BCBSND: CompChoice 80 1000

Coverage Period:

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single, Single Plus Dependent, Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.BCBSND.com or by calling 1-800-342-4718.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person / **$1,500** single plus dependent / **$2,000** family Doesn't apply to preventive care or prescription drugs. Copays and coinsurance do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** person / **$3,750** single plus dependent / **$5,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	No.	This plan treats providers the same in determining payment for the same services.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-342-4718 or visit us at www.BCBSND.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.BCBSND.com/sbc or call 1-800-342-4718 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; 20% coinsurance	Deductible is waived.
	Specialist visit	$25 copay/visit; 20% coinsurance	Deductible is waived.
	Other practitioner office visit	$25 copay/visit; 20% coinsurance	Deductible is waived.
	Preventive care/screening/immunization	No Charge	None
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.	Formulary drugs	$15 copay/prescription; 20% coinsurance	Covers up to a 34 day supply. Two copays for a 35-100 day supply. $1,000 coinsurance maximum per person per benefit period.
	Nonformulary drugs	$15 copay/prescription; 50% sanction	Covers up to a 34 day supply. Two copays for a 35-100 day supply.
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 services	$75 copay/visit; 20% coinsurance	Deductible is waived.
	Emergency medical transportation	20% coinsurance	None
	Urgent care	$25 copay/visit; 20% coinsurance	Deductible is waived.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	None
	Physician/surgeon fee	20% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0%/20% coinsurance	First 5 hours plan pays 100%.
	Mental/Behavioral health inpatient services	20% coinsurance	None
	Substance use disorder outpatient services	0%/20% coinsurance	First 5 visits plan pays 100%.
	Substance use disorder inpatient services	20% coinsurance	None
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Deductible is waived.
	Delivery and all inpatient services	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	None
	Rehabilitation services	$20 copay/visit; 20% coinsurance	Deductible is waived.
	Habilitation services	$20 copay/visit; 20% coinsurance	Deductible is waived. Limited to 90 visits per benefit period.
	Skilled nursing care	20% coinsurance	None
	Durable medical equipment	20% coinsurance	None
	Hospice service	20% coinsurance	None
If your child needs dental or eye care	Eye exam	Not Covered	
	Glasses	Not Covered	
	Dental check-up	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Pediatric dental and vision care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery; lifetime maximum of 1 operative procedure
- Chiropractic care
- Hearing aids; $3000 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-342-4718. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Blue Cross Blue Shield of North Dakota at 1-800-342-4718 or visit us at www.BCBSND.com
- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
- North Dakota Insurance Department at 1-701-328-2440 or 1-800-247-0560 or www.nd.gov/ndins/contact

Additionally, a consumer assistance program can help you file your appeal. Contact the North Dakota Insurance Department to schedule an appointment with the Consumer Assistance Center. Call 1-701-328-2440 or 1-800-247-0560.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-342-4718.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-342-4718.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-342-4718.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-342-4718.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,020
- **Patient pays** $2,520

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$20
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$2,520**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,300
- **Patient pays** $2,100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$800
Coinsurance	$900
Limits or exclusions	$200
Total	**$2,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.