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 network providers **$3,500** individual / **$7,000** parent and child / **$7,000** parent and children / **$7,000** two person / **$7,000** family For out-of-network providers **$7,000** individual / **$14,000** parent and child / **$14,000** parent and children / **$14,000** two person / **$14,000** family	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?	Yes, preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers **$6,500** individual / **$13,000** parent and child / **$13,000** parent and children / **$13,000** two person / **$13,000** family For out-of-network providers **$13,000** individual / **$26,000** parent and child / **$26,000** parent and children / **$26,000** two person / **$26,000** 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, 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?	Yes. See www.bcbsnd.com/find-a-doctor or call 1-844-363-8457 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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	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 provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnd.com/manage-my-benefits/pharmacy-listings	Generic drugs	$20 copay/prescription; deductible does not apply (retail & mail order)	Not covered	Benefits are subject to the copay application described in the benefit plan. *See section 1. Mail order prescriptions must be received from the preferred mail order pharmacy.
	Preferred brand drugs	$100 copay/prescription; deductible does not apply (retail & mail order)	Not covered	Benefits are subject to the copay application described in the benefit plan. *See section 1. Mail order prescriptions must be received from the preferred mail order pharmacy.
	Nonpreferred brand drugs	$200 copay/prescription; deductible does not apply (retail & mail order)	Not covered	Benefits are subject to the copay application described in the benefit plan. *See section 1. Mail order prescriptions must be received from the preferred mail order pharmacy.
	Specialty drugs	20% coinsurance	Not covered	Specialty drugs must be received from the preferred specialty pharmacy network.

*For more information about limitations and exceptions, see the plan 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)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay/visit; deductible does not apply	$300 copay/visit; deductible does not apply	None
	Emergency medical transportation	20% coinsurance	20% coinsurance; network deductible applies	None
	Urgent care	$50 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
If you are pregnant	Office visits	20% coinsurance; deductible does not apply	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	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	Home health care	20% coinsurance	40% coinsurance	40 visits max/benefit period. Precertification is required.
	Rehabilitation services	$50 copay/visit; deductible does not apply	40% coinsurance	30 visits max/benefit period for each therapy: physical, occupational and speech.
	Habilitation services	$50 copay/visit; deductible does not apply	40% coinsurance	30 visits max/benefit period for each therapy: physical, occupational and speech.
	Skilled nursing care	20% coinsurance	40% coinsurance	30 days max/benefit period. Precertification is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice services	20% coinsurance	40% coinsurance	Precertification is required.
If your child needs dental or eye care	Children's eye exam	$40 copay/visit; deductible does not apply	Not covered	One exam/benefit period.
	Children's glasses	30% coinsurance	Not covered	Lenses allowed 1/benefit period. Frames allowed once every other benefit period.
	Children's dental check-up	$40 copay/visit; deductible does not apply	40% coinsurance	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. 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**

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 the 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.

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)

The plan's overall deductible	$3,500
Specialist copayment	$50
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	$3,500
Copayments	$20
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,380**

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

The plan's overall deductible	$3,500
Specialist copayment	$50
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	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,460**

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

The plan's overall deductible	$3,500
Specialist copayment	$50
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	$1,300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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