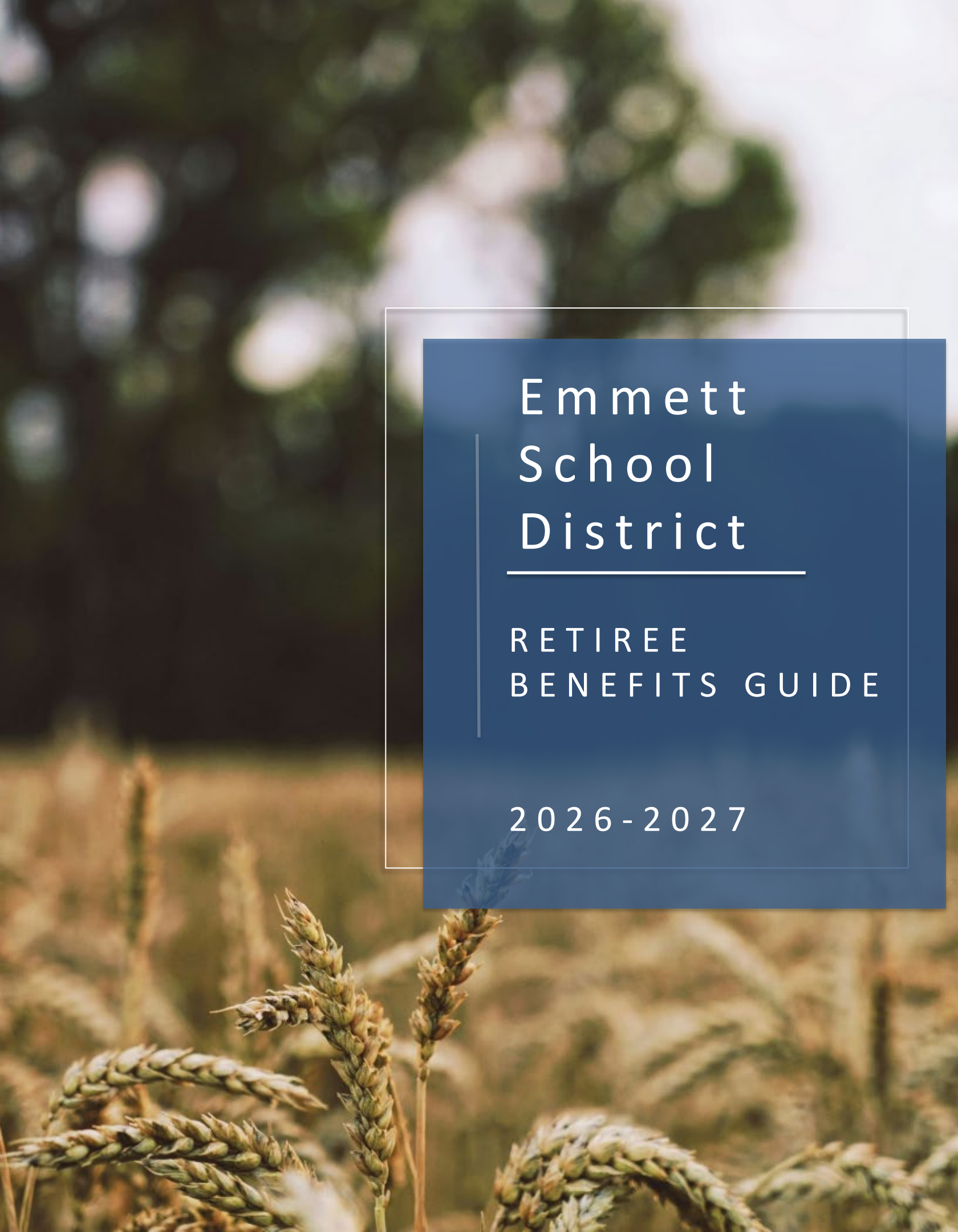




Emmett School District

RETIREE
BENEFITS GUIDE

2026-2027

Retiree Benefit Guide 2026-2027

This guide contains information regarding the Medical, Dental, Vision and Life benefits offered to you as an under Age 65 Retiree of the Emmett School District. If you have any questions about the information provided, please contact our benefit consulting team at Acrisure for assistance at (208) 765-2620.

