Important Information for Providers about Sanford Health Plan

P.O. Box 91110
Sioux Falls, SD 57109-1110
Phone: (800) 752-5863
Fax: (605) 328-6811
TTY: (877) 652-1844
sanfordhealthplan.com

SANFORD HEALTH PLAN

Sanford Health Plan (Plan) asks you to take some time and review this information. The following annual notices are required to keep you informed of Sanford Health Plan operations and outcomes.

Where can I find important Plan information?

If you have any questions...

Provider Relations	Phone: (800) 752-5863 (TTY: 711), Monday – Friday, 8 a.m. to 5 p.m. CST Email: providerrelations@sanfordhealth.org
Care Management	Phone: (888) 315-0884: Email: shpcasemanagement@sanfordhealth.org
Utilization Management NDPERS Utilization Management	Phone: (800) 805-7938 (TTY: 711) | Fax: (605) 328-6813 Phone: (888) 315-0885 | TTY: 711, Monday – Friday, 8 a.m. to 5 p.m. CST
Pharmacy Management NDPERS Pharmacy Management	Phone: (855) 305-5062 | Fax: (701) 234-4568 Phone: (877) 658-9194, Monday – Friday, 8 a.m. to 5 p.m. CST
Compliance / Privacy	Phone: (877) 473-0911 Email: shpcompliance@sanfordhealth.org
Customer Service NDPERS Customer Service	Phone: (800) 752-5863, Monday – Friday, 8 a.m. to 5 p.m. CST Phone: (800) 499-3416, Monday – Friday, 8 a.m. to 5 p.m. CST *(After business hours, you may leave a confidential voicemail and someone will return your call the next business day.)*
Medicare Advantage Customer Medicare Advantage Health Navigator	Phone: (888) 278-6485 (TTY: (888) 279-1549), Monday – Friday, 8 a.m. to 8 p.m. CST Phone: (877) 701-0788, Monday – Friday, 8 a.m. to 5 p.m. CST

Sanford Health Plan's provider webpage (sanfordhealthplan.com/providers) contents:

- Forms, Documents and Manuals link
  - o Provider manual
  - o Contracting and credentialing information
  - o Miscellaneous forms and documents
  - o Request for benefit consideration form
- Referral Center
  - o Provider service form
- Provider News link
  - o Provider newsletters and annual notices
- Medical Services and Drugs Prior Authorization link
  - o Pharmacy benefits/formulary information
  - o Locating a provider or pharmacy
  - o How to prior authorize and what needs prior authorizations
- Provider EDI Resources link
  - o Electronic data interchange services and information
- Clinical Resources link
  - o Behavioral health resources and tools
  - o Clinical resources and tools
  - o Clinical practice guidelines
  - o Preventive health guidelines
  - o Various training and education for practitioners and members including those for our clinical areas of improvement
  - o Cultural Competency Resources
- Quality Improvement Program link
  - o Quality improvement program
  - o HEDIS® report*

mySanfordHealthPlan Provider Portal (sanfordhealthplan.com/providerlogin)

mySanfordHealthPlan is Sanford Health Plan's online tool available to providers. Through this secure online tool, you have access to information 24/7 to:

- View copay deductibles, coinsurance and out-of-pocket totals for members
- Verify member eligibility and view covered family member(s)
- Submit medical and pharmacy prior authorizations and online claim reconsiderations
- Access the provider manual and policies
- Check status of claims
- Obtain copies of explanation of payments
- View the HEDIS provider guide and toolkit

To request a mySanfordHealthPlan account, follow these steps:

1. Go to **sanfordhealthplan.com/providers/provider-portal-access-request**
2. Enter all the required account information on the following screens, then click "Next"

Your information will then be submitted to be reviewed for approval. Once your account has been approved, you will receive an email from Sanford Health Plan. Afterward, you will be able to log on to your provider account using the User ID and Password you created upon setting up your account. If you have any questions or need assistance with setting up an account, please contact Provider Relations.

Fraud, Waste and Abuse and Related Laws

Sanford Health Plan's (SHP) fraud, waste and abuse policy and program were established to identify and eliminate any fraudulent, wasteful or abusive uses of claims/services perpetrated by employees, members, participating/nonparticipating providers and facilities. Compliance is the responsibility of every employee of SHP, provider and anyone providing services to members of any of SHP benefit plans. Providers should ensure ALL staff, subcontracted staff and vendors are thoroughly educated on state and federal requirements and appropriate compliance programs are in place.

Sanford Health Plan expects First-Tier, Downstream and Related entities (FDRs) (providers) to operate in accordance with all applicable federal and state laws, regulations, Medicare, Medicaid/Medicaid Expansion and Marketplace program requirements including, but not limited to the following:

1. Deficit Reduction Act of 2005
2. Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733)
3. Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)
4. Civil Remedies False Claims Act 31U.S.C. 22729 - 3372
5. Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
6. The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))
7. Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn)
8. Fraud Enforcement and Recovery Act (FERA) of 2009
9. Social Security Act (United States Code: Social Security Act, 42 U.S.C. §§ 1128c-1128e, 1128k)
10. Minnesota Statutes-609.611 INSURANCE FRAUD
11. South Dakota Code section 58-4A-2: Fraudulent Insurance Acts
12. North Dakota Century Code- CHAPTER 26.1-02.1- INSURANCE FRAUD

** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS® results do not include elite1 individual plan membership data.*

FWA Training and Education

All health care practitioners/providers or staff who render health care services are required to complete fraud, waste, and abuse (FWA) training (42 CFR 422.503 and 423.504). Examples of plans include but are not limited to Medicare, Medicaid/Medicaid Expansion, Marketplace, etc.

