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 1-877-586-6222. 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 1-877-586-6222 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers **$750** person / **$1,500** single plus dependent / **$1,500** two-party adult / **$1,500** family For out-of-network providers **$3,000** person / **$6,000** single plus dependent / **$6,000** two-party adult / **$6,000** 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?	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?	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?	For in-network providers **$3,000** person / **$6,000** single plus dependent / **$6,000** two-party adult / **$6,000** family For outpatient prescription drug services received in-network: **$4,000** person / **$7,500** single plus dependent / **$7,500** two-party adult / **$7,500** family. For out-of-network providers **$6,000** person / **$12,000** single plus dependent / **$12,000** two-party adult / **$12,000** 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, non-formulary drug sanction, 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?	Yes. See www.BCBSND.com or call 1-877-586-6222 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
		Your Cost If You Use an In-network Provider (You will pay the least)	Your Cost If You Use and 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	$25 copay/visit; 20% coinsurance	40% coinsurance	Deductible is waived in-network.
	Specialist visit	$50 copay/visit; 20% coinsurance	40% coinsurance	Deductible is waived in-network.
	Preventive care/screening/ immunization	No Charge	Not Covered.	None
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

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 and Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BCBSND.com	Retail Pharmacy Generic drugs	$8 copay/ prescription; 20% coinsurance	$15 copay/ prescription; 50% sanction	**In-Network Pharmacies:** In-network pharmacies in Minot include: B&B NW Pharmacy, Keycare Pharmacy, Trinity Hospital Pharmacy; Outside of Minot, utilize Prime Therapeutics network pharmacies for in-network benefit. Covers up to 34 day supply. Two copays for a 35-100 day supply. $4,000 single and $7,500 single plus dependent two-party adult and family coinsurance maximums per benefit period for In-Network drugs. **Out-of-Network Pharmacies:** Covers up to 34 day supply. Two copays for a 35-60 day supply. Three copays for a 61-100 day supply. **Specialty Drugs are subject to a dispensing limit of a 30-day supply.**
	Brand Name Formulary drugs	$13 copay/ prescription; 20% coinsurance	$25 copay/ prescription; 50% sanction	
	Brand Name Nonformulary drugs	$23 copay/ prescription; 50% coinsurance	$35 copay/ prescription; 50% sanction	
	Preferred Mail Order Pharmacy Generic drugs	$8 copay/ prescription; 20% coinsurance	$15 copay/ prescription; 50% sanction	Two copays for a 61-100 day supply. **Mail order prescriptions must be received from the preferred mail order pharmacy.** $4,000 single and $7,500 single plus dependent two-party adult and family coinsurance maximums per benefit period for In- Network drugs. **Specialty Drugs are subject to a dispensing limit of a 30-day supply.**
	Brand Name Formulary drugs	$13 copay/ prescription; 20% coinsurance	$25 copay/ prescription; 50% sanction	
	Brand Name Nonformulary drugs	$23 copay/ prescription; 50% coinsurance	$35 copay/ prescription; 50% sanction	

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 and 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	$200 copay/visit; 20% coinsurance	$200 copay/visit; 20% coinsurance	Deductible is waived.
	Emergency medical transportation	20% coinsurance	20% coinsurance; in network deductible applies	None
	Urgent care	$50 copay/visit; 20% coinsurance	40% coinsurance	Deductible is waived in-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health or behavioral health services	Outpatient services	0%/20% coinsurance	0%/40% coinsurance	First five hours plan pays 100%.
	Inpatient services	20% coinsurance	40% coinsurance	None
If you need substance abuse services	Outpatient services	0%/20% coinsurance	0%/40% coinsurance	First five visits plan pays 100%.
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	$25 copay/visit; 20% coinsurance	40% coinsurance	Copayment and Deductible are waived in-network.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	$25 copay/visit; 20% coinsurance	40% coinsurance	Deductible waived in network.
	Habilitation services	$25 copay/visit; 20% coinsurance	40% coinsurance	Deductible is waived in network. Limited to 90 visits per benefit period.
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	None

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 and Out-of-network Provider (You will pay the most)	
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	N/A
	Children's glasses	Not covered	Not covered	N/A
	Children's dental check-up	Not covered	Not covered	N/A

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; 1 hearing aid per ear 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 1-877-586-6222 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 1-877-586-6222 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	$750
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	$750
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,110**

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

The plan's overall deductible	$750
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	$600
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,760**

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

The plan's overall deductible	$750
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	$750
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**