City of Fargo
Blue Cross Blue Shield of North Dakota (BCBSND)
Health Insurance Premiums - Effective January 1, 2026

	BCBSND DakotaBlue 80 500 (Essentia Network)						
		Employee Pay Period Contribution	COF Pay Period Contribution	Employee Monthly Contribution	COF Monthly Contribution	Combined Monthly Premium	Total Annual Premium
Full-time 40*	Individual	$ 52.24	$ 320.91	$ 104.48	$ 641.82	$ 746.30	$ 8,955.60
2080	Parent + Children	$ 131.36	$ 525.44	$ 262.72	$ 1,050.88	$ 1,313.60	$ 15,763.20
annual hrs	Family	$ 194.05	$ 776.20	$ 388.10	$ 1,552.40	$ 1,940.50	$ 23,286.00
Full-time 30-39*	Single	$ 126.87	$ 246.28	$ 253.74	$ 492.56	$ 746.30	$ 8,955.60
1560-2079	Parent + Children	$ 262.72	$ 394.08	$ 525.44	$ 788.16	$ 1,313.60	$ 15,763.20
annual hrs	Family	$ 388.10	$ 582.15	$ 776.20	$ 1,164.30	$ 1,940.50	$ 23,286.00
Part-time 20-29*	Single	$ 186.57	$ 186.58	$ 373.14	$ 373.16	$ 746.30	$ 8,955.60
1040-1559	Parent + Children	$ 394.08	$ 262.72	$ 788.16	$ 525.44	$ 1,313.60	$ 15,763.20
annual hrs	Family	$ 582.15	$ 388.10	$ 1,164.30	$ 776.20	$ 1,940.50	$ 23,286.00

COBRA Monthly Premiums	
COBRA Single	$ 761.23
COBRA Parent+	$ 1,339.87
COBRA Family	$ 1,979.31

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 Copay 80/500

Large Group

	Preferred Network	Enhanced Network	Standard Network	Out-of-network
Deductibles				
Individual	$500	$1,000	$1,250	$1,875
Parent + Child(ren)	$750	$1,500	$1,875	$2,800
Two-person/Family	$1,000	$2,000	$2,500	$3,750
Out-of-pocket maximums				
Individual	$3,000	$6,000	$7,500	$11,250
Parent + Child(ren)	$4,500	$9,000	$11,250	$16,875
Two-person/Family	$6,000	$12,000	$15,000	$22,500
Service costs paid by members. Coinsurance (%) subject to deductible. Copays ($) and ** not subject to deductible. *Preferred Network deductible applies				
Virtual visits/check-ins	$0	40%	50%	50%
Primary/Specialist office visit	$5/$30	40%	50%	50%
Hospital in/outpatient	20%	40%	50%	50%
Emergency room visit	20%	20%*	20%*	20%*
Lab, X-ray, CT/PET, MRI	20%	40%	50%	50%
Preventive care (see definition)	$0	$0	$0	Not covered
Contraceptive office visit	$0	$0	$0	Not covered
Maternity office visit	$0	40%	50%	50%
Pre/Postnatal care	20%**	40%	50%	50%
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.
Generic non-preferred drug	$35			
Brand preferred drug	$85			
Brand non-preferred drug	$150			
Specialty preferred drug	$225			
Specialty non-preferred drug	$325			
Value drug	$5			

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.

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.

Premium - The amount you pay each month to maintain coverage under your health insurance plan.

Coinsurance (%) - The percentage of costs you pay for covered services after reaching your deductible.

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.

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

Preventive care - Visit nd.blue_DBPreventiveCare or scan the QR code to see the most recent preventive care guidelines for your gender and age.

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.

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

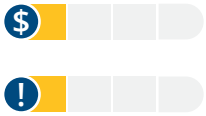
DakotaBlue is available in Cass, Ransom and Richland counties..

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.

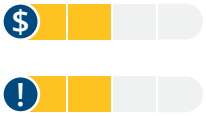
Virtual Care Visits[1]



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

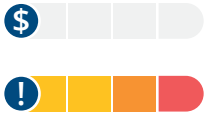
Sprains/strains | Persistent diarrhea
Painful urination | Allergic reactions
Mild abdominal pain | Animal bites
Small cuts that may require stitches
Rashes without fever

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

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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

[1]Many 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 deductible?	For Preferred network providers **$500** individual / **$750** parent and child / **$750** parent and children / **$1,000** two person / **$1,000** family For Enhanced network providers **$1,000** individual / **$1,500** parent and child / **$1,500** parent and children / **$2,000** two person / **$2,000** family For Standard network providers **$1,250** individual / **$1,875** parent and child / **$1,875** parent and children / **$2,500** two person / **$2,500** family For Nonparticipating providers **$1,875** individual / **$2,800** parent and child / **$2,800** parent and children / **$3,750** two person / **$3,750** family	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 medical 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.