Not Making Changes:

- If you do not need to make changes to your current plans, you will not need to complete any of the forms in this packet. All your plans will remain the same with new monthly rates beginning on September 1, 2026.

Making Changes:

- To change plans or add/remove dependents, you must complete the corresponding Medical, Dental, Vision or Life forms included in this packet. Please be sure to include your signature and indicate the changes on the top of the form.
 - * You are only able to make changes to medical, dental, vision and life benefits if you elected them at your initial retirement.
- If you have your premiums deducted from your unused sick leave or PERSI retirement, please understand that any changes you make to your enrollment are subject to PERSI review and eligibility. You may be required to pay for your premiums by direct bill if you do not have funds available.
- Contact PERSI if you need to view your account balance.
- **If you or your spouse are turning 65 this year, please contact Acrisure at (208) 765-2620 for more information about the Retiree Benefits for Medicare-eligible Retirees.**

All forms must be completed and returned to Human Resources by August 14, 2026.

You can mail, fax, or email the forms to Human Resources.

By Mail: Human Resources
119 N Wardwell Avenue
Emmett, ID 83617

By Fax: (208) 365-2961
Attention: Leah Barrus

By Email: lbarrus@isd221.net

PLEASE NOTE:

- › Independent School District of Emmett will continue using **Regence** for health coverage this year. No Changes to the vision or dental plans.

Insurance Premiums

Medical – Regence \$500 Deductible PPO Plan

	Retiree Premium
Employee Only	\$890.17
Employee & Spouse	\$1,688.92
Employee & 1 Child	\$1,217.75
Employee & 2+ Children	\$1,409.13
Family	\$1,940.15

Medical – Regence \$3,400 Deductible HSA Plan

	Retiree Premium
Employee Only	\$752.90
Employee & Spouse	\$1,397.00
Employee & 1 Child	\$1,007.00
Employee & 2+ Children	\$1,166.20
Family	\$1,604.80

Delta Dental

	Retiree Premium
Employee Only	\$37.10
Employee & Spouse	\$82.25
Employee & 1 Child	\$71.25
Employee & 2+ Children	\$106.00
Family	\$141.85

NorthWest Dental Benefits

	Retiree Premium
Employee Only	\$48.02
Employee & Spouse	\$97.48
Employee & 1 Child	\$98.32
Employee & 2+ Children	\$146.10
Family	\$177.56

Willamette Dental *Dental Blue Connect*

	Retiree Premium
Employee Only	\$56.86
Employee & Spouse	\$123.05
Employee & 1 Child	\$109.30
Employee & 2+ Children	\$162.72
Family	\$217.93

Vision

	Retiree Premium
Employee Only	\$7.83
Employee & Spouse	\$15.69
Employee & Child(ren)	\$16.78
Family	\$26.81

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

2026 – 2027 Medical Plans

Plan Highlights:	Option 1: Regence \$500 PPO	Option 2: Regence \$3,400 HSA
Deductible (Calendar Year)		
Individual	\$500	\$3,400
Family	\$1,000	\$5,000
Coinsurance (In-Network) <i>Cost-sharing after deductible is met</i>	Plan pays 70% / You pay 30%	Plan pays 80% / You pay 20%
Out-of-Pocket Maximum <i>(Once member reaches this, plan will pay 100% for remainder of calendar year)</i>	<i>(Includes Deductible + Coinsurance + Copays)</i>	<i>(Includes Deductible + Coinsurance)</i>
Individual	\$5,000	\$5,500
Family	\$10,000	\$11,000
	No Deductible	
Physician Office Visit	Primary Care: \$30 copay Specialist: \$45 copay	Primary Care: \$15 (after deductible) Specialist: \$40 (after deductible)
Preventive Care	Covered 100%	Covered 100%
Diagnostic Labs / Imaging	No deductible up to \$400, then applied to deductible + coinsurance	Applied to deductible + coinsurance
Hospitalization/Maternity	Applied to deductible + coinsurance	Applied to deductible + coinsurance
Emergency Room	30% after \$300 copay per visit (waive if admitted)	\$300 Copay + deductible + coinsurance
Pharmacy / RX		Deductible & OOP combined w/Medical
Preferred Generic:	\$10 (deductible waived)	\$10 (deductible waived)
Preferred Brand Name:	25%	\$30 (after ded)
Non-Preferred Brand Name:	50%	\$60 (after ded)
Specialty:	N/A	\$150 (after ded)

