

City of Fargo

Blue Cross Blue Shield of North Dakota (BCBSND)

Health Insurance Premiums - Effective January 1, 2026

BCBSND DakotaBlue 80 3400 (Essentia Network) High Deductible Health Plan

		Employee Pay Period Contribution	COF Pay Period Contribution	Employee Monthly Contribution	COF Monthly Contribution	Combined Monthly Premium	Total Annual Premium
Full-time 40* 2080 annual hrs	Individual	\$ 44.42	\$ 272.88	\$ 88.84	\$ 545.76	\$ 634.60	\$ 7,615.20
	Parent + Children	\$ 111.70	\$ 446.80	\$ 223.40	\$ 893.60	\$ 1,117.00	\$ 13,404.00
	Family	\$ 165.00	\$ 660.00	\$ 330.00	\$ 1,320.00	\$ 1,650.00	\$ 19,800.00

Full-time 30-39* 1560-2079 annual hrs	Single	\$ 107.88	\$ 209.42	\$ 215.76	\$ 418.84	\$ 634.60	\$ 7,615.20
	Parent + Children	\$ 223.40	\$ 335.10	\$ 446.80	\$ 670.20	\$ 1,117.00	\$ 13,404.00
	Family	\$ 330.00	\$ 495.00	\$ 660.00	\$ 990.00	\$ 1,650.00	\$ 19,800.00

Part-time 20-29* 1040-1559 annual hrs	Single	\$ 158.65	\$ 158.65	\$ 317.30	\$ 317.30	\$ 634.60	\$ 7,615.20
	Parent + Children	\$ 335.10	\$ 223.40	\$ 670.20	\$ 446.80	\$ 1,117.00	\$ 13,404.00
	Family	\$ 495.00	\$ 330.00	\$ 990.00	\$ 660.00	\$ 1,650.00	\$ 19,800.00

COBRA Monthly Premiums	
COBRA Single	\$ 647.29
COBRA Parent+	\$ 1,139.34
COBRA Family	\$ 1,683.00

Health Insurance is effective the 1st of the month following date of hire. Premiums apply to employees who are benefit eligible as defined in COF Policy.

DakotaBlue HDHP 80/3400

Large Group



ND

Preferred Network	Enhanced Network	Standard Network	Out-of-network	Definitions
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Deductibles

Individual	\$3,400	\$6,000	\$7,000	\$10,500	Deductible - The out-of-pocket amount you must pay for certain covered health services and prescription drugs before your insurance plan starts sharing the cost.
Parent + Child(ren)	\$5,100	\$9,000	\$10,500	\$15,750	
Two-person/Family	\$6,800	\$12,000	\$14,000	\$21,000	

Out-of-pocket maximums

Individual	\$6,600	\$11,000	\$13,750	\$20,625	Out-of-pocket maximum - The most you'll pay for covered services in a calendar year (Jan. 1 - Dec. 31). Once this limit is reached, your plan covers 100% of eligible expenses for the rest of the year.
Parent + Child(ren)	\$9,900	\$16,500	\$20,625	\$30,900	
Two-person/Family	\$13,200	\$22,000	\$27,500	\$36,750	

Service costs paid by member after network deductible is met. \$0 costs not subject to deductible.

*Preferred Network deductible applies

Virtual visits/check-ins	\$0	40%	50%	50%	Premium - The amount you pay each month to maintain coverage under your health insurance plan.
Primary/Specialist office visit	20%	40%	50%	50%	
Hospital in/outpatient	20%	40%	50%	50%	Coinurance (%) - The percentage of costs you pay for covered services after reaching your deductible.
Emergency room visit	20%	20%*	20%*	20%*	
Lab, X-ray, CT/PET, MRI	20%	40%	50%	50%	Copays (\$) - Fixed amounts you pay for certain covered services or medications at the time you receive care. The deductible does not apply to most copays.
Preventive care (see definition)	\$0	\$0	\$0	Not covered	
Contraceptive office visit	\$0	\$0	\$0	Not covered	 Preventive care - Visit nd.blue_DBPreventiveCare or scan the QR code to see the most recent preventive care guidelines for your gender and age.
Maternity office visit	\$0	40%	50%	50%	
Pre/Postnatal care	20%	40%	50%	50%	

Coinurance and copays count toward your out-of-pocket maximum.

Prescription drug costs paid by member after Preferred Network deductible is met. Preventive drugs not subject to deductible.

