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/plandocuments or call 1-800-280-9951. 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 1-800-280-9951 to request a copy. This is a grandfathered plan.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For PPO Plan: $500 person / $1,500 family For Basic Plan: $500 person / / $1,500 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?	No	You will have to meet the deductible before the plan pays for any services.
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 PPO Plan: $1,500 person / $3,500 family For Basic Plan: $2,000 person / $4,500 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, 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.
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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
		PPO Plan After Deductible Amount (You will pay the least)	Basic Plan After Deductible Amount (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	$30 copay/visit	$35 copay/visit	Deductible is waived.
	Specialist visit	$30 copay/visit	$35 copay/visit	Deductible is waived.
	Preventive care	$30 copay/visit	$35 copay/visit	$200 maximum for members over age 6. Deductible is waived. Benefits are available beyond the maximum subject to cost share.
	Preventive screening/ immunization	$30 copay/related office visit; No charge for other services.	$35 copay/related office visit; No charge for other services.	20% coinsurance for prostate cancer screening with a PPO Plan and 25% coinsurance for prostate cancer screening with a Basic Plan. No charge for immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	25% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan After Deductible Amount (You will pay the least)	Basic Plan After Deductible Amount (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 Formulary	Generic: $10 copay/prescription; 15% coinsurance Brand: $25 copay/prescription; 25% coinsurance	Generic: $10 copay/prescription; 15% coinsurance Brand: $25 copay/prescription; 25% coinsurance	Covers up to 34 day supply. Two copays for a 35-60 day supply. Three copays for a 61-100 day supply. Deductible is waived. $1,200 coinsurance maximum per person per benefit period.
	Nonformulary	$30 copay/prescription; 50% coinsurance	$30 copay/prescription; 50% coinsurance	
	Preferred Mail Order Pharmacy Formulary	Generic: $10 copay/prescription; 15% coinsurance Brand: $25 copay/prescription; 25% coinsurance	Generic: $10 copay/prescription; 15% coinsurance Brand: $25 copay/prescription; 25% coinsurance	Two copays for a 61-100 day supply. Deductible is waived. $1,200 coinsurance maximum per person per benefit period. Mail order prescriptions must be received from the preferred mail order pharmacy.
	Nonformulary	$30 copay/prescription; 50% coinsurance	$30 copay/ prescription; 50% coinsurance	
	Preferred Specialty Pharmacy Formulary	Generic: $10 copay/prescription; 15% coinsurance Brand: $25 copay/prescription; 25% coinsurance	Generic: $10 copay/prescription; 15% coinsurance Brand: $25 copay/prescription; 25% coinsurance	One copay for up to a 34 day supply. Two copays for a 35-100 day supply. Deductible is waived. $1,200 coinsurance maximum per person per benefit period.
	Nonformulary	$30 copay/prescription; 50% coinsurance	$30 copay/prescription; 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan After Deductible Amount (You will pay the least)	Basic Plan After Deductible Amount (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	25% coinsurance	None
	Physician/surgeon fees	20% coinsurance	25% coinsurance	None
If you need immediate medical attention	Emergency room care	$60 copay/visit; 20% coinsurance	$60 copay/visit; 20% coinsurance	Deductible is waived.
	Emergency medical transportation	20% coinsurance	25% coinsurance	None
	Urgent care	$30 copay/visit	$35 copay/visit	Deductible is waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	None
	Physician/surgeon fees	20% coinsurance	25% coinsurance	None
If you need mental health or behavioral health services	Outpatient services	0%/20% coinsurance	0%/20% coinsurance	First five hours plan pays 100%.
	Inpatient services	20% coinsurance	25% coinsurance	None
If you need substance abuse services	Outpatient services	0%/20% coinsurance	0%/20% coinsurance	First five visits plan pays 100%.
	Inpatient services	20% coinsurance	25% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	25% coinsurance	Deductible is waived.
	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	Deductible is waived for delivery services received from a PPO health care provider when a member is enrolled under the prenatal plus program.
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	Deductible is waived for delivery services received from a PPO health care provider when a member is enrolled under the prenatal plus program.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	25% coinsurance	None
	Rehabilitation services	$20 copay/visit; 20% coinsurance	$25 copay/visit; 25% coinsurance	Deductible is waived.
	Habilitation services	$20 copay/visit; 20% coinsurance	$25 copay/visit; 25% coinsurance	Limited to 90 visits per benefit period.
	Skilled nursing care	20% coinsurance	25% coinsurance	None
	Durable medical equipment	20% coinsurance	25% coinsurance	None
	Hospice services	20% coinsurance	25% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan After Deductible Amount (You will pay the least)	Basic Plan After Deductible Amount (You will pay the most)	
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: BCBSND at www.BCBSND.com or 1-800-280-9951 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 1-800-342-4718 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 or North Dakota Insurance Department at 1-701-328-2440 or 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 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
(PPO Plan: 9 months of pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$30
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	$500
Copayments	$20
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,580

Managing Joe's type 2 Diabetes
(PPO Plan: a year of routine care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$30
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	$1,100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,360

Mia's Simple Fracture
(PPO Plan emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$30
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	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$900

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-280-9951.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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 1-800-342-4718 (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 (email)

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*

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-342-4718 (TTY: 1-800-366-6888 o 711).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-342-4718 (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 1-800-342-4718（TTY：1-800-366-6888 或 711）。

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-342-4718 (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 1-800-342-4718 (TTY: 1-800-366-6888 hoặc 711).

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-342-4718 (TTY: 1-800-366-6888 canke 711).

العربية **(Arabic)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-342-4718 (رقم هاتف الصم والبكم: 1-800-366-6888 أو711).

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-342-4718 (TTY: 1-800-366-6888 au 711).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-342-4718 (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。1-800-342-4718（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: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-342-4718 (टिटिवाइ: 1-800-366-6888 वा 711) ।

Français (French)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-342-4718 (ATS : 1-800-366-6888 ou 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-342-4718 (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 1-800-342-4718 (TTY: 1-800-366-6888 o 711).

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-342-4718 (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'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-342-4718 (TTY: 1-800-366-6888 éí doodagó 711.)