Regence PPO vs. Regence HSA

Regence PPO

- ✓ Members pay flat copays for physician office visits and most prescriptions.
- ✓ Great choice for members who have ongoing medical costs and prefer copays and upfront coverage for services.

Regence HSA

- ✓ The Regence HSA is a high-deductible health plan. Members receive coverage for medical services once they reach their deductible.
- ✓ Great choice for members with minimal medical expenses each year who want to save money on health insurance premiums.

➤ Both plans include 100% coverage for Preventive Care Services with no copay and no deductible.

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NEW Dental Option

NORTHWEST Dental Benefits



With **NorthWest Dental Benefits**, you may visit any of their in-network licensed dentists and orthodontists with fixed copays for each services. Diagnostic & Preventative services are a \$0 copay to you.

COVERED SERVICE	BENEFIT
Annual Maximum	\$2500 Maximum
Deductible	No Deductible
Diagnostic & Preventive Services	\$0 Copay
Cleanings (2 Per 12 months)	\$0 Copay
Fillings	You Pay a \$35 Copay
Porcelain-Metal Crown	You Pay a \$350 -\$400 Copay
Complete Upper or Lower Denture	You Pay a \$750 Copay
Root Canal Therapy	You Pay a \$250 -\$400 Copay
Osseous Surgery (per Quadrant)	You Pay a \$500 - \$600 Copay
Root Planing (per Quadrant)	You Pay a \$85 Copay
Routine Extraction (Single Tooth)	You Pay a \$30 Copay
Surgical Extraction	You Pay a \$60 -\$135 Copay
Comprehensive Orthodontia Treatment	Up to a \$2,500 Benefit Adults & Children
Dental Implant Surgery (6 month Waiting Period)	\$850 Copay
Nitrous Oxide	You Pay a \$40 Copay
Specialty Office Visit	You Pay \$30 Copay per Visit

SUPERIOR ORTHODONTIA COVERAGE

No age limit
Use towards traditional braces
or Invisalign® treatment

CONVENIENT VISITS & CARE

Providers authorized to approve
same-day treatment
No need for traditional
preauthorizations to save you time

**Schedule list of copayments and covered dental codes can be requested by emailing: Admin@NorthwestDentalBenefits.com

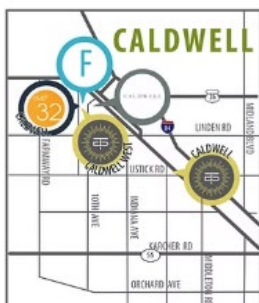
Orthodontic Services for Everyone

Maximum orthodontic lifetime benefit to use on braces or Invisalign is \$2500;
Replacement of orthodontic appliance is not covered; Orthodontic benefits have a 6-month waiting period starting from your coverage start date. You can begin treatment before the waiting period is over but benefit payments will only begin after 6 months. If your coverage ends before all payments are made, you'll be responsible for any remaining costs, including amounts that would have been paid by NWDB.