Important Questions	Answers	Why This Matters:
What is the out-of-pocket limit for this plan?	For Preferred network providers **$3,000** individual / **$4,500** parent and child / **$4,500** parent and children / **$6,000** two person / **$6,000** family For Enhanced network providers **$6,000** individual / **$9,000** parent and child / **$9,000** parent and children / **$12,000** two person / **$12,000** family For Standard network providers **$7,500** individual / **$11,250** parent and child / **$11,250** parent and children / **$15,000** two person / **$15,000** family For Nonparticipating providers **$11,250** individual / **$16,875** parent and child / **$16,875** parent and children / **$22,500** two person / **$22,500** 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, 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/find-a-doctor or call 1-844-363-8457 for a list of network providers.	You pay the least if you use a provider in the Preferred network. You pay more if you use a provider in the Enhanced or Standard network. You will pay the most if you use a Nonparticipating 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 a Nonparticipating 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
		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 provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	50% coinsurance	None
	Specialist visit	$30 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	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 **prescription drug coverage** is available at www.bcbsnd.com/members/rx-tools	Value drugs	$5 copay/ prescription; deductible does not apply (retail & mail order)	$5 copay/ prescription; deductible does not apply (retail & mail order)	$5 copay/ prescription; deductible does not apply (retail & mail order)	Not covered	Benefits are subject to the copay application described in the benefit plan. *See section 1.
	Generic preferred drugs (Tier 1)	$20 copay/ prescription; deductible does not apply (retail & mail order)	$20 copay/ prescription; deductible does not apply (retail & mail order)	$20 copay/ prescription; deductible does not apply (retail & mail order)	Not covered	
	Generic nonpreferred drugs (Tier 2)	$35 copay/ prescription; deductible does not apply (retail & mail order)	$35 copay/ prescription; deductible does not apply (retail & mail order)	$35 copay/ prescription; deductible does not apply (retail & mail order)	Not covered	
	Brand name preferred drugs (Tier 3)	$85 copay/ prescription; deductible does not apply (retail & mail order)	$85 copay/ prescription; deductible does not apply (retail & mail order)	$85 copay/ prescription; deductible does not apply (retail & mail order)	Not covered	
	Brand name nonpreferred drugs (Tier 4)	$150 copay/ prescription; deductible does not apply (retail & mail order)	$150 copay/ prescription; deductible does not apply (retail & mail order)	$150 copay/ prescription; deductible does not apply (retail & mail order)	Not covered	
	Specialty preferred drugs (Tier 5)	$225 copay/ prescription; deductible does not apply	$225 copay/ prescription; deductible does not apply	$225 copay/ prescription; deductible does not apply	Not covered	Benefits are subject to the copay application described in the benefit plan. *See section 1. Specialty drugs must be received from the preferred specialty pharmacy network.
	Specialty nonpreferred drugs (Tier 6)	$325 copay/ prescription; deductible does not apply	$325 copay/ prescription; deductible does not apply	$325 copay/ prescription; deductible does not apply	Not covered	

*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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance; Preferred network deductible applies	20% coinsurance; Preferred network deductible applies	20% coinsurance; Preferred network deductible applies	None
	Emergency medical transportation	20% coinsurance	20% coinsurance; Preferred network deductible applies	20% coinsurance; Preferred network deductible applies	20% coinsurance; Preferred network deductible applies	None
	Urgent care	$5 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/office visit; deductible does not apply 20% coinsurance for other outpatient services	20% coinsurance/ office visit; Preferred network deductible applies 20% coinsurance for other outpatient services; Preferred network deductible applies	50% coinsurance/ office visit 50% coinsurance for other outpatient services	50% coinsurance/ office visit 50% coinsurance for other outpatient services	No charge for first five hours of mental health services or first five visits for substance use services. Precertification may be required.
	Inpatient services	20% coinsurance	20% coinsurance; Preferred network deductible applies	50% coinsurance	50% coinsurance	Precertification may be required.

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 are pregnant	Office visits	No charge	40% coinsurance	50% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	Precertification is required.
	Rehabilitation services	$5 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	50% coinsurance	None
	Habilitation services	$5 copay/visit; deductible does not apply	40% coinsurance	50% coinsurance	50% coinsurance	90 visits max/benefit period may apply for each therapy: physical, occupational and speech.
	Skilled nursing care	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	Precertification is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	Precertification may be required.
	Hospice services	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance	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
- Cosmetic surgery
- Dental care (pediatric or adult)
- Long-term (custodial) care
- Routine eye care (adult)
- Routine foot care
- Weight loss/management drugs
- 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 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; 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 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,980**

Managing Joe's type 2 Diabetes
(a year of routine in-network 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$400
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$630**

Mia's Simple Fracture
(in-network 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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$30
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$830**

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

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South • Fargo, ND 58121

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.

العربية (Arabic) – تنبيه: إذا كنت تتحدث العربية، فتتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا وسائل وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات سهلة الاستخدام من 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 yáníłti'go, t'áá íiyisí t'áá bee yáhoot'ééł dóó baa áháyá' át'é. T'áá jíík'ehígíí bee na'ách'ąą' holne' dóó t'áá shikaadéé' danilį́į'ígíí t'áá jíík'ehgo bee hóló, dóó t'áá íiyisí doo béésh bee hadooleeł da. 1-844-363-8457 bee hojiiį' (TTY: 1-800-366-6888 dóó 711), dóó naaltsoos nínízingo bee iiná bee nił hane'ígíí nihił ch'á hodool'į'.