- The training should be completed upon hire (within 90 days) and annually thereafter. The training will be accepted if taken on the Centers for Medicare and Medicaid Services (CMS) Medicare Learning Network website (MLN). Link to the CMS FWA **and** compliance training slides are listed below.
- MLN General Information - Centers for Medicare and Medicaid Services
  - cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications
  - cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining
- All health care practitioners/providers and employees that have taken the trainings should maintain records for 10 years to show completion of these trainings.
- Practitioners/providers who utilize vendor services are responsible to attest their oversight of the vendors, compliance and FWA training/education.

Reporting

Sanford Health Compliance actively reviews all reports of suspected FWA or noncompliance. To report suspected fraud, waste or abuse and/or suspected compliance issues email shpcompliance@sanfordhealth.org or call the compliance hotline at (877) 473-0911.

You may also call the toll-free hotline established by the Federal Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services. The hotline number is (800) HHS-TIPS (800) 447-8477). For more information about this hotline and about other ways to contact the OIG, you can go to oig.hhs.gov/fraud/report-fraud/index.asp.

Sanford Health Plan maintains a **NO TOLERANCE** policy in terms of retaliation for anyone reporting issues in good faith; everyone should feel confident that **NO** adverse actions can or will be taken for reporting issues of concern. All issues may be reported anonymously.

Quality Improvement

Sanford Health Plan and its participating providers are committed to providing high quality health care to our members. For more information on the Plan's QI program and outcomes, see our latest HEDIS® Report and the Quality Improvement Program summary on our website.

Our Commitment to Quality

Sanford Health Plan is part of a larger integrated system, Sanford Health, and we are proud to offer Members a variety of resources, information and tools to help improve their health and quality of life. You may receive communications if we feel these programs may suit your needs. Additionally, we perform quality improvement activities and offer Care Management Programs for Members who have more serious health needs.

Member Feedback

Member Experience Surveys

The Plan's member experience surveys take place on a yearly basis. These surveys are conducted by an independent survey vendor and provide information on the experiences of our members with the Plan and how well we meet our members' expectations. There are overall ratings of satisfaction in addition to more focused composite scores which summarize survey responses in key areas. The Plan's QI Committee analyzes the results and takes actions for improvement. For more information on the Plan's rates, refer to our HEDIS® Report as referenced in the Website Content section above.

Population Health Programs

Wellness Portal: Sanford Health Plan offers an online wellness portal and mobile app to make it easier to commit to your health and well-being. The Wellness Portal, powered by WebMD, provides a customized well-being experience.
Health Assessment: Provides a confidential report about current health status, and gives immediate suggestions and resources to help improving their well-being.
Daily Habits: These plans help encourage long-term behavior change by breaking down goals into shorter, actionable steps. There are numerous plans available and each one is customizable.
Community: Connect with other members through fun and motivating group chats on a variety of topics including exercise, eating well, reducing stress, sleeping better and finding joy.
Media Library: Watch easy-to-follow exercise videos and recipes, listen to engaging mental health podcasts and more.
Device and App Connection Center: Automatically upload and track your activity with a fitness device or app.
Personal Health Record: A simple way to view all your health information in one place.

Log into your account at **sanfordhealthplan.com/memberlogin. (Forgot username and password options are available, if necessary.)** If you do not have an account, select the "Request Access for Yourself" button. Click Menu, and under the Insurance header, click Portals and Links. Then, select Wellness Portal.

Better Choices, Better Health® Workshop

If you or someone you care for has chronic, physical or mental health condition, including chronic pain, this free workshop can help you take charge of your life. Meeting weekly for six weeks, you'll get the support you need while finding useful ways to deal with pain, fatigue and stress. The workshop also offers information on good nutrition, exercise, goal setting, and how to talk with your doctor and family to help support your wellness goals.

Healthy Pregnancy Program

Sanford Health Plan offers education and support for you and your baby. After completing a health assessment with a nurse, we tailor support, tips and tools to help you meet your healthy pregnancy goals. A nurse will also be available to answer any questions about your pregnancy, childbirth and postpartum. Access to Text4baby to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more. Text BABY (or BEBE) to 511411 to sign up.

Fitness Center Reimbursements
Sanford Health Plan will pay up to $20 per Member per month when you use your home fitness center 12 days per month. To sign up, go to **NIHCArewards.org** to enroll online. Under "Member Options", click "First Time Enrollment" and select Sanford Health Plan from the drop down menu. Select your home fitness center location and click "Enroll Online". Read and agree to the terms of service, and enter your contact, health plan and banking information. Click "Submit".

If you visit your home fitness center at least 12 times per month, most participants receive an automatic deposit into a bank account around the 21st of each month. If your fees are less than $20 per month, the credit will reflect the amount you pay each month. You can view the status of your reimbursements in your NIHCA Member account at **NIHCArewards.org**. Please contact your fitness center directly if you find any errors regarding reimbursement. For other errors, please contact Sanford Health Plan for assistance. Please note, it is the Member's responsibility to ensure your gym visits are recorded and payments are received.

