Align powered by Sanford Health Plan

Align ChoiceElite (PPO) H3186-001

SUMMARY OF BENEFITS

January 1, 2026 - December 31, 2026

This booklet gives you a summary of drug and health services covered by Align powered by Sanford Health Plan for Align ChoiceElite (PPO). It is an overview of what we cover and what you pay. The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Member Services and request the "Evidence of Coverage" or access it online at align.sanfordhealthplan.com.

Align ChoiceElite (PPO) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the plan depends on the contract renewal.

- **Primary Care Physician (PCP)** – We encourage you to choose a primary care physician. Your health is better supported when we know who your doctor is.
- **Referrals** – Align powered by Sanford Health Plan does not require a referral to see a specialist.
- **Prior Authorizations** – Align powered by Sanford Health Plan offers Direct Access for Sanford providers. This means your Sanford doctor does not have to get approval before you receive services. We depend on their expertise to drive your healthcare options. Restrictions may apply.

To Reach a Member Services Representatives:

- Current members please call 1-877-509-4979 (TTY 711) for more information.
- Prospective members please call 1-888-605-9277.
- For Medicare Part D drug coverage information, call 1-844-642-9090.
- Hours are 7 days a week, 8 a.m. to 8 p.m., Oct. 1-March 31; and Monday through Friday, 8 a.m. to 8 p.m., April 1-Sept. 30. This call is free.

  If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.

To join Align ChoiceElite (PPO) you must:

- be entitled to Medicare Part A,
- *and* be enrolled in Medicare Part B,
- *and* live in our service area.

The Align powered by Sanford Health Plan service area includes these counties in:

- **Minnesota**: Becker, Beltrami, Big Stone, Clay, Clearwater, Hubbard, Lac qui Parle, Mahnomen, Marshall, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Red Lake, Rock, Traverse, and Wilkin.

Align powered by Sanford Health Plan has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services; but if you want to, you can also use providers that are not in our network. You can choose to see either in-network or out-of-network providers. You will pay less for covered services through an in-network provider. Please note out-of-network/non-contracted providers are under no obligation to treat Align ChoiceElite (PPO) members, except in emergency situations.

- You can choose from a variety of pharmacies (i.e. standard or preferred Pharmacies) to fill your prescriptions for covered Part D drugs.
- You can see our plan's provider directory at our website sanfordhealthplan.com/align.
- You can see our plan's pharmacy directory at our website sanfordhealthplan.com/align/pharmacy-and-drug-coverage.
- Or call us and we will send you a copy of the provider and pharmacy directories. The pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call the Member Services number.

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
+ Your provider must obtain prior authorization from our plan.		
Monthly Plan Premium	$94 You must continue to pay the Medicare Part B premium.	
Deductible Medical Part D Prescription Drugs Part D Deductible	$0 $0 per year for Tier 1, Tier 2, Tier 6 $300 per year for Tier 3, Tier 4, Tier 5	$0 In general, Part D drug coverage is not available out of network. See Chapter 5, Section 2.4 in the Evidence of Coverage.
Maximum Out-of-Pocket Amount *Does not include costs related to prescription drugs*	$3,000 yearly limit for combined In-network and Out-of-network Medicare-covered services If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your Medicare Part B premium, your plan premium and any cost sharing for your Part D prescription drugs.	
Inpatient Hospital Coverage+	$250 copay per day for days 1-5; $0 copay per day for days 6-90	$425 copay per day for days 1-5; $0 copay per day for days 6-90
Outpatient Hospital Services+	$150 copay per visit 20% coinsurance for Medicare-covered outpatient diagnostic colonoscopies	20% coinsurance per visit 20% coinsurance for Medicare-covered outpatient diagnostic colonoscopies
Outpatient Hospital Observation Services+	$125 copay per stay	$250 copay per stay
Ambulatory Surgical Center (ASC) Services+	$100 copay per visit	20% coinsurance per visit