Emmett, Canyon County & ADA County Locations:

Elkins Dental – Emmett Idaho

1110 S Washington Ave, Emmett, ID 83617



Find your
provider here



Delta Dental



PROVIDER NETWORK	PPO	PREMIER
Annual Deductible (Individual / Family)	None	None
	Plan Pays:	Plan Pays:
Preventive Care (Exam, cleanings, x-rays)	70-100%	70-100%
Basic Procedures (Fillings, extractions, root canal)	70-100%	70-100%
Major Procedures (Crowns, bridges, dentures)	50%	50%
Annual Maximum Benefit (Per Member)	\$1,000	\$1,000

Visit www.deltadentalid.com to view network providers, claims, and member discounts

Willamette Dental (Dental Blue Connect)



****Must go to the Willamette Dental Clinic for services****

BENEFITS	COPAY
General Office Visit	\$15 Copay
Annual Benefit Maximum	No Annual Maximum
Must go to the Willamette Dental Clinic for services	
Preventive (Cleanings, X-Rays, Exam)	Covered 100% after Copay
Fillings	\$15 Copay
Extraction / Surgical Extraction	\$15 Copay / \$75 Copay
Root Canal	\$50 Copay
Crowns & Bridges	\$150 Copay (each service)
Dentures	\$200 Copay
Orthodontia	\$1,500 Copay
Nitrous Oxide	\$20 Copay
Dental Implant	N/A

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

Vision

United Heritage Insurance

In Partnership with VSP®



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	\$10	Every 12 months
PRESCRIPTION GLASSES		\$25	See frame and lenses
FRAME*	• \$170 featured frame brands allowance • \$150 frame allowance • 20% savings on the amount over your allowance • \$80 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	\$0 \$95 - \$105 \$150 - \$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• \$150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation), billed amount not to exceed \$60		Every 12 months
EXTRA SAVINGS	Glasses and Sunglasses • Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. Routine Retinal Screening • No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider. Your plan provides the following out-of-network reimbursements:

Exam	up to \$45	Lined Bifocal Lenses	up to \$50	Progressive Lenses	up to \$50
Frame	up to \$70	Lined Trifocal Lenses	up to \$65	Contacts	up to \$105
Single Vision Lenses	up to \$30				

You do not need a card to access your VSP benefits. Simply give your Eye Clinic your Name and DOB. Dependents covered on vision will be accessed under the Employee's Information.

FIND VSP PROVIDERS AT: WWW.VSP.COM



This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

Retiree Life Insurance



Employer Paid Life Insurance	
Options	Retiree Monthly Premium
\$30,000	\$105.30
\$20,000	\$70.20
\$10,000	\$35.10
\$5,000	\$17.55

* Only available to Retirees who opted-in prior to retirement

<i>Benefit Contact Information</i>			
<i>Benefit Plan</i>	<i>Carrier Name</i>	<i>Website</i>	<i>Phone Number</i>
Benefit Advocates	Acrisure	acrisure.com/northwest	877.765.2620
Medical	Regence	regence.com	888.494.2583
Dental	Willamette Dental	willamettedental.com	855.433.6825
Dental	Delta Dental of Idaho	deltadentalid.com	800.356.7586
Dental	NORTHWEST Dental Benefits	northwestdentalbenefits.com	208.618.6932
Vision	VSP Vision Plan	vsp.com	800.877.7195
Life /LTD	United Heritage Life	unitedheritage.com	800.830.1140

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.



NORTHWEST DENTAL BENEFITS

NEW ENROLLMENT

Please complete all sections of this form.

SECTION A: GENERAL INFORMATION

TYPE OF PROGRAM

NWDB – Blue Square Plan

PLAN (check one)

- ☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child
☐ Employee + Children
☐ Employee + Family

EFFECTIVE DATE: _____

EMPLOYER: _____

GROUP NUMBER: _____

SECTION B: EMPLOYEE INFORMATION *(please print clearly)*

Social Security Number

____/____/_____
Original Employment Date (mm/dd/yyyy)

☐ M ☐ F

Employee Name

____/____/_____
Date of Birth

Email Address

Home Address

City

ZIP Code

SECTION C: DEPENDENT INFORMATION

(Please list any added/cancelled dependents in this section. For more than four dependent children, complete and attach an additional form.)

