible may apply.
			----------none----------
	No charge after deductible	20% coinsurance after deductible	
Children's dental check-up	Not covered	Not covered	None None

*For more information about preauthorization, see the requirements document at https://www.capbluecross.com/preauthorization.

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

If your plan

Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

	$1,000
	$35
	0%
	0%

Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
	$1,070

	$1,000
	$35
	0%
	0%

Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,100
	$4,800

	$1,000
	$35
	0%
	0%

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Cost Sharing	
Deductibles	$900
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
	$1,310

The plan would be responsible for the other costs of these EXAMPLE covered services.

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