If you end your fitness membership or become delinquent in your membership dues, you will not be eligible for reimbursement. If you move your gym membership to a new facility, log on to **NIHCArewards.org** and select your new gym to continue receiving reimbursements.

Advance Care Planning
Advance care planning is the process of planning and deciding your future health care in case you are suddenly unable to make your own decisions because of illness or injury. Advance care planning allows you to:

- Think about and discuss treatment options with your family and health care providers to make treatment decisions based on your goals, values and preferences.
- Document and communicate your decisions to those who need to know.
- Select someone you trust to make decisions on your behalf when you are unable to speak for yourself.

Sanford Health Plan encourages all Members to complete an advance directive. A copy should be provided to the person responsible for making decisions in case you cannot speak for yourself, the hospital where you are most likely to receive treatment and your primary provider. For more information and to complete the form, go to **sanfordhealthplan.org/-/media/org/files/patient-education/advance-care-planning.pdf**.

Sanford Health Plan Case Management
To connect members with the right resources at the right time, we offer case management services to all members with complex or high-risk health conditions. Our services help members better understand their health while coordinating their care to develop and implement a care plan that's focused on their goals and health needs. The case management services are available to all members at no cost.

Case Management Programs
Complex case management: Members with multiple chronic conditions, catastrophic events, complex or uncontrolled health conditions.

Specialty case management

- **Transplant:** Members undergoing transplant evaluation or currently on a list for a transplant.
- **Oncology:** Members with an active or complicated cancer diagnosis.
- **NICU:** Newborns with complications or conditions requiring a neonatal intensive care stay.
- **Kidney care:** Members with an active diagnosis of chronic kidney disease or undergoing dialysis.
- **Specialized pregnancy care:** Expectant mothers with a high-risk pregnancy due to carrying multiples or complicated medical conditions.
- **Mental wellness:** Members with substance-use disorders, depression, anxiety, bipolar disorder, schizophrenia or personality disorders with admissions or emergency room use.
- **Care transitions – medical or behavioral health:** Members with inpatient hospitalizations for a medical or behavioral health need that is managed for 30 days.
- **Social work:** To address psychosocial needs, members with identified social determinants of health are referred to a social worker for assistance to connect with community resources

A designated case manager is responsible for managing our enrolled members to ensure high quality, cost-effective and appropriate utilization of health services. Case managers act as member advocates, seeking and coordinating creative solutions to meet health care needs without compromising quality health outcomes for selected medical diagnoses. The case manager contacts our members by phone or mail and acts as a resource, educator and coordinator of medical services.

If you would like more information about our available case management programs, or if you would like to refer a Sanford Health Plan member, please contact our Care Management department at (888) 315-0884 or shpcasemanagement@sanfordhealth.org. **For Sanford practitioners:** If a Plan case manager is currently following a member, the case manager will be listed on the patient care team in One Chart. Referrals to the team can be submitted by sending an in-basket message to "SHP CRM CT Case Management".

Behavioral Health and Substance Use Disorders
The Plan's activities to improve follow-up after inpatient treatment for behavioral health and/or substance use disorder discharges and compliance with antidepressant medications.

Medication Adherence
SHP has partnered with our Pharmacy Benefit Manager (PBM) to enhance medication adherence through our Meds on Track program, launched in March 2023. This program focuses on conditions such as behavioral health, hypertension, diabetes and elevated cholesterol. Outreach is conducted to members who are new to therapy (defined as having been prescribed medication within the last 200 days) and may benefit from refill reminders. Additionally, providers are contacted regarding members identified as potentially non-adherent.

Practitioners are notified of recommended clinical practice guidelines for depression through the provider newsletter and **sanfordhealthplan.com**.

Our Timeliness of Care Survey included an assessment of sample clinics primarily treating behavioral health and substance use disorders, and their compliance with the Plan's access standards for behavioral health, substance use disorders and appointments. Clinics included in the survey were sent a follow-up letter to notify them of their compliance or noncompliance and educate them on required standards.

The Plan's Behavioral Health Care Managers work with the hospital's discharge planners to arrange a follow-up appointment within seven days of discharge.

The Living Well Member newsletter includes articles on managing chronic health conditions and substance abuse.

The Plan's Pharmacy department refers members with opioid use to Behavioral Health Care Management for case management services.

The Plan collaborates with behavioral health and substance use disorder treatment professionals and external organizations to ensure the appropriateness of our activities involving behavioral health and/or substance use disorders.

Health Surveys are completed annually and includes an assessment of member satisfaction responses of provider care, access and appointment availability, medication management, and satisfaction of user ability of the Plan's website. From this data, the Plan is able to identify quality improvement activities, implement interventions and measure intervention effectiveness.

Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
Sanford Health Plan is committed to improving the rates of appropriate follow-up for Members prescribed ADHD medications by:

- Providing educational materials on symptoms, treatment and follow up recommendations for newly diagnosed Members taking ADHD medications.

Adolescent Health
Adolescent Members and their parent(s)/guardian(s) are provided educational information about the importance of wellness visits and staying up to date on immunizations. Examples include:

- Immunization schedule is available at **sanfordhealthplan.com** and updated on an annual basis
- The Living Well Member newsletter featured an article on adolescent well care visits and what the provider will assess. There is also information on how to find a provider in the newsletter article. Practitioners are notified of Clinical Practice Guidelines in the provider newsletter.