Social Security #	Type	Last Name	First Name	MI	Gender	Date of Birth
	Spouse/ Domestic Partner				M / F	
	Dependent (A)				M / F	
	Dependent (B)				M / F	
	Dependent (C)				M / F	
	Dependent (D)				M / F	

SECTION D: OTHER DENTAL COVERAGE

(Please list any added/cancelled dependents in this section. For more than four dependent children, complete and attach an additional form.)

Do you have another dental policy with Northwest Dental Benefits?

☐ YES ☐ NO

If yes, please provide the following information:

Policy Holder

Employer

Group #

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Employee Signature

Date

SECTION E: PAYMENT OPTIONS

☐ **PERSI Pay** – Payment will automatically be deducted each month from your PERSI sick leave account or monthly pension check.

PERSI sick leave account that premiums will be deducted from:

- ☐ Person Retiring
☐ Spouse's Account

If deducting from a spouse's PERSI sick leave account, please provide the name on the PERSI account:

☐ **Direct Pay** – You will be billed for your premium (select one):

- ☐ Monthly
☐ Quarterly

☐ **Bank Draft** – Payment will be automatically withdrawn from your bank account.

A completed Bank Draft Authorization form is required.

I authorize **Northwest Dental Benefits (NWDB)** and PERSI to exchange my address and enrollment information for purposes of administering this plan.

Retiree Signature: _____ Date: _____

School District Official's Signature: _____ Date: _____

Group Insurance Benefits Request Idaho School Retirees

Retirees Name _____ Subscriber Number _____

Birth Date _____

Address _____

Phone Number _____

City/State/Zip _____

Date of Retirement _____

Coverage paid by School District through _____, 20____

Signed, School District Official _____

School District's Name and Number _____

School District's Address _____

Total monthly dental premium: \$_____ Total back premiums/adjustments: \$_____

Sufficient sick leave available to cover 1st payment due? Yes ☐ No ☐Sufficient sick leave available to cover back premiums/adjustments? Yes ☐ No ☐Are you over the age of 65? Yes ☐ No ☐

Please pay the Delta Dental premium of \$_____ until my sick leave entitlement is exhausted. I understand that rates, benefits and continuing eligibility for coverage for me and my dependents are all subject to the Master Contract between the School District and Delta Dental of Idaho. I understand the School District will notify me of any rate changes. I realize that should the Contract between the School District from which I retired and Delta Dental of Idaho be terminated, my coverage through Delta Dental of Idaho will terminate.

Please include the following eligible dependents for coverage under Delta Dental.

Dependent Spouse's Name _____ Birthdate _____

Dependent Child's Name and Birthdate:

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

I understand that if coverage is voluntarily terminated for myself, it can never be reinstated. I may add or terminate my dependents only when a status change has occurred. Dependent additions are subject to the contractual limitations stated in the contract between Delta Dental and the School District.

Signature: _____

Date: _____

Instructions:

Complete this form, including signatures by the School District Official and Retiree, and monthly premium amount. Send to Delta Dental of Idaho, 555 E. Parkcenter Blvd, Boise, ID, 83706 by the tenth of the month preceding retirement. Delta Dental of Idaho will send notification to the Public Employee Retirement System.



Statewide Schools Retiree Application

Requested Effective Date _____

☐ Retiree Deferral Request

SCHOOL DISTRICT INSTRUCTIONS: Please have the Retiree complete and sign this form, then complete your portion on the back. Have your participating school district or school related group official sign and return the form to Blue Cross of Idaho.

RETIREE INSTRUCTIONS: Please complete the information below and sign and date the back of the form.

Applicant Information (Retiree)					
First Name	Last Name	Middle Initial	Marital Status ☐ Single ☐ Divorced	☐ Married ☐ Widowed	Gender ☐ Male ☐ Female
Address	City, State, Zip Code		Phone Number		
Social Security Number	Blue Cross of Idaho Identification Number		Blue Cross of Idaho Group Number		
Medicare Beneficiary Number	Date of Retirement		Birthdate		

Dependent Information - Please include the following eligible dependents who are currently covered under my program and will continue to be covered under my Retiree Program. List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (*copy of certification required*).

