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. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.BCBSND.com or call 1-800-342-4718. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-342-4718 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 person / $375 single plus dependent / $500 family Doesn't apply to preventive care or prescription drugs. Copays and coinsurance do not apply to the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. $500 for infertility services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$1,250 person / $1,875 single plus dependent / $2,500 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, copays, prescription drug services, infertility services, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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	Your Cost	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; 20% coinsurance	Deductible is waived.
	Specialist visit	$20 copay/visit; 20% coinsurance	Deductible is waived.
	Preventive care	$20 copay/visit	For Members to their 6th birthday. Deductible is waived.
	Preventive screening/ Immunization	$20 copay/related office visit; 20% coinsurance	Limited to mammography, pap smears, prostate cancer screening and fecal occult blood testing. No charge for immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.BCBSND.com	Retail Pharmacy Formulary Nonformulary	$5 copay/prescription; 20% coinsurance $5 copay/prescription; 50% sanction	One copay for a 1-100 day supply. $500 coinsurance maximum per person per benefit period.
	Preferred Mail Order Pharmacy Formulary Nonformulary	$5 copay/prescription; 20% coinsurance $5 copay/prescription; 50% sanction	One copay for a 1-100 day supply. $500 coinsurance maximum per person per benefit period. Mail order prescriptions must be received from the preferred mail order pharmacy.
	Preferred Specialty Pharmacy Formulary Nonformulary	$5 copay/prescription; 20% coinsurance $5 copay/prescription; 50% sanction	One copay for a 1-100 day supply. $500 coinsurance maximum per person per benefit period. Specialty Drugs must be received from the preferred specialty pharmacy network.

Common Medical Event	Services You May Need	Your Cost	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$50 copay/visit	Deductible is waived.
	Emergency medical transportation	20% coinsurance	None
	Urgent care	$20 copay/visit 20% coinsurance	Deductible is waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	None
If you need mental health or behavioral health services	Outpatient services	0%/20% coinsurance	First five hours plan pays 100%.
	Inpatient services	20% coinsurance	None
If you need substance abuse services	Outpatient services	0%/20% coinsurance	First five visits plan pays 100%.
	Inpatient services	20% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	Deductible is waived.
	Childbirth/delivery professional services	20% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	None
	Rehabilitation services	$15 copay/visit	Deductible is waived.
	Habilitation services	$15 copay/visit	Deductible is waived. Limited to 90 visits per benefit period.
	Skilled nursing care	20% coinsurance	None
	Durable medical equipment	20% coinsurance	None
	Hospice services	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Long-Term/Custodial Nursing Home Care
- Pediatric Dental and Vision Care
- Routine Dental Services (Adult)
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery; lifetime maximum of 1 operative procedure
- Chiropractic Care
- Hearing Aids; $3,000 every 3 years for Members under age 18
- Infertility Treatment; $20,000 lifetime maximum
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Contact BCBSND at www.BCBSND.com or 1-800-342-4718 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross Blue Shield of North Dakota at 1-800-342-4718 or www.BCBSND.com, The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. 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 price 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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,320

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$400
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,660

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$650

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-342-4718.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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