Generic preferred drug	20%	Rx filled at non-participating pharmacies are not covered.	 Formulary - a list of prescription drugs covered by your health plan. Preferred - drugs that cost less. Non-preferred - drugs that cost more. To check which medications are covered and their costs, visit www.bcbsnd.com/rx-tools or scan the QR code. Click the blue "Find drugs and estimates" button. Follow the prompts until you reach the "Choose your drug list" drop-down. Select "NetResults Performance" from the list.
Generic non-preferred drug	20%		
Brand preferred drug	20%		
Brand non-preferred drug	20%		
Specialty preferred drug	20%		
Specialty non-preferred drug	20%		
Preventive drug	\$5		DakotaBlue drug coverage is considered creditable.

DakotaBlue is a tiered-network plan. What does that mean?



Most health plans have two categories: in-network and out-of-network. DakotaBlue has four. Members get the lowest out-of-pocket costs in the Preferred Network tier. To find a specific doctor, visit www.bcbsnd.com/find-a-doctor or scan the QR code.

Preferred Network - Providers in the Essentia Health System

Enhanced Network - Providers in North Dakota who accept Blue Cross Blue Shield plans

Standard Network - Providers outside of North Dakota who accept Blue Cross Blue Shield plans

Out-of-network - Providers who do not accept Blue Cross Blue Shield plans

DakotaBlue is available in Cass, Ransom and Richland counties..

Information applies to fully insured and self-funded groups. Self-funded groups: This medical plan is that of your employer. Blue Cross Blue Shield of North Dakota is serving only as the Claims Administrator.

Where to get care

Get the right care at the right time and place. Knowing where to go for medical attention helps you get the right treatment based on how serious your symptoms are. This guide outlines your care options, from virtual visits to emergency services, so you can make informed decisions and get help quickly and effectively.

Virtual Care Visits¹

See a doctor or therapist without leaving your home



Flu | Rash | Earache | Strep throat
Allergies | Fever | Sinus infections
Diarrhea | Pink eye | Skin infection



Doctor's Office

Your primary care provider is always a good place to begin



Mild asthma | Eye issues | Vaccinations
Minor fever/burns | Allergic reactions
Ear/throat pain | Preventive care visits
Chronic condition management



Walk-in Clinic

The place for non-life-threatening but urgently needed care



Sprains/strains | Persistent diarrhea
Painful urination | Allergic reactions
Mild abdominal pain | Animal bites
Small cuts that may require stitches
Rashes without fever



Emergency Room (ER)

Care for urgent, critical or life-threatening illness



Serious injuries | Severe allergic reactions
Life-threatening situations | Chest pain
Severe abdominal pain | Severe bleeding
Difficulty breathing



988 Suicide & Crisis Lifeline

24/7 support for mental health-related distress



Thoughts of suicide | Substance use issues
Mental health concerns | Any other kind of emotional distress



Call 911 or go to the ER if you think you are having a life-threatening emergency or if your health is at serious risk by delaying care.

If you or someone you know is experiencing thoughts of suicide, mental health concerns or substance use disorder or any other kind of emotional distress, call 988 to speak to a trained crisis counselor.



Find providers, virtual care options and care support programs using the Find Care tool located within BCBSND.me

¹Many doctor and urgent care offices offer virtual visits. Talk with your provider about available options.

For further details of the coverage, including exclusions, any reductions or limitations and the terms under which the benefit plan may be continued, see your Sales and Account Executive.

This is a brief explanation of covered services and payment levels of this product. It should not be used to determine whether health care expenses will be paid. The written certificate of insurance 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.

Essentia Health is an independent health system partnering with BCBSND to provide the lowest out-of-pocket costs with the highest quality care to members through the DakotaBlue preferred network.



Scan the QR code to view the non-discrimination notice or visit nd.blue/non-discrimination-notice



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 <u>deductible</u> ?	For Preferred <u>network providers</u> \$3,400 individual / \$5,100 parent and child / \$5,100 parent and children / \$6,800 two person / \$6,800 family For Enhanced <u>network providers</u> \$6,000 individual / \$9,000 parent and child / \$9,000 parent and children / \$12,000 two person / \$12,000 family For Standard <u>network providers</u> \$7,000 individual / \$10,500 parent and child / \$10,500 parent and children / \$14,000 two person / \$14,000 family For Nonparticipating <u>providers</u> \$10,500 individual / \$15,750 parent and child / \$15,750 parent and children / \$21,000 two person / \$21,000 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 <u>deductible</u> ?	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 www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.