Cancer Screening
Sanford Health Plan is focused on improving the rates of screening for breast, cervical and colorectal cancers by:

- Annually updating our Preventive Health Guidelines and making them available in the Living Well Member newsletter and at **sanfordhealthplan.com** and print if requested. Additionally, nurse case managers address preventive screenings during Member conversations when appropriate.
- Notifying practitioners of recommended clinical practice guidelines for cancer screening via the provider newsletter and **sanfordhealthplan.com**.

- Featuring various cancer screening and plan benefit information in the Member and provider newsletters.
- Outreach phone calls are done to targeted age groups who did not have a colorectal cancer screening. These outlined FIT and Cologuard as a screening option and encouraged Members to speak with their practitioner regarding screening.

Tobacco Cessation

- Member Care Programs, quality improvement activities and the newsletters stress the importance of smoking cessation and resources available.
- Care Management nurses discuss tobacco use with Members and assist in coordinating resources for tobacco cessation.
- Practitioners are notified of the recommended clinical guidelines for tobacco cessation via the provider newsletter.

Clinical Practice Guidelines

Sanford Health Plan is responsible for adopting and distributing clinical practice guidelines for acute, chronic and behavioral health care services that are relevant to our membership. The Plan's multi-specialty physician committee, the Physician Quality Committee, has reviewed, approved and updated practice guidelines for numerous conditions for use as the Plan's primary clinical practice guidelines.

Please visit our website at **sanfordhealthplan.com/providers/resources** to find links to the adopted guidelines. If you have any questions or suggestions regarding these guidelines, or to request a copy of the guidelines, please call Provider Relations.

Preventive Health Guidelines

Sanford Health Plan recognizes that health promotion and disease prevention are the best opportunities to reduce the ever-increasing portion of resources spent to treat preventable illnesses and impairments. As a Plan, we want to educate our members on how to cut health care costs, prevent premature onset of disease and disability, and to help all members achieve healthier and more productive lives.

Preventive Health Guidelines are age- and gender-specific. They describe prevention or early detection interventions, recommendations for frequency and conditions under which the interventions are required. Appropriate practitioners are involved in the development of preventive health guidelines (i.e., practitioners who are from specialties that would use the guidelines).

Members of Sanford Health Plan are encouraged to utilize preventive health services, health education and health promotion through preventive health services, educational classes and other articles on prevention in special mailings or in the Member Messenger newsletters.

Current Preventive Health Guidelines are available on our website at **sanfordhealthplan.com/providers/resources** for both members and practitioners (the practitioner version includes the codes that are to be used for these preventive services). A paper copy is available by calling Provider Relations.

Utilization Management (UM)

Utilization Management (UM) decision-making is evidence-based and reviewed for medical necessity in accordance with Plan coverage. Sanford Health Plan does not reward practitioners or other individuals conducting utilization review for issuing denials. Financial incentives are not offered to UM decision-makers, and do not encourage any decisions that result in under-utilization, nor denials of service or coverage. Decision-makers sign an "Affirmative Statement Regarding Incentives" verifying the above conditions.

Physician or pharmacist reviewer availability

A physician or pharmacist reviewer is available by phone to any practitioner to discuss determinations based on medical appropriateness.

Services that require pre-approval (pre-authorization/certification)

Inpatient hospital or other facility admissions, including medical, surgical, neonatal intensive care nursery, mental health and/or substance use disorders; select outpatient services, home health services, skilled nursing and sub-acute care, transplant and oncology services, prosthetic limbs, genetic testing, insulin infusion devices, high-end imaging, requests to non-participating providers recommended by participating providers, dental anesthesia (for certain ages and conditions), bariatric surgery (if a covered benefit), and/or external hearing aids (that is not due to the gradual deterioration that occurs with aging or other lifestyle factors) if a covered benefit. For a more complete listing of services that require prior authorization, please visit **sanfordhealthplan.com/providers/prior-authorization**.

Not all services prescribed or recommended by yourself or health care practitioner may be covered by the Plan.

Services
Admission before the day of non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan.

Points to remember:

- All requests for authorization are to be made by the provider's office at least three (3) working days prior to the scheduled admission or requested service. In the event that health care services need to be provided within less than three (3) working days, contact the Utilization Management department to request an expedited review.
- All referrals to non-participating providers (at the recommendation of a participating provider) require prior authorization.

How to request Pre/Prior Authorization
Prior authorizations for health care services should be obtained online by logging in to the mySanfordHealthPlan provider portal at sanfordhealth.org/provider. Open the member record and choose "Create Referral". The tutorial explaining how to request a prior authorization is located within the provider portal.

NOTE: Oncology treatment and services must be entered and authorized through eviti|Connect online at eviti.com. High-end imaging services for select members and health plans must be entered and authorized through eviCore at evicore.com.

- Online: Select "Authorizations" in your secure mySanfordHealthPlan account. Click on either "Submit a Pharmacy Preauthorization" or "Submit a Medical Preauthorization" depending on your request. Once you complete the required information click "Submit."

