



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, go to

[www.BCBSND.com/plandocuments](http://www.BCBSND.com/plandocuments) or call 1-844-363-8457. 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](http://www.healthcare.gov/sbc-glossary) or call 1-844-363-8457 to request a copy.

| Important Questions  | Answers  | Why This Matters:   |
|--|--|---|
| <p><b>What is the overall <a href="#">deductible</a>?</b></p>                                | <p>For in-network providers <b>\$500</b> individual / <b>\$1,000</b> parent and child / <b>\$1,000</b> parent and children / <b>\$1,000</b> two person / <b>\$1,000</b> family</p> <p>For out-of-network providers <b>\$1,000</b> individual / <b>\$2,000</b> parent and child / <b>\$2,000</b> parent and children / <b>\$2,000</b> two person / <b>\$2,000</b> family</p> <p>Does not apply to preventive care. Copays and coinsurance do not apply to the deductible.</p> | <p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>   |
| <p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>    | <p>Yes, Preventive care.</p>   | <p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a>.</p> |
| <p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>             | <p>No</p>  | <p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>  |
| <p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p> | <p>For in-network providers <b>\$1,800</b> individual / <b>\$3,600</b> parent and child / <b>\$3,600</b> parent and children / <b>\$3,600</b> two person / <b>\$3,600</b> family</p> <p>For out-of-network providers <b>\$3,600</b> individual / <b>\$7,200</b> parent and child / <b>\$7,200</b> parent and children / <b>\$7,200</b> two person / <b>\$7,200</b> family</p>  | <p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>   |

|  |  |   |
|--|--|---|
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>            | Premiums, balance-billed charges, and health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>            | Yes. See <a href="http://www.BCBSND.com">www.BCBSND.com</a> or call 1-844-363-8457 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b> | No   | You can see the <a href="#">specialist</a> 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                                  | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|--|
|   |  | Your Cost If You Use an In-network Provider (You will pay the least) | Your Cost If You Use an Out-of-network Provider (You will pay the most) |  |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b> | Primary care visit to treat an injury or illness       | \$20 copay/visit   | 30% coinsurance   | Deductible is waived in-network.                       |
|   | <a href="#">Specialist</a> visit                       | \$20 copay/visit   | 30% coinsurance   | Deductible is waived in-network.                       |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge  | Not covered   | None   |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 10% coinsurance  | 30% coinsurance   | None   |
|   | Imaging (CT/PET scans, MRIs)                           | 10% coinsurance  | 30% coinsurance   | None   |

|  |  |                         |                 |  |
|--|--|-------------------------|-----------------|--|
| <p><b>If you need drugs to treat your illness or condition</b><br/> More information about <a href="http://www.BCBSND.com">prescription drug coverage</a> is available at <a href="http://www.BCBSND.com">www.BCBSND.com</a><br/> Formulary drug list is available at <a href="http://www.bcbsnd.com/drug-formulary-2019">www.bcbsnd.com/drug-formulary-2019</a></p> | Generic drugs                                  | \$10 copay/prescription | Not covered     | Deductible is waived in-network. Covers up to a 30 day supply. Preferred Mail Order Pharmacy: Two copay amounts per prescription order or refill for a 60-90 day supply. Mail order prescriptions must be received from the preferred mail order pharmacy. |
|  | Preferred brand drugs                          | \$20 copay/prescription | Not covered     | Deductible is waived in-network. Covers up to a 30 day supply. Preferred Mail Order Pharmacy: Two copay amounts per prescription order or refill for a 60-90 day supply. Mail order prescriptions must be received from the preferred mail order pharmacy. |
|  | Nonpreferred brand drugs                       | \$40 copay/prescription | Not covered     | Deductible is waived in-network. Covers up to a 30 day supply. Preferred Mail Order Pharmacy: Two copay amounts per prescription order or refill for a 60-90 day supply. Mail order prescriptions must be received from the preferred mail order pharmacy. |
|  | <a href="#">Specialty drugs</a>                | 10% coinsurance         | Not covered     | Specialty drugs must be received from the preferred specialty pharmacy network.  |
| <p><b>If you have outpatient surgery</b></p>   | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance         | 30% coinsurance | None   |
|  | Physician/surgeon fees                         | 10% coinsurance         | 30% coinsurance | None   |