Important Questions	Answers	Why This Matters:
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For Preferred <u>network providers</u> \$6,600 individual / \$9,900 parent and child / \$9,900 parent and children / \$13,200 two person / \$13,200 family For Enhanced <u>network providers</u> \$11,000 individual / \$16,500 parent and child / \$16,500 parent and children / \$22,000 two person / \$22,000 family For Standard <u>network providers</u> \$13,750 individual / \$20,625 parent and child / \$20,625 parent and children / \$27,500 two person / \$27,500 family For Nonparticipating <u>providers</u> \$20,625 individual / \$30,900 parent and child / \$30,900 parent and children / \$36,750 two person / \$36,750 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 <u>out-of-pocket limit</u> ?	<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> .	You pay the least if you use a <u>provider</u> in the Preferred <u>network</u> . You pay more if you use a <u>provider</u> in the Enhanced or Standard <u>network</u> . You will pay the most if you use a Nonparticipating <u>provider</u> , and you might receive a bill from a provider 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 a Nonparticipating <u>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
		Preferred Network Provider (You will pay the least)	Enhanced Network Provider	Standard Network Provider	Nonparticipating 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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive</u> care/screening/immunization	No charge	No charge	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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Enhanced Network Provider	Standard Network Provider	Nonparticipating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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)	\$5 <u>copay</u> /prescription; <u>deductible</u> does not apply (retail & mail order)	Not covered	Benefits are subject to the <u>copay</u> application described in the benefit plan. *See section 1.
	Generic preferred drugs (Tier 1)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	Not covered	None
	Generic nonpreferred drugs (Tier 2)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	Not covered	
	Brand name preferred drugs (Tier 3)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	Not covered	
	Brand name nonpreferred drugs (Tier 4)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> (retail & mail order)	Not covered	
	Specialty preferred drugs (Tier 5)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not covered	<u>Specialty drugs</u> must be received from the preferred specialty pharmacy <u>network</u> .
	Specialty nonpreferred drugs (Tier 6)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> ; Preferred network <u>deductible</u> applies	20% <u>coinsurance</u> ; Preferred network <u>deductible</u> applies	20% <u>coinsurance</u> ; Preferred network <u>deductible</u> applies	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> ; Preferred network <u>deductible</u> applies	20% <u>coinsurance</u> ; Preferred network <u>deductible</u> applies	20% <u>coinsurance</u> ; Preferred network <u>deductible</u> applies	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <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
		Preferred Network Provider (You will pay the least)	Enhanced Network Provider	Standard Network Provider	Nonparticipating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Precertification</u> may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> /office visit 20% <u>coinsurance</u> for other outpatient services	20% <u>coinsurance</u> /office visit; Preferred network <u>deductible</u> applies 20% <u>coinsurance</u> for other outpatient services; Preferred network <u>deductible</u> applies	50% <u>coinsurance</u> /office visit 50% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u> /office visit 50% <u>coinsurance</u> for other outpatient services	<u>Precertification</u> may be required.
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u> ; Preferred network <u>deductible</u> applies	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Precertification</u> may be required.
If you are pregnant	Office visits	No charge	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Enhanced Network Provider	Standard Network Provider	Nonparticipating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Precertification</u> is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	90 visits max/benefit period may apply for each therapy: physical, occupational and speech.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Precertification</u> is required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Precertification</u> may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	N/A
	Children's glasses	Not covered	Not covered	Not covered	Not covered	N/A
	Children's dental check-up	Not covered	Not covered	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 | • Long-term (custodial) care | • Weight loss/management drugs |
| • Cosmetic surgery | • Routine eye care (adult) | • Weight loss programs |
| • Dental 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) | • Hearing aids (1 hearing aid per ear every 3 years for members under age 18) | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic care | • Infertility treatment (\$20,000 lifetime maximum) | • 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; 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, 1-800-247-0560 or www.nd.gov/ndins/contact.

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 the 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>	\$3,400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,800
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$5,220

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>	\$3,400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$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

Blue Cross Blue Shield of North Dakota (BCBSND) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, sexual orientation or sex. BCBSND:

- 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 and information written in other languages.

If you need these services, please call Member Services at 1-844-363-8457 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711. If you believe BCBSND has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, gender identity, sexual orientation 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) (unencrypted emails present a risk.)

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 1-844-363-8457. 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 Ave. S.W. 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 con el idioma. También hay disponibles ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles sin cargo. Llame al 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o hable con su proveedor.

Deutsch (German) – ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen kostenfreie fremdsprachliche Unterstützung zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Rufen Sie 1-844-363-8457 (TTY: 1-800-366-6888 oder 711) an oder sprechen Sie mit Ihrem Anbieter.