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Doctor Visits		
Primary Care Providers	$0 copay per primary care physician visit	$10 copay per primary care physician visit $20 copay per primary care office visit billed from a facility.
Specialists	$25 copay per specialist visit	$45 copay for Medicare-covered specialist care office visits. $40 copay per specialist office visits billed from a facility.
Preventive Care Such as immunizations, wellness visits, and diabetic screenings. See your Evidence of Coverage for a full list of covered services.	$0 copay per visit for Medicare Covered Preventive care	$0 copay per visit for Medicare Covered Preventive care
Emergency Care	$110 copay per visit *ER cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*	$110 copay per visit *ER cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*
Urgently Needed Services	$30 copay per visit *Urgently needed care services cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*	$30 copay per visit *Urgently needed care services cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.*

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Diagnostic Services / Labs / Imaging+		
Lab Services+	$5 copay per visit	$10 copay per visit
Diagnostic Tests and Procedures+	$10 copay per visit	$30 copay per visit
Diagnostic Radiology Services (e.g. MRI, CAT Scan) +	$0 for peripheral vascular disease ultrasounds only. You pay a $250 copay for complex diagnostic services such as MRI, CT, PET, IMRT, SBRT, CTA and ECHO. You pay a $140 copay for all other diagnostic radiological services.	20% coinsurance per visit
Therapeutic Radiology Services+	$60 copay per visit	20% coinsurance per visit
Outpatient X-rays+	$15 copay per visit	$30 copay per visit
	Prior Authorization is not required for lab services rendered in any place of service; however, Prior Authorization is required for Genetic Testing and for High-End Imaging.	

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Hearing Services		
Medicare-Covered Hearing Exam	$0 copay per visit	50% coinsurance per visit
Supplemental Benefits		
Routine Hearing Exam	$0 copay per visit;1 exam every year	50% coinsurance per visit; 1 exam every year
Hearing Aids	$800 maximum plan coverage amount every year (for both ears combined) for in- and out-of-network prescription hearing aids. Note: Cost-sharing for hearing aids is not included in the annual maximum out-of-pocket amount.	$800 maximum plan coverage amount every year (for both ears combined) for in- and out-of-network prescription hearing aids. Note: Cost-sharing for hearing aids and non-Medicare covered hearing exam is not included in the annual maximum out-of-pocket amount.
	Your Healthy Benefits+ Flex Card will provide you with an annual shared allowance for hearing and vision out-of-pocket costs for additional covered services. See your plan's Evidence of Coverage for additional details.	

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Dental Services Medicare-Covered Dental Services	$0 copay per visit	$0 copay per visit
Supplemental Benefits Preventive Dental Services	$0 copay for the following preventive dental services: • 2 oral exams every year • 2 cleanings every year • 1 bitewing x-ray per year; 1 full mouth x-ray every 5 years.	$0 copay for the following preventive dental services: • 2 oral exams every year • 2 cleanings every year • 1 bitewing x-ray per year; 1 full mouth x-ray every 5 years.
Comprehensive Dental Services	$1,000 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. <u>Comprehensive Dental</u> Services include – Restorative Service: 1 visit every 2 years Endodontics: 1 visit; root canal therapy - 1 per lifetime Periodontics: 1 visit every 3 years Note: Cost-sharing for non-Medicare covered dental services are not included in the annual maximum out-of-pocket amount.	$1,000 maximum plan coverage amount every year for in- and out-of-network non-Medicare-covered comprehensive dental services. <u>Comprehensive Dental</u> Services include – Restorative Service: 1 visit every 2 years Endodontics: 1 visit; root canal therapy - 1 per lifetime Periodontics: 1 visit every 3 years Note: Cost-sharing for non-Medicare covered dental services are not included in the annual maximum out-of-pocket amount.
	Your Healthy Benefits+ Flex Card will provide you with an annual allowance for dental out-of-pocket costs for additional covered services. See your plan's Evidence of Coverage for additional details.	