|   |  |                   |  |   |
|---|--|-------------------|--|---|
| <b>If you need immediate medical attention</b>                        | <a href="#">Emergency room care</a>              | \$150 copay/visit | \$150 copay/visit                              | Deductible is waived.   |
|   | <a href="#">Emergency medical transportation</a> | 10% coinsurance   | 10% coinsurance; in-network deductible applies | None  |
|   | <a href="#">Urgent care</a>                      | \$20 copay/visit  | 30% coinsurance                                | Deductible is waived in-network.  |
| <b>If you have a hospital stay</b>                                    | Facility fee (e.g., hospital room)               | 10% coinsurance   | 30% coinsurance                                | Precertification may be required.   |
|   | Physician/surgeon fees                           | 10% coinsurance   | 30% coinsurance                                | None  |
| <b>If you need mental health or behavioral health services</b>        | Outpatient services                              | 10% coinsurance   | 30% coinsurance                                | First five hours plan pays 100%.  |
|   | Inpatient services                               | 10% coinsurance   | 30% coinsurance                                | Precertification may be required.   |
| <b>If you need substance abuse services</b>                           | Outpatient services                              | 10% coinsurance   | 30% coinsurance                                | First five visits plan pays 100%.   |
|   | Inpatient services                               | 10% coinsurance   | 30% coinsurance                                | Precertification may be required.   |
| <b>If you are pregnant</b>  | Office visits                                    | 10% coinsurance   | 30% coinsurance                                | Deductible is waived in-network.  |
|   | Childbirth/delivery professional services        | 10% coinsurance   | 30% coinsurance                                | None  |
|   | Childbirth/delivery facility services            | 10% coinsurance   | 30% coinsurance                                | None  |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>                 | 10% coinsurance   | 30% coinsurance                                | Limited to 40 visits per benefit period. Precertification is required.  |
|   | <a href="#">Rehabilitation services</a>          | \$20 copay/visit  | 30% coinsurance                                | Deductible is waived in-network. Benefits are subject to an allowance of 30 visits for each therapy: physical, occupational and speech. |
|   | <a href="#">Habilitation services</a>            | \$20 copay/visit  | 30% coinsurance                                | Deductible is waived in-network. Benefits are subject to an allowance of 30 visits for each therapy: physical, occupational and speech. |
|   | <a href="#">Skilled nursing care</a>             | 10% coinsurance   | 30% coinsurance                                | Limited to 30 days per benefit period. Precertification is required.  |
|   | <a href="#">Durable medical equipment</a>        | 10% coinsurance   | 30% coinsurance                                | Precertification may be required.   |
|   | <a href="#">Hospice services</a>                 | 10% coinsurance   | 30% coinsurance                                | Precertification is required.   |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                              | \$40 copay/visit  | Not covered                                    | Deductible is waived in-network. Limited to one per benefit period.   |
|   | Children's glasses                               | 10% coinsurance   | Not covered                                    | Frames are limited to one every other benefit period. Lenses are limited to one pair per benefit period.                                |
|   | Children's dental check-up                       | \$40 copay/visit  | Not covered                                    | Deductible is waived in-network.  |

## 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 for those necessary to prevent the death of the woman
- Acupuncture
- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Traveling Outside the U.S.
- Nonformulary Drugs
- Private-Duty Nursing
- Routine Dental Services (Adult)
- Routine Eye Care (Adult)
- 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 per benefit period
- Routine Foot Care; (for diabetics only)

**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](http://www.BCBSND.com) or 1-844-363-8457 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://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 1-844-363-8457 or [www.BCBSND.com](http://www.BCBSND.com), The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or North Dakota Insurance Department at 1-701-328-2440 or 1-800-247-0560 or [www.nd.gov/ndins/contact](http://www.nd.gov/ndins/contact).

### 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other <a href="#">coinsurance</a>                             | 10%   |

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$20           |
| Coinsurance                       | \$1,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,780</b> |

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

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other <a href="#">coinsurance</a>                             | 10%   |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$200        |
| Copayments                        | \$600        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Joe would pay is</b> | <b>\$860</b> |

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

|   |       |
|---|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist copayment</a>                          | \$20  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%   |
| ■ Other <a href="#">coinsurance</a>                             | 10%   |

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$500        |
| Copayments                        | \$300        |
| Coinsurance                       | \$80         |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$880</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



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, 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, 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, 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](mailto: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 800-342-4718. 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>

4510 13<sup>th</sup> Avenue South, Fargo, North Dakota 58121

*Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association*

## **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).

## **繁體中文 (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 انكر 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 yáníłt'i'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiiik'eh, éí ná hóló, kojji' hódííłnih 1-844-363-8457 (TTY: 1-800-366-6888 éí doodagó 711.)