Criteria
Every year, the Plan's Physician Quality Committee reviews the Plan's medical policies and procedures, quality programs and clinical practice guidelines. The Physician Quality Committee is charged with supporting the Plan's Board of Directors and Senior Director, Medical Services in meeting quality assurance goals on issues of care.

The Committee consists of physician members from various specialties, including a behavioral health practitioner, and meets at least six times a year. The Plan's Chief Medical Officer, Medical Services reports on the Committee's activities to the Board of Directors. The Committee is actively involved in the development of quality initiatives and health management programs. It is also responsible for approving and annually reviewing utilization management criteria. Any recommended changes in the criteria or any other program changes are approved by the Board of Directors.

The Pharmacy and Therapeutics Committee is charged with supporting the Plan's Board of Directors and Senior Director, Medical Services in meeting quality assurance goals on pharmaceutical coverage. The Committee membership consists of physicians and pharmacists representing retail and hospital-based pharmacies. Specific specialty physicians are also invited to attend meetings per drug topic or disease managed state reviewed if current Committee membership does not support the topic up for review. The Pharmacy Benefit Manager (PBM) has an assigned clinical pharmacist that actively participates in all aspects of formulary development, ongoing management, and resource management. Sanford Health Plan employs clinical pharmacists to assist in the day-to-day management of the pharmacy program. No incentives are given to providers or pharmacists for using specific drugs. Sanford Health Plan currently does have some mandated generic substitution programs in place in their pharmacy benefit program, as well as some step-therapy protocols for multiple drug categories.

All practitioners are welcome to have input into the activities of both committees. Suggestions concerning quality programs, health management programs, clinical practice guidelines, and utilization management criteria are welcome and can be directed to the Senior Director, Medical Services by mail or by phone at (605) 328-6807 or (800) 805-7938.

To access medical policy criteria, providers may log into our Cite Transparency® through the Provider Portal at **sanfordhealthplan.com/providerlogin** to access. You may also request a copy of the criteria used by contacting the Utilization Management Department.

New medical technologies/new applications for existing technologies, experimental/investigational procedures

To ensure members access to safe and effective care, Sanford Health Plan has adopted a process to evaluate and address new developments and new technology in medical and behavioral health procedures, pharmaceuticals and devices.

The Physician Quality Committee is responsible to recognize and evaluate new health care services, medical and behavioral health procedures, pharmacological treatments and devices as well as their application for the Plan members.

The Physician Quality Committee includes a practitioner who specializes in behavioral health care in this decision-making process. A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a member of the Committee, may be invited to present the technological aspects of the service/procedure/pharmacological treatment, as needed.

Published scientific evidence and information from literature and the internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies. Investigational and experimental treatments/medications will not be approved for usage under the Sanford Health Plan Benefits Policy guidelines.

To be eligible for consideration of coverage all of the following must be met:

1. The technology must have final approval from appropriate government regulatory bodies (i.e. FDA).
2. The published scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. (literature, internet or specialist review).
3. The technology must improve net health outcomes.
4. The technology must be at least as beneficial as all established alternatives.
5. The health benefit must be attainable outside an investigative setting.
6. External health care experts utilized in the review process shall include licensed or qualified health care professionals in the field of study or treatment for which the experimental treatment review is taking place, i.e., licensed chiropractors will review experimental/investigative treatments in the area of chiropractic care.

This review will start with the completion and submission of the Request for Benefit Consideration form (Forms, Documents and Manuals link) that will be reviewed for medical content and prioritization. This process will consider factors such as medical impact, safety, efficacy, clinical trial phase, and cost-to-benefit ratios. After submitting the Request for Benefit Consideration form, it may take several months to be incorporated into a covered benefit option.

The completion of the Request for Benefit Consideration form does not guarantee coverage of benefits, and the request must be completed prior to claim submission of the new product or service.

The next step is the determination of coverage or a denial. This step will be a review by many departments in the Plan. Once the coverage options are discovered, it will move onto a Physician Quality Committee review. Once the new technology or new application of an existing technology has been reviewed by the Physician Quality Committee, this review can result in either of two types of decisions:

1. A policy determination to include a new technology as a covered benefit in the future. The Medical Management policy that uses the MCG (Milliman Care Guidelines) criteria will be developed by the Medical Management staff and will be presented at the same time. This would become the policy for this new health care service, medical and behavioral health procedure, pharmacological treatment or device.
2. A case-based decision on whether or not to cover a specifically requested service. There must be evidence that case-based decisions result in a review of medical necessity guidelines and procedures for possible revision.

Upon approval from the Board of Directors, Sanford Health Plan will notify practitioners by way of the newsletter, if appropriate.

The Senior Director, Medical Services and the Physician Quality Committee will consider all requests for coverage based on the Benefits Policy guidelines. If you would like more information on either of these policies, please contact Utilization Management.

Pharmacy and Formulary information

The Sanford Health Plan Pharmacy Department will help you get the most out of your medication benefits. The Sanford Health Plan Formulary is a list of FDA approved brand-name and generic medications chosen by health care providers on the Pharmacy and Therapeutics (P and T) Committee. Selection criteria include clinical efficacy, safety, and cost effectiveness. Changes are made throughout the year as warranted, with a complete review performed each year.

A listing of the formularies, medications requiring step therapy, medications requiring prior authorization, and a link to pharmacy directories are available online at **sanfordhealthplan.com/providers/pharmacy-information**.

