

 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, call 1-844-363-8457 or visit www.bcbsnd.com/plandocuments. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-844-363-8457 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | For <u>network providers</u> \$500 individual / \$1,000 parent and child / \$1,000 parent and children / \$1,000 two person / \$1,000 family For <u>out-of-network providers</u> \$1,000 individual / \$2,000 parent and child / \$2,000 parent and children / \$2,000 two person / \$2,000 family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes, <u>preventive care</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits . |
| Are there other deductibles for specific services? | Yes, \$2,500 individual / \$5,000 family for outpatient prescription medication or drug services. There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | For <u>network providers</u> \$8,000 individual / \$16,000 parent and child / \$16,000 parent and children / \$16,000 two person / \$16,000 family For <u>out-of-network providers</u> \$16,000 individual / \$32,000 parent and child / \$32,000 parent and children / \$32,000 two person / \$32,000 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billed</u> charges and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| | | |
|--|---|---|
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.bcbsnd.com/find-a-doctor or call 1-844-363-8457 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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 |
|--|--|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$25 <u>copay</u> /visit; <u>deductible</u> does not apply | 50% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | \$25 <u>copay</u> /visit; <u>deductible</u> does not apply | 50% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| <p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsnd.com/members/rx-tools</p> | Value drugs | \$5 <u>copay</u> /prescription; <u>deductible</u> and outpatient prescription medications or drug <u>deductible</u> amount do not apply (retail & mail order) | Not covered | Benefits are subject to the <u>copay</u> application described in the benefit plan. *See section 1. Mail order prescriptions must be received from the preferred mail order pharmacy. |
| | Generic preferred drugs (Tier 1) | \$10 <u>copay</u> /prescription; subject to the outpatient prescription medications or drug <u>deductible</u> amount. Deductible does not apply. (retail & mail order) | Not covered | |
| | Generic nonpreferred drugs (Tier 2) | \$10 <u>copay</u> /prescription; subject to the outpatient prescription medications or drug <u>deductible</u> amount. Deductible does not apply. (retail & mail order) | Not covered | |
| | Brand name preferred drugs (Tier 3) | \$60 <u>copay</u> /prescription; subject to the outpatient prescription medications or drug <u>deductible</u> amount. Deductible does not apply. (retail & mail order) | Not covered | |
| | Brand name nonpreferred drugs (Tier 4) | \$150 <u>copay</u> /prescription; subject to the outpatient prescription medications or drug <u>deductible</u> amount. Deductible does not apply. (retail & mail order) | Not covered | |
| | Specialty preferred drugs (Tier 5) | 40% <u>coinsurance</u> ; subject to the outpatient prescription medications or drug <u>deductible</u> amount. Deductible does not apply. | Not covered | Specialty drugs must be received from the preferred specialty pharmacy <u>network</u> . |
| | Specialty nonpreferred drugs (Tier 6) | 50% <u>coinsurance</u> ; subject to the outpatient prescription medications or drug <u>deductible</u> amount. Deductible does not apply. | Not covered | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsnd.com/plandocuments.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 30% <u>coinsurance</u> | 30% <u>coinsurance</u> ; network deductible applies | None |
| | <u>Emergency medical transportation</u> | 30% <u>coinsurance</u> | 30% <u>coinsurance</u> ; network deductible applies | None |
| | <u>Urgent care</u> | \$25 <u>copay/visit</u> ; deductible does not apply | 50% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Precertification</u> may be required. |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$25 <u>copay/office visit</u> ; deductible does not apply 30% <u>coinsurance</u> for other outpatient services | 50% <u>coinsurance/office visit</u> 50% <u>coinsurance</u> for other outpatient services | <u>Precertification</u> may be required. |
| | Inpatient services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Precertification</u> may be required. |
| If you are pregnant | Office visits | No charge | 50% <u>coinsurance</u> | None |
| | Childbirth/delivery professional services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Childbirth/delivery facility services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | 40 visits max/benefit period. <u>Precertification</u> is required. |
| | <u>Rehabilitation services</u> | \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply | 50% <u>coinsurance</u> | 30 visits max/benefit period may apply for each therapy: physical, occupational and speech. |
| | <u>Habilitation services</u> | \$25 <u>copay/visit</u> ; <u>deductible</u> does not apply | 50% <u>coinsurance</u> | 30 visits max/benefit period may apply for each therapy: physical, occupational and speech. |
| | <u>Skilled nursing care</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | 30 days max/benefit period. <u>Precertification</u> is required. |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Precertification</u> may be required. |
| | <u>Hospice services</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If your child needs dental or eye care | Children's eye exam | \$40 <u>copay/visit</u> ; <u>deductible</u> does not apply | Not covered | One exam/benefit period. |
| | Children's glasses | 30% <u>coinsurance</u> | Not covered | Lenses allowed 1/benefit period. Frames allowed once every other benefit period. |
| | Children's dental check-up | \$40 <u>copay/visit</u> ; <u>deductible</u> does not apply | 50% <u>coinsurance</u> | Routine exam allowed 2/benefit period and cleanings allowed 4/benefit period. |

