



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 <u>network providers</u> \$3,500 individual / \$5,250 parent and child / \$5,250 parent and children / \$7,000 two person / \$7,000 family For <u>out-of-network providers</u> \$7,000 individual / \$10,500 parent and child / \$10,500 parent and children / \$14,000 two person / \$14,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, <u>preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> \$3,500 individual / \$5,250 parent and child / \$5,250 parent and children / \$7,000 two person / \$7,000 family For <u>out-of-network providers</u> \$7,000 individual / \$10,500 parent and child / \$10,500 parent and children / \$14,000 two person / \$14,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsnd.com/find-a-doctor or call 1-844-363-8457 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Specialist</u> visit	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsnd.com/members/rx-tools	Preventive drugs	\$5 <u>copay</u> /prescription; <u>deductible</u> does not apply (retail & mail order)	\$5 <u>copay</u> /prescription; <u>deductible</u> does not apply (retail & mail order)	Benefits are subject to the <u>copay</u> application described in the benefit <u>plan</u> . *See section 1.
	Generic preferred drugs (Tier 1)	0% <u>coinsurance</u> (retail & mail order)	0% <u>coinsurance</u> (retail & mail order); <u>network deductible</u> applies	None
	Generic nonpreferred drugs (Tier 2)	0% <u>coinsurance</u> (retail & mail order)	0% <u>coinsurance</u> (retail & mail order); <u>network deductible</u> applies	
	Brand name preferred drugs (Tier 3)	0% <u>coinsurance</u> (retail & mail order)	0% <u>coinsurance</u> (retail & mail order); <u>network deductible</u> applies	
	Brand name nonpreferred drugs (Tier 4)	0% <u>coinsurance</u> (retail & mail order)	0% <u>coinsurance</u> (retail & mail order); <u>network deductible</u> applies	
	Specialty preferred drugs (Tier 5)	0% <u>coinsurance</u>	0% <u>coinsurance</u> ; <u>network deductible</u> applies	Specialty drugs must be received from the preferred specialty pharmacy <u>network</u> .
	Specialty nonpreferred drugs (Tier 6)	0% <u>coinsurance</u>	0% <u>coinsurance</u> ; <u>network deductible</u> applies	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u> ; <u>network deductible</u> applies	None
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u> ; <u>network deductible</u> applies	None
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Precertification</u> may be required.
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None

*For more information about limitations and exceptions, see the plan or policy 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 need mental health, behavioral health or substance abuse services	Outpatient services	0% <u>coinsurance</u> /office visit 0% <u>coinsurance</u> for other outpatient services	0% <u>coinsurance</u> /office visit 0% <u>coinsurance</u> for other outpatient services	<u>Precertification</u> may be required.
	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Precertification</u> may be required.
If you are pregnant	Office visits	No charge	0% <u>coinsurance</u>	None
	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	Childbirth/delivery facility services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Precertification</u> is required.
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None
	<u>Habilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	90 visits max/benefit period may apply for each therapy: physical, occupational and speech.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Precertification</u> is required.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Precertification</u> may be required.
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	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
- Dental care (pediatric or adult)
- Long-term (custodial) care
- Routine eye care (pediatric or adult)
- Routine foot care

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 may apply)
- 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 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/ebsa/healthreform. 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 <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: 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/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

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 <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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*)

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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*)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> <u>coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	0%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$20
The total Peg would pay is	\$3,520

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Joe would pay is	\$1,100

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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