To be covered, medications must be

1. Approved and prescribed by a licensed health care professional (physician, physician assistant, nurse practitioner, or dentist) within the scope of his or her practice.
2. Listed in the Plan Formulary, an exception or a prior authorization is given by the Plan.
3. Provided by an in-network pharmacy except in the event of a medical emergency.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Formulary Designs

Depending on the plan, prescriptions may apply toward a tiered copay structure when choosing generic or preferred brand name medications, or medications may go toward the deductible if it's a high deductible health plan. If the benefit plan offers tiered formularies, the higher the tier means the higher the copay/cost-share (except for high-deductible HSA plans).

2-Tier Formulary

- Tier 1: generic medications
- Tier 2: covered brand name medications

3-Tier Formulary

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications

4-Tier Formulary

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: specialty medications*

5-Tier Formulary

- Tier 1: preferred generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: preferred specialty medications*
- Tier 5: non-preferred specialty medications*

6-Tier Formulary

- Tier 1: preferred generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: generic/preferred biosimilar specialty medications*
- Tier 5: preferred specialty medications*
- Tier 6: non-preferred specialty medications*

*Specialty medications may include original reference product, generics (if applicable), or biosimilar (if applicable).

Specialty Pharmacies

Specialty pharmacy options include in-network retail pharmacies located in North Dakota, Sanford Pharmacies, Optum Specialty Pharmacy, and Monument Health Specialty Pharmacy.

Pharmacy Procedures

Specialty Medications

Specialty medications are typically used to treat complex medical conditions. These medications may require frequent dosing adjustments, close monitoring, special training, or compliance assistance. In addition, specialty medications may need special handling and/or administration, and may have limited or exclusive product availability and distribution. Specialty medications can be obtained through: in-network retail pharmacies located within the state of North Dakota, Sanford Specialty Pharmacy, Optum Specialty Pharmacy, or Monument Health Specialty Pharmacy.

Generic Medications

By following the formulary and asking your provider for generic medications when available, you will save money and help control the costs of your healthcare. If you request a brand name medication when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic product, in addition to any copay and/or cost-share as determined by your plan benefits.

Medication Step Therapy Program

A program that requires certain medications to be used in a specific order, or by "steps." If there's a trial of a "first-step" medication and it does not work, the member experiences adverse side effects, or any of the other exceptions listed in the Step Therapy policy, then the next step medication may be tried, etc. This program is designed to save the member money by trying alternative medications before more expensive medications are used.

Quantity Limit/ Amount Allowed
Medication may be limited to a certain quantity.

Pre/Prior-Authorization of medication (Pre/Prior-Authorization/certification)
Select medications require Pre/Prior-Authorization before coverage. Pre/Prior-Authorizations for medications may be obtained by contacting the Pharmacy Management Department:

- **Online:** Providers: Select "Authorizations" in your secure mySanfordHealthPlan account when you open the member's information. Step by Step instructions are available with the mySanfordHealthPlan Provider Portal.
- **Fax:** Fax the Prescription Drug Prior Authorization Request and Formulary Exception Form and supporting documentation (this form is REQUIRED for all requests submitted via fax).

Exceptions to the Formulary
If the member, or you, as their health care practitioner, feels that a certain non-formulary medication is medically necessary for their condition, an exception may be available. They must first try formulary medications before an exception to the formulary will be made for non-formulary medication, unless the member has contraindications to all covered formulary medications or there is a specific clinical basis where the formulary medications are not appropriate (clinic notes documenting the contraindications or clinical basis for exception must be provided). To request an exception, you, as their provider, must complete the Prescription Drug Prior Authorization Request and Formulary Exception form, and return to Sanford Health Plan (along with supporting clinical documentation), or submit an exception request through the Provider Portal at **sanfordhealthplan.com/providerlogin**. Requests will be reviewed and the member and provider will be notified of the determination by mail. For urgent requests, or requests for members with MN-based benefit plans, the determination will also be communicated via telephone or telecommunication device.

The Plan will use appropriate pharmacists and/or practitioners to consider exception requests and promptly grant an exception to the formulary, including exceptions for anti-psychotic and other behavioral health medications, when the health care practitioner prescribing the medication indicates to the Plan that:

1. The formulary medication causes an adverse reaction in the patient;
2. The formulary medication is contraindicated for the patient; or
3. The prescription medication must be dispensed as written to provide maximum medical benefit to the patient.

If there is an adverse determination regarding the request, or if there is a wish to appeal, please follow the Complaints and Appeals Procedure and the External Review Rights, located in the Provider Manual. This applies to requests for coverage of non-covered medications, generic substitutions, therapeutic interchanges and step-therapy protocols.

Over-the-counter medications, vitamins and/or supplements
Medications that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care practitioner and/or provider are available at a $0 copay (no member cost-share) if the member meets specific conditions, such as age or gender. If the member does not meet the specific conditions, the usual member benefit will apply.

Medical benefit
Medications covered under the medical benefit that are subject to the medical deductible, coinsurance and maximum out of pocket.

Generic substitutions/therapeutic interchange
To promote value optimization, the formularies generally endorse the use of generic medications over their brand counterparts, whenever possible. Where most substitutions for generic/therapeutic interchange occur outside the purview of the health plan, specific policies related to brand ancillary penalties are maintained separately. The purpose of these policies is to standardize the review process for cases where a brand may be medically necessary, in order to bypass these ancillary penalties.