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Vision Care Medicare-Covered Eye Exams	20% coinsurance	50% coinsurance
Supplemental Benefits Routine Eye Exam	$0 copay for one routine eye exam every year	0-50% coinsurance for one routine eye exam every year
<u>Eyewear:</u> Eyeglasses & Contacts (lenses and frames), Upgrades	You pay $0 for eyeglasses or contact lenses (in lieu of eyeglasses). Eyeglasses: single vision, lined bifocal, lined trifocal and lenticular: 1 pair every year. You pay $0 copay for standard progressive upgrades. VSP provides an annual hardware allowance of $200 at in-network providers. You pay any amount over $200.	You pay 0-50% coinsurance for eyeglasses or contact lenses (in lieu of eyeglasses). You pay 50% coinsurance for standard progressive upgrades.
	Note: Cost-sharing for non-Medicare covered eyewear are not included in the annual maximum out-of-pocket amount.	Note: Cost-sharing for non-Medicare covered eye exam and eyewear are not included in the annual maximum out-of-pocket amount.
	Your Healthy Benefits+ Flex Card will provide you with an annual shared allowance for hearing and vision out-of-pocket costs for additional covered services. See your plan's Evidence of Coverage for additional details.	

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Mental Health Services+ Inpatient Psychiatric+	$250 copay per day for days 1-5; $0 copay per day for days 6-90 *Prior authorization is required for Medicare-covered inpatient mental health stays.*	$425 copay per day for days 1-5; $0 copay per day for days 6-90
Outpatient individual/group therapy visits (non-psychiatrist).	$0 copay per visit	$20 copay per visit
Outpatient individual/group therapy visits with a psychiatrist.	$0 copay per visit	$45 copay per visit
Ambulance Services Ground Ambulance	$200 copay per trip	$200 copay per trip
Air Ambulance	$200 copay per trip	$200 copay per trip

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Skilled Nursing Facility (SNF) Care+	An inpatient hospital stay is not required prior to admission. You pay the 2026 Medicare-defined cost-sharing amounts. These are the 2025 cost-sharing amounts and may change for 2026. Days 1-20: $0 copay for each benefit period. Days 21-100: $209.50 copay per day of each benefit period. Days 101 and beyond: You pay 100% of the cost. Align ChoiceElite (PPO) will provide updated rates on align.sanfordhealthplan.com as soon as they are available. *Prior authorization is required for Medicare-covered SNF stays.*	An inpatient hospital stay is not required prior to admission. You pay the 2026 Medicare-defined cost-sharing amounts. These are the 2025 cost-sharing amounts and may change for 2026. Days 1-20: $0 copay for each benefit period. Days 21-100: $209.50 copay per day of each benefit period. Days 101 and beyond: You pay 100% of the cost.
Physical Therapy & Speech Therapy	$25 copay per visit $30 copay for Medicare covered therapy visits in a Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$45 copay per visit 20% coinsurance for Medicare covered therapy visits in a Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Occupational Therapy	$25 copay per visit $30 copay for Medicare covered therapy visits in a Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$45 copay per visit 20% coinsurance for Medicare covered therapy visits in a Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Transportation	Not covered	Not covered

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
Worldwide Emergent/Urgent Coverage	$250 maximum plan benefit coverage amount every year for the worldwide benefit. Note: Cost-sharing for non-Medicare covered Worldwide emergency and urgently needed care outside of the United States are not included in the annual maximum out-of-pocket amount.	
Medicare Part B Prescription Drugs+* Insulin Part B covered drugs and biologicals, including chemotherapy drugs+ Medicare identifies Part B "rebatable" drugs that have a price increasing at a rate higher than the rate of inflation. Your cost for Part B rebatable drugs is limited to the cost under Original Medicare and will be no more than 20% coinsurance. However, your cost could change each quarter and will be between $0 and 20%. Medicare will notify Align powered by Sanford Health Plan of your cost for these drugs on a quarterly basis.	Up to 20% coinsurance, limited to $35 copay for a one-month supply. Up to 20% coinsurance *Prior authorization is required for some medications.*	20% coinsurance

Benefits and Premiums	You Pay	
	In-network costs	Out-of-network costs
**Select Part B drugs are subject to step therapy restrictions.*		