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.)

- Abortions (except if necessary to prevent the woman's death)
- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term (custodial) care
- Non-emergency care when traveling outside the U.S.
- Nonformulary drugs
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care (except if medically necessary for members with diabetes or circulatory disorders)
- 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 (20 visits/benefit period)

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: BCBSND at 1-844-363-8457 or www.bcbsnd.com; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-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: North Dakota Insurance Department at 1-701-328-2440, 1-800-247-0560 or www.nd.gov/ndins/contact.

Does this plan provide Minimum Essential Coverage? Yes

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.

Does this plan meet the Minimum Value Standards? Not Applicable

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.

Language Access Services:

See BCBSND's attached disclosure for information on available language assistance services.

—————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 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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|--|-------|
| ■ <u>The plan's overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$25 |
| ■ <u>Hospital (facility) coinsurance</u> | 30% |
| ■ <u>Other coinsurance</u> | 30% |

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500* |
| <u>Copayments</u> | \$50 |
| <u>Coinsurance</u> | \$3,600 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Peg would pay is | \$4,170 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|-------|
| ■ <u>The plan's overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$25 |
| ■ <u>Hospital (facility) coinsurance</u> | 30% |
| ■ <u>Other coinsurance</u> | 30% |

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$200* |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$50 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$750 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|--|-------|
| ■ <u>The plan's overall deductible</u> | \$500 |
| ■ <u>Specialist copayment</u> | \$25 |
| ■ <u>Hospital (facility) coinsurance</u> | 30% |
| ■ <u>Other coinsurance</u> | 30% |

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500* |
| <u>Copayments</u> | \$100 |
| <u>Coinsurance</u> | \$500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,100 |

*This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.



In accordance with federal regulations, Blue Cross Blue Shield of North Dakota is required to provide you the following disclosure:

Blue Cross Blue Shield of North Dakota complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. Blue Cross Blue Shield of North Dakota does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex.

Blue Cross Blue Shield of North Dakota:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - 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, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

If you believe that Blue Cross Blue Shield of North Dakota has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex, you can file a grievance with:

Civil Rights Coordinator

4510 13th Ave S

Fargo, ND 58121

701-297-1638 or North Dakota Relay at 800-366-6888 or 711

701-282-1804 (fax)

CivilRightsCoordinator@bcbsnd.com (email) (Communication by unencrypted email presents a risk.)

You can file a grievance in person or by mail, fax, or email within 180 days of the date of the alleged discrimination. Grievance forms are available at <http://www.bcbsnd.com/report> or by calling 1-844-363-8457. If you need help filing a grievance, the Civil Rights Coordinator 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

800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-363-8457 (TTY: 1-800-366-6888 oder 711).

中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-363-8457（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-363-8457 (TTY: 1-800-366-6888 ykn 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-844-363-8457 (TTY: 1-800-366-6888 canke 711).

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-363-8457 (رقم هاتف الصم والبكم: 1-800-366-6888 أو 711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-363-8457 (телетайп: 1-800-366-6888 или 711).

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-363-8457（TTY: 1-800-366-6888 または 711）まで、お電話にてご連絡ください。

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-844-363-8457 (टिडिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-363-8457 (TTY: 1-800-366-6888 또는 711)번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistanstjenester tilgjengelige for deg. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711).

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kojí' hódíílnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)