



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

Generic drugs

Non-preferred brand drugs

[Specialty drugs](#)

Facility fee (e.g., ambulatory surgery center)

Physician/surgeon fees

[Emergency room care](#)

No charge after deductible

No charge after deductible

\$200 [copayment](#)/service

20% coinsurance after deductible

20% coinsurance after deductible

20% coinsurance after deductible

\$200 [copayment](#)/service

*See [preauthorization](#) schedule attached to your [plan](#) document.

Services at [out-of-network](#) ambulatory surgical facilities 20% [coinsurance](#).

*See [preauthorization](#) schedule attached to your [plan](#) document.

[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

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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.



- 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



- 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



- 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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