Supplemental Benefits	You Pay
Fitness Program: **Gym Membership (Silver & Fit)**	$0 copay / month
Healthy Benefits+ Flex Card	Your Healthy Benefits+ Flex Card will provide you with an annual shared allowance of $800 for additional covered hearing and vision services. See your plan's Evidence of Coverage for additional details. Your Healthy Benefit+ Flex Card also provides an allowance for covered dental services and over the counter benefits. See section for details.
Meal Benefit: **Mom's Meals*** **Referral is required*	$0 copay for 56 meals / 28 days maximum. Benefit can be used 4 times per year. Meals are covered following inpatient hospitalization or SNF Part A Stay.
Over the Counter (OTC) Benefit Members must obtain OTC from plan-authorized vendor. Members may order OTC items from vendor via mail, in-store shopping, phone, mobile phone app or website. Members may access their OTC benefit through a program that delivers to their home.	Your Healthy Benefit+ Flex Card will provide a quarterly OTC allowance of $85 maximum plan coverage amount every 3 months for OTC items. Unused OTC Allowance dollars do not roll over to the next quarter or the next calendar year.

Outpatient Prescription Drugs	
Deductible	$0 per year for Tier 1 Preferred Generic, Tier 2 Generic, Tier 6 Select Care Drugs $300 per year for Tier 3 Preferred Brand, Tier 4 Non-Preferred Drug, Tier 5 Specialty Tier
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $2,100. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. • Cost sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. • This plan requires prior authorization and has quantity limit restrictions for certain drugs. Please refer to the formulary to determine if your drugs are subject to any limitations. You can see the most complete and current information about which drugs are covered on our website. • Cost sharing may differ based on point-of-service (retail, Long Term Care (LTC)), home infusion, whether the pharmacy is in our standard network, or whether the prescription is a short-term supply (34-day supply) or long-term supply (102-day supply). • You can choose from a variety of pharmacies (i.e. standard or preferred Pharmacies) to fill your prescriptions for covered Part D drugs. You may search for network providers and pharmacies on our website at sanfordhealthplan.com/align/pharmacy-and-drug-coverage, or call us and we will send you a copy of the provider and pharmacy directories • Preferred Pharmacies Include: Sanford, Lewis Drug, CVS, Seip, Gateway, Thrifty White, and Optum Mail Order

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (up to a 34-day supply)	**Preferred retail cost sharing (in-network)** (up to a 34-day supply)	**Standard/ Preferred Mail-order cost sharing** (up to a 34-day supply)	**Long-term care (LTC) cost sharing** (up to a 34-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 34-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$2 copay	$0 copay	$2/$0 copay	$2 copay	$2 copay
Cost-Sharing Tier 2* (Generic)	$10 copay*	$4 copay*	$10/$4 copay*	$10 copay*	$10 copay*
Cost-Sharing Tier 3* (Preferred Brand)	$47 copay*	$42 copay*	$47/$42 copay*	$47 copay*	$47 copay*
Cost-Sharing Tier 4* (Non-Preferred Drug)	50% coinsurance*	50% coinsurance*	50% coinsurance*	50% coinsurance*	50% coinsurance*
Cost-Sharing Tier 5 (Specialty Tier)	29% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance	29% coinsurance
Cost-Sharing Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

* You pay no more than $10 for standard retail and $4 for preferred retail for tier 2 and $35 for tiers 3-4 for standard/preferred retail for a one-month supply of each covered insulin product, even if you haven't paid your deductible.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard/Preferred retail cost sharing (in-network) (102-day supply)	Standard/Preferred Mail-order cost sharing (102-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$6/$0 copay	$6/$0 copay
Cost-Sharing Tier 2* (Generic)	$30/$12 copay*	$30/$12 copay*
Cost-Sharing Tier 3* (Preferred Brand)	$141/$126 copay*	$141/$126 copay*
Cost-Sharing Tier 4* (Non-Preferred Drug)	50% coinsurance*	50% coinsurance*
Cost-Sharing Tier 5 (Specialty Tier)	29% coinsurance	29% coinsurance
Cost-Sharing Tier 6 (Select Care Drugs)	$0 copay	$0 copay

* You pay no more than $30 for standard retail and $12 for preferred retail for tier 2 and $105 for tier 3-4 for standard/preferred retail per three-month (102-day) supply of each covered insulin product, even if you haven't paid your deductible.