Dependent Spouse's Name	Spouse's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate
Dependent Child's Name	Child's Social Security Number	Medicare Beneficiary Number	Birthdate

Medical Coverage - Please choose appropriate coverage from the selections below.

Retiree enrollment may be equal to or lesser than active employee enrollment.

UNDER 65				OVER 65						
	Health	Dental (if applicable)	Vision (if applicable)		Retiree Plan with RX	Retiree Plan without RX	Dental Coverage (if applicable)	Vision (if applicable)	Medicare Supplement*	Medicare Advantage**
Employee	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	Employee	☐	☐	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	☐	☐
Spouse	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	Spouse	☐	☐	☐ PPO Dental Plan ☐ Dental Blue Connect	☐	☐	☐
Child	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐							
Child	☐ PPO ☐ HSA ☐ POS	☐ PPO Dental Plan ☐ Dental Blue Connect	☐							

* A Medicare Supplement enrollment form is required to enroll in Blue Cross of Idaho's Medicare Supplement plans. Call 1-888-GO CROSS (1-888-462-7677) toll free to request a form and plan information.

**A Medicare Advantage enrollment form is required to enroll in Blue Cross of Idaho's Medicare Advantage plans. Call 1-888-492-2583 toll free to request a form and plan information.

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID			Class	Reason Code
			M	D	V		

Street Address: 3000 E. Pine Ave., Meridian, ID 83642-5995 • Mailing Address: P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550

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Current/Prior Coverage

(For Coordination of Benefits, please complete the section below. Use extra paper if necessary).

Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy		Will Current Policy Continue?
				Start Date (mm/dd/yy)	End Date (mm/dd/yy)	

Benefits offered to Retirees **under age 65**, under the Blue Cross of Idaho School Insurance Program, are to be the same benefits offered to active employees. If you had dental coverage through BCI while an active employee, you will be allowed to continue that dental coverage as a Retiree, as long as the group offers that benefit to its employees.

Retirees and/or spouses **over the age of 65** will be enrolled in our Blue Cross of Idaho School Insurance Over 65 Medicare Program and **must** be enrolled in Parts A and B. You are eligible for dental benefits if the participating school district or school related group you retired from participates in BCI's school program and you were enrolled in a dental plan through your participating school district or school related group for **12 months prior to enrolling in this retiree program**.

Please note that Blue Cross of Idaho cannot guarantee billing or payment of all policies selected by PERSI. If for any reason your premiums cannot be paid by PERSI, Blue Cross of Idaho will bill you directly.

RETIREE'S signature: _____ Date: _____

I authorize the Public Employee Retirement System of Idaho (PERSI) and Blue Cross of Idaho to exchange my address and enrollment information for the purpose of administering this plan.

RETIREE'S signature: _____ Date: _____

Sign for Deferment Only

I choose to defer my enrollment in the retiree program as well as my draw on unused sick leave entitlement with PERSI. I understand if I choose not to continue coverage at the time of retirement I may not be able to enroll at a later date. Later enrollment is possible only if your school district or school related group remains with Blue Cross of Idaho and you maintain continuous coverage. If your school district chooses another carrier, you will not be able to enroll in the program.

RETIREE'S signature: _____ Date: _____

TO BE COMPLETED BY THE PARTICIPATING SCHOOL DISTRICT OR SCHOOL RELATED GROUP:

Not necessary for currently enrolled retirees

Coverage paid by the Participating School District or School Related Group through the month of: _____, 20_____

Signature of Participating School District or School Related Group Official

Name of Participating School Group or School Related Group

Group Number

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) 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 of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o 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:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 711), or call the customer service phone number on the back of your card. If you believe that Blue Cross of Idaho has failed to provide these services or

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

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 1-800-627-1188 (TTY: 711)。

Farsi: توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

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。1-800-627-1188 (TTY: 711) まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: grievances&appeals@bcidaho.com
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team 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, 1-800-368-1019, 800-537-7697 (TTY). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोलनुहुन्छ भने तपाईंको नमिति भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविडि: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).