Formulary Updating
The Plan updates the formulary on an annual basis and as needed when new drugs enter the market or when a drug is removed from the market, as described in the Pharmacy and Therapeutics Committee's responsibilities.

Pharmacy Management Staff Updating
Those who handle pharmacy benefit inquiries are provided updated formulary change information prior to the effective date of change. Notifications and training (if necessary) are provided through email and/or staff meetings. The Pharmacy Management Team also has access to the PBM Early Systems Delivery (EDI) in handling pharmacy benefit inquiries, which contains accurate and current formulary information as changes are made.

Practitioner Updating

- The notice must include a description specific enough to give readers a clear idea of the topic and the general content and must include a link or direction to the specific information. Sanford Health Plan may group or summarize the information by theme.
- Direct emailing to practitioners by newsletter is done on a yearly basis with information on how to access the formulary and pharmaceutical management procedures on the website/portal or to call for a copy. If email doesn't exist for said practitioner, a postcard will be sent that refers them to the Plan website, or to call the Plan for a copy.
- The provider manual includes contact information for the pharmacy management team, instructions on how to access the formulary online, and a description of the formulary exception process.
- Sanford Health Plan's mySanfordHealthPlan portal contains an overview of medication benefits, formularies and descriptions of the formulary exception process including providing information to support their exception request, step therapy program, prior authorization process, generic substitution and therapeutic interchange.
- Providers may also obtain this information by contacting the pharmacy management or provider relations departments.
- General notice of removal of drugs from the formulary includes member and practitioner notification as these changes occur, or at least annually as the formulary is updated for the following year.

Member Updating

Upon enrollment, all members are provided a member handbook and summary of pharmacy benefits by

- The employer group human resources department.
- Or through direct mail by newsletter on a yearly basis that includes information on how to access the formulary and pharmaceutical management procedures on the website/portal or to call for a copy. If email doesn't exist for said member, a postcard will be sent that refers them to our website or to call the Plan for a copy.

mySanfordHealthPlan Website Portal

The member has confidential access to their pharmacy account via the PBM link on our portal. This site can be accessed 24 hours a day, seven days a week. The website provides the member with formulary information including covered and not covered drugs, copay information, quantity level limits, prior authorization information, exception request process including providing information to support this request, use of generic substitution, therapeutic interchange or step-therapy protocols, etc.

Contacting the Pharmacy Management Department

General notice of removal of drugs from the formulary is sent via the member newsletter as these changes occur or at least annually as the formulary is updated for the following year.

Members who are directly affected by a removal of a drug from the formulary are sent a letter with information about the change, the effective date of the removal, and the alternative drugs available to them, prior to the drug being removed from the formulary.

For more detailed pharmacy information

Please refer to the Pharmacy Information link for the following documents for specific medication coverage information. Members received this information upon enrollment, but copies may also be obtained (1) online on our Provider Portal or (2) by calling Customer Service.

1. Summary of Benefits and Coverage – describes the payments for which members are responsible when purchasing prescription medications and supplies;
2. Policy/SPD/COC/COI – describes how and where to obtain prescription medications and supplies, dispensing limitations, and excluded medications and supplies.
3. Covered Medication List or Formulary– list containing the most commonly prescribed medications that are covered under a member's benefit plan (for the complete list, or for specific details about drug coverage, login to the Provider Portal and click "Covered Medication List" under the specific member.)

Please contact us at least three days before the requested service to ensure timely processing of your request.

In the event that health care services need to be provided within less than three (3) working days, contact the Utilization Management Department to request an expedited review. Admission the day before a non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan. Coverage for hospital expenses prior to the day of surgery at an out-of-network facility will be denied unless authorized prior to being incurred.

Filing Claims

Sanford Health Plan participating providers are required to submit claims on members' behalf. Claims should be submitted to Sanford Health Plan. We encourage you to transmit claims electronically for faster reimbursement and increased efficiency. Accepted claims forms are a standard CMS, UB or ADA claim. Submitting these forms with complete and accurate information ensures timely processing of your claim. All claims should be submitted using current coding and within 180 days, or as defined in your contract, even if the member has exceeded their deductible or copay amounts. For more information on what EDI transactions are available to you through Sanford Health Plan, see the 'Provider EDI Resources' page on our website, or view the information in the provider manual.

Paper Claims Submission

If you cannot file claims electronically, paper claims may be mailed to:

Sanford Health Plan Claims Department
P.O. Box 91110
Sioux Falls, SD 57109-1110

To improve our turnaround time and accuracy of paper claim processing, we use a scanning procedure through the Smart Data Solutions (SDS) system. It is important for you to know that the SDS system uses optical character recognition (OCR). Therefore, when OCR is used, your provider name must match our records in order for the system to correctly identify the "pay to" information. If a mismatch occurs, or if the claim cannot be read, you will receive a letter from SDS asking you for the missing or illegible information. A prompt response will prevent further delay in processing your claim. When sending paper claims, please follow the 'Paper Claims Submission' guidelines outlined in the Provider Manual.

Member Rights and Responsibilities

Important Member Enrollee Information (Minnesota Plan Members Only)

The HMO coverage described in a Member's policy may not cover all their health care expenses. Providers can review the policy in detail or contact Customer Service to determine which expenses are covered.