Notice of Availability

English: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-509-4979 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-509-4979 (TTY: 711) o hable con su proveedor.

Oromo: HUBADHAA: Yoo afaan Oromoo dubbattu ta'e, tajaajilli gargaarsa afaanii bilisaa siniif ni argama. Gargaarsi gargaaraa fi tajaajilli sirrii ta’ee fi odeeffannoo bifa dhaqqabamaa ta’een kennuunis bilisaan ni argama. Bilbilaa 1-877-509-4979 (TTY: 711) yookiin dhiyeessaa kee waliin haasa'aa.

Amharic: ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-509-4979 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

Hmong: LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-877-509-4979 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-509-4979 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Simplified Chinese: 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-877-509-4979（文本电话：711）或咨询您的服务提供商。

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-509-4979 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

French: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-509-4979 (TTY: 711) ou parlez à votre fournisseur.

Arabic:

نبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-509-4979 (711) أو تحدث إلى مقدم الخدمة.

Karen: ဆူ- နမ့်ကတိၤ ထၢနှာ်လီၤဖဲအံၤ အဃိ, တၢ်အိဉ်ဒီး ကျိာ်တၢ်ဆီဉ်ထွဲမၤစၢၤ လၢတလာ် ဘူဉ်လာ်စ့ၤလၢနဂီၢ်လီၤ. တၢ်အိဉ်ဒီး တၢ်မၤစၢၤတၢ်နှၤ်ဟူပီးလီဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအ ကြၢးအဘဉ် လၢကဟ့ဉ်တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်မၤနှ့်အီၤသ့တဖဉ် လၢတလာ်ဘူဉ်လာ်စ့ၤ လၢနဂီၢ်လီၤ. ကိး 1-877-509-4979 (TTY: 711) မ့တမ့်ၢ် ကတိၤတၢ်ဒီး နပှၤလၢဟ့ဉ် နၤတၢ်ကွၢ်ထွဲမၤစၢၤတကွၢ်.

Swahili: MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-509-4979 (TTY: 711) au zungumza na mtoa huduma wako.

Yoruba: ÀKÍYÈSI: Tí o bá lè sọ èdè Yorùbá, àwọn ètò ìrànlọ́wọ́ èdè wà lọ́fẹ̀ẹ́ fún ọ. A ó tún pèsè àwọn ohun èlò ìrànlọ́wọ́ àti àwọn iṣẹ́ tó bá yẹ láti pèsè ìsọfúnni nípa àwọn ọ̀nà tí ó rọrùn láti lóye lọ́fẹ̀ẹ́. Pe 1-877-509-4979 (TTY: 711) tàbí kí o bá olùpèsè rẹ sọ̀rọ̀.

Russian: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-509-4979 (TTY: 711) или обратитесь к своему поставщику услуг.

Laos: ຊຶ່ນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-509-4979 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Nepali: सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-509-4979 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

Large print – If you require materials in large print, please call 1-877-509-4979 (TTY: 711).

Notice of Nondiscrimination

Discrimination is against the law. Sanford Health complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Sanford Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - 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
  - Information written in other languages
  - If you need these services, please contact Member Services at 1-877-509-4979 (TTY 711)

If you believe that Sanford Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation, you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator, 2301 E. 60th Street, Sioux Falls, SD 57103
Telephone Number: (877) 473-0911 (TTY 711)
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Section 504 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 Avenue SW. Room 509F, HHH Building Washington, DC 20201
Phone: 1-800-368-1019 (TDD 800-537-7697)
More information is available at http://www.hhs.gov/ocr/index.html.