中文 (Chinese) – 注意: 如果您說中文，我們可以為您提供免費的語言協助服務。亦免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-844-363-8457（聽障服務專線 TTY: 1-800-366-6888 或 711）或與您的醫療服務提供者討論。

Oromoo (Oromo) – XIYYEEFFANNOO: Afaan Oromoo dubbattu yoo ta'e, tajaajilli gargaarsa afaan hiikuu kaffaltii malee ni argama. Gargaarsi dabalataa gargaaraadhaaf tajaajilli sirrii ta'ee fi odeeffannoo bifa dhaqqabamaa ta'een kennuunis bilisaan ni argama. Bilbili 1-844-363-8457 (TTY: 1-800-366-6888 or 711) ykn dhiyeessaa kee waliin haasa'i.

Tiếng Việt (Vietnamese) – CHÚ Ý: Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận. Xin gọi 1-844-363-8457 (TTY: 1-800-366-6888 hoặc 711) hoặc nói chuyện với nhà cung cấp của quý vị.

Ikirundi (Bantu – Kirundi) – Wiyubare: Nimba uvuga Ikirundi, wemerewe ubufasha bwo kuronka ururimi ku buntu. Wemerewe kandi ubufasha bukwiye bw’inyongera na serivisi vyo gutanga amakuru mu buryo bworoshe ku buntu. Hamagara kuri 1-844-363-8457 (TTY: 1-800-366-6888 canke 711) canke uvugane n’ujejwe kugufasha.

(Arabic) العربية – تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا وسائل وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات سهلة الاستخدام دون أي تكلفة. اتصل على الرقم: 1-844-363-8457 (الهاتف النصي: 1-800-366-6888 أو 711) أو تحدث إلى مقدم الرعاية المتابع لك.

Kiswahili (Swahili) – ZINGATIA: Ikiwa unazungumza Kiswahili, huduma za msaada wa lugha bila malipo zinapatikana kwa ajili yako. Vifaa na huduma saidizi zinazofaa ili kutoa taarifa katika miundo inayoweza kufikiwa pia hupatikana bila malipo. Piga simu 1-844-363-8457 (TTY: 1-800-366-6888 au 711) au zungumza na mtoa huduma wako.

Русский (Russian) – ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах. Позвоните по телефону 1-844-363-8457 (TTY: 1-800-366-6888 или 711) или обратитесь к своему поставщику услуг.

日本語 (Japanese) – お知らせ: 日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。情報を利用可能な形式で提供するための適切な補助具やサービスも無料でご利用いただけます。1-844-363-8457 (TTY: 1-800-366-6888 または 711) にお電話いただくか、医療提供者にご相談ください。

नेपाली (Nepali) – ध्यान दिनुहोस्: तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-844-363-8457 (TTY: 1-800-366-6888 वा 711) मा कल गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Français (French) – ATTENTION : Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés dans des formats accessibles. Appelez le 1-844-363-8457 (ATS : 1-800-366-6888 ou 711) ou adressez-vous à votre fournisseur.

한국어 (Korean) – 주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 수단 및 서비스도 무료로 이용하실 수 있습니다. 1-844-363-8457 (TTY: 1-800-366-6888 또는 711) 번으로 전화하거나 담당 의료 서비스 제공자와 상의하십시오.

Tagalog (Tagalog) – PAUNAWA: Kung nagsasalita kayo ng Tagalog, mayroong kayong magagamit na libreng tulong na mga serbisyo sa wika. Mayroon ding mga angkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format na makukuha ng walang singil. Tumawag sa 1-844-363-8457 (TTY: 1-800-366-6888 o 711) o makipag-usap sa iyong provider.

Norsk (Norwegian) – OBS: Hvis du snakker norsk, er gratis språkhjelp tilgjengelig for deg. Passende ytterligere hjelpemidler og tjenester for å oppgi informasjon i tilgjengelige formater er også tilgjengelig kostnadsfritt. Ring 1-844-363-8457 (TTY: 1-800-366-6888 eller 711) eller snakk med leverandøren din.

Diné (Navajo) – YÁ'ÁT'ÉÉH NITSÁHÁKEES: Díí Diné bizaad bee yániit'go, t'áá íiyisí t'áá bee yáhoot'ééí dóó baa áháyá' át'é. T'áá jíí'k'ehígíí bee na'ách'ąą' holne' dóó t'áá shikaadéé' danilj'ígíí t'áá jíí'k'ehgo bee hóló, dóó t'áá íiyisí doo béesh bee hadooleel da. 1-844-363-8457 bee hojii' (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee nił hane'ígíí nihił ch'á hodoool'j'.