The laws of the state of Minnesota provide Members of an HMO certain legal rights, including the following:

1. **COVERED SERVICES**: Services provided by SHP will be covered only if services are provided by participating SHP network providers or authorized by SHP. Your Policy fully defines what services are covered and describes procedures you must follow to obtain coverage.
2. **PROVIDERS:** Enrolling in SHP does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the SHP network, you must choose from remaining SHP network providers.
3. **REFERRALS**: Certain services are covered only upon referral. See your Policy for referral requirements. All referrals to non-SHP network providers and certain types of health care providers must be authorized.
4. **EMERGENCY SERVICES**: Emergency services from providers who are not affiliated with SHP will be covered. Your policy explains the procedures and benefits associated with emergency care from SHP network and non-SHP network providers.
5. **EXCLUSIONS**: Certain services or medical supplies are not covered. You should read the Policy for a detailed explanation of all exclusions.
6. **CONTINUATION**: You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your Policy.
7. **CANCELLATION**: Your coverage may be canceled by you or SHP only under certain conditions. Your Policy describes all reasons for cancellation of coverage.
8. **NEWBORN COVERAGE**: If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating SHP network providers or authorized by SHP. Certain services are covered only upon referral. SHP will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify SHP of the infant's birth and that you would like coverage. If your Policy requires an additional premium for each dependent, SHP is entitled to all enrollment premiums due from the time of the infant's birth until the time you notify SHP of the birth. SHP may withhold payment of any health benefits for the newborn infant until any premium you owe is paid.
9. **PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT**: Enrolling in SHP does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Policy year.

ENROLLEE BILL OF RIGHTS (Minnesota Plan Members Only)

1. Enrollees have the right to available and accessible services including emergency services, as defined in your contract, 24 hours a day and seven days a week.
2. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
3. Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law.
4. Enrollees have the right to file a complaint with the health maintenance organization and/or submit a complaint at any time to the commissioner for investigation. The toll-free number for the Minnesota Commissioner is 1-800-657-3602. Members also have the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers. You are entitled to file a complaint with the Minnesota Commissioner of Health for investigation at any time by contacting 1-800-657-3602.
5. Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.
6. Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law.
7. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

Member Rights

The Plan is committed to treating members in a manner that respects their rights. In this regard, the Plan recognizes that each member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) has the right to the following:

1. Members have the right to refuse treatment.
2. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; gender identity; sexual orientation; medical condition; including current or past history of a mental health and substance use disorder; disability; religious beliefs; national origin; age; or sources of payment for care.
3. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
4. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
5. Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
6. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable South Dakota, North Dakota, Minnesota, and Iowa law.
7. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
8. Members have the right to a candid discussion with the practitioner(s) and/or Provider(s) responsible for coordinating appropriate or medically necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with practitioners and/or Providers in decision-making regarding their treatment plan.
9. Members have the right to give informed consent before the start of any procedure or treatment.
10. When Members do not speak or understand the predominant language of the community, the Plan will provide access to an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the member.
11. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and read.
12. Members have the right to a clear grievance and appeal process for complaints and comments and to have their issues resolved in a timely manner.

13. Members have the right to appeal any decision regarding medical necessity made by the Plan and its practitioners and/or providers.
14. Members have the right to terminate coverage under the Plan, in accordance with applicable Employer and/or Plan guidelines.
15. Members have the right to make recommendations regarding the organization's member's rights and responsibilities policies.
16. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities policies.
17. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, or the use of restraints and seclusion.

Member Responsibilities

Each member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) is responsible for cooperating with those providing health care services to the member, and shall have the following responsibilities:

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having member identification numbers available when telephoning or contacting the Plan, or when seeking health care services.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking emergency care at a Plan participating emergency facility whenever possible. In the event an ambulance is used, members are encouraged to direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State laws require that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
5. Members are responsible for notifying the Plan of an emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
6. Members are responsible for keeping appointments, and when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.
7. Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health care conditions, including mental health and/or substance use disorders.
8. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
9. Members are responsible for providing name, address, or telephone number changes within thirty (30) days. Members who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Members with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.
10. Members are responsible for reporting any changes of eligibility that may affect their membership or access to services. Members who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Members with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.

Non-discrimination notice

SANFORD HEALTH PLAN

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law.

Sanford Health Plan:

- 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, call (800) 752-5863 (TTY: 711)

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), 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 phone, 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, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Help in Other Languages

For help in any language other than English, call (800) 752-5863 (TTY: 711).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 752-5863 (رقم هاتف الصم والبكم:711)

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶችማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 752-5863 (መስማት ለተሳናቸው: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 (800) 752-5863 (TTY: 711)。

Cushite (Oromo) – XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 752-5863 (TTY: 711).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 752-5863 (TTY: 711).

Hmong – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 752-5863 (TTY: 711).

Karen – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ်ၤ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး (800) 752-5863 (TTY: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 752-5863 (TTY: 711) 번으로 전화해 주십시오.

Laotian – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 752-5863 (TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 752-5863 (TTY: 711).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 752-5863 (телетайп: 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 752-5863 (TTY: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 752-5863 (TTY: 711).

Thai – เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 752-5863 (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 (800) 752-5863 (TTY: 711).