


 Deductible	 OOPM
Individual	\$0	\$1,000
Parent and Child	\$0	\$1,500
Parent and Children	\$0	\$1,500
Two Person	\$0	\$2,000
Family	\$0	\$2,000

Benefit Highlights: Your Cost Sharing Amounts

Service/Benefit	 Copay	 Coinsurance
Pediatric Preventive Services	\$30	0%
Immunizations		0%
Mammography, Pap Smear, Fecal Occult Blood Testing & Prostate Cancer Screening Services		0%
Home and Office Visits	\$35	0%
Diagnostic Services		10%
Inpatient Hospital Services	\$250/day	0%
Professional Health Care Provider Visits May require precertification		0%
Outpatient Hospital Services	\$100/admission	0%
Outpatient Surgery	\$100/admission	0%
Emergency Services		10%
Provider Visit	\$35	0%
Emergency Room Charge	\$75	0%
<i>May require precertification</i>		
Outpatient Prescription Drugs		
Formulary Drugs	\$15	20%
Nonformulary Drugs	\$15	50% sanction
<i>Number of copays may vary based on day supply.</i>	Benefits are subject to the Outpatient Prescription Drug Coinsurance Maximum Amount.	

Amounts are the % of allowed charge before out-of-pocket maximum is met when covered services are received from the BCBSND participating provider network.

After the out-of-pocket maximum is met, services are covered at 100% when received from a participating BCBSND provider.

Covered services received from a non-participating BCBSND provider will increase out-of-pocket expenses.

Refer to your benefit plan for details.

COMMON TERMS

Deductible

The dollar amount paid by you for certain covered services during the benefit period.

Coinsurance

A percentage of the allowed charge for covered services that is your responsibility. Some medical providers may require that the coinsurance amount be paid at the time of service.

Copayment (Copay)

A set amount paid for a certain covered service at the time the service is received.

Inpatient copayment (Copay)

A set amount paid per inpatient day for inpatient hospital services only, at the time the service is received. This amount does not include copayment amounts for inpatient professional visits.

Formulary drug

A preferred drug on the formulary drug list.

Nonformulary drug

A drug not on the formulary drug list.

Outpatient prescription drug coinsurance maximum amount

The outpatient prescription drug coinsurance maximum amount is \$1,000 per member per benefit period. When the prescription drug coinsurance maximum has been met, copay amounts will continue to apply, and prescription drugs will be covered at 100% of the allowed charge for the remainder of the benefit period. Copays do not apply to this coinsurance maximum.

Out-of-pocket maximum (OOPM)

The most you will pay for covered services received during the benefit period, which includes the total coinsurance amounts and inpatient copay amounts per day for hospital services. After that, BCBSND pays 100% for covered expenses, less copays. The benefit period is on a calendar year (January 1 through December 31). The OOPM amount does not include the outpatient prescription drug coinsurance maximum amount.

FIND A DOCTOR OR A SPECIALIST

You should select a health care provider in your network through the “Find a Doctor” link on your online member services account at BCBSND.com. Services received out-of-network will increase your out-of-pocket expenses.



Your plan includes HealthyBlue online wellness center powered by WebMD

BCBSND partners with WebMD Health Services to provide powerful online tools to help you meet your personal health goals. You can access WebMD through your online member services account at BCBSND.com.



QUESTIONS?

Call the number on the back of your member ID card.

This health plan is that of your employer. Blue Cross Blue Shield of North Dakota is serving only as the Claims Administrator and does not assume any financial risk except for stop-loss coverage.

www.BCBSND.com

This benefit grid presents a brief overview of covered services and payment levels of this product. It should not be used to determine whether your health care expenses will be paid. The written benefit plan governs the benefits available. For premium rates and further details of the coverage, including definitions; exclusions; criteria for medically appropriate and necessary care; credentialing process; confidentiality policy; description of experimental drugs, medical devices or treatments; grievance and appeals process; provider listings; drugs eligible for coverage; reductions or limitations; and the terms under which this benefit plan may be continued, call, write or visit Blue Cross Blue Shield of North Dakota (BCBSND).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to BCBSND at the telephone number and address on the back of the Member's Identification Card. If this Benefit Plan is affected by ERISA, the Member may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Members may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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