




The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, [sanfordhealthplan.com/sbcfinder](http://sanfordhealthplan.com/sbcfinder) or by calling 1-800-752-5863 (toll free) | TTY/TDD: 1-877-652-1844 (toll-free). For general definitions of common terms, such as allowed amount, balance-billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-752-5863 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <b>What is the overall deductible?</b>                             | For <u>network providers</u> <b>\$1,500</b> individual / <b>\$3,000</b> family.<br><b>No out-of-network coverage.</b><br><b>Copays do not apply to deductible.</b> | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                              |
| <b>Are there other deductibles for specific services?</b>          | No.  | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <u>network providers</u> <b>\$6,500</b> individual / <b>\$13,000</b> family.<br><b>No out-of-network coverage.</b>   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover.                          | Even though you pay these expenses, they don't count toward the out-of-pocket limit.   |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.sanfordhealthplan.com">www.sanfordhealthplan.com</a> or call 1-800-752-5863 for a list of <u>network providers</u> .                  | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance-billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services. |
| <b>Do you need a referral to see a specialist?</b>                 | No.  | You can see the in-network <u>specialist</u> you choose without a <u>referral</u> .  |

Provider Network: Focused

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event  | Services You May Need                            | What You Will Pay                                   |   | Limitations, Exceptions, & Other Important Information  |
|---|--|---|---|---|
|   |  | <u>Network provider</u><br>(You will pay the least) | <u>Out-of-network provider</u><br>(You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$10 <u>copay</u> / office visit                    | Not covered   | None  |
|   | Chiropractic visit                               | \$10 <u>copay</u> / office visit                    | Not covered   | Office visit <u>copay</u> applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 20 visits per calendar year.  |
|   | <u>Specialist</u> visit                          | \$35 <u>copay</u> / office visit                    | Not covered   | None  |
|   | <u>Preventive care/screening/immunization</u>    | No charge   | Not covered   | You may have to pay for services that aren't part of the <u>preventive</u> health guidelines. Ask your <u>provider</u> if these services you need are preventive. Then check what your <u>plan</u> will pay for.  |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u> (x-ray, blood work)       | No charge   | Not covered   | Some diagnostic x-rays, ultrasounds, specimens, and blood work done in an office visit setting that occur on the same date of service are included in your office visit copay. Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> . Contact the Plan for full details on included benefits. |
|   | Imaging (CT/PET scans, MRIs)                     | 30% <u>coinsurance</u> after <u>deductible</u>      | Not covered   | None  |

| Common Medical Event   | Services You May Need                          | What You Will Pay                              |  | Limitations, Exceptions, & Other Important Information  |
|--|--|--|--|---|
|  |  | Network provider<br>(You will pay the least)   | Out-of-network provider<br>(You will pay the most) |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://sanfordhealthplan.com/pharmacy">sanfordhealthplan.com/pharmacy</a> | Generic drugs less than \$6                    | \$0 <u>copay</u> / prescription                | Not covered  | Covers up to a 30-day supply. Generic cost is based on total drug cost per 30-day supply. Brand name drugs with generic equivalents require additional cost share. Difference in cost does not apply to <u>deductible</u> or <u>out-of-pocket limit</u> . There are no limitations or restrictions for use of manufacturer coupons if used in conjunction with our current benefit offering. If the cost of the prescription falls under the copay amount, you will pay the least.<br>Refer to your <u>Formulary</u> to determine which benefit applies to your medication. |
|  | Generic drugs greater or equal to \$6          | \$20 <u>copay</u> / prescription               |  |   |
|  | Preferred brand drugs                          | \$50 <u>copay</u> / prescription               | Not covered  |   |
|  | Non-preferred brand drugs                      | \$125 <u>copay</u> / prescription              | Not covered  |   |
|  | Specialty drugs                                | 30% <u>coinsurance</u> after <u>deductible</u> | Not covered  |   |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> after <u>deductible</u> | Not covered  | Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at <a href="http://sanfordhealthplan.com">sanfordhealthplan.com</a> .  |
|  | Physician/surgeon fees                         | 30% <u>coinsurance</u> after <u>deductible</u> | Not covered  | None  |
| <b>If you need immediate medical attention</b>   | <u>Emergency room care</u>                     | 30% <u>coinsurance</u> after <u>deductible</u> | 30% <u>coinsurance</u> after <u>deductible</u>     | None  |
|  | <u>Emergency medical transportation</u>        | 30% <u>coinsurance</u> after <u>deductible</u> | 30% <u>coinsurance</u> after <u>deductible</u>     | None  |
|  | <u>Urgent care</u>                             | \$25 <u>copay</u> / office visit               | \$25 <u>copay</u> / office visit                   | Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> .  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 30% <u>coinsurance</u> after <u>deductible</u> | Not covered  | Prior authorization required.   |
|  | Physician/surgeon fees                         | 30% <u>coinsurance</u> after <u>deductible</u> | Not covered  | None  |

| Common Medical Event   | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|--|---|---|--|---|
|  |   | Network provider<br>(You will pay the least)  | Out-of-network provider<br>(You will pay the most) |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$10 <u>copay</u> / office visit and 20% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | Not covered  | For outpatient treatment services, the first 5 hours or visits of any calendar year will be covered at 100% (no charge). For full details, please refer to your Policy.   |
|  | Inpatient services                        | 30% <u>coinsurance</u> after <u>deductible</u>  | Not covered  | Prior authorization required.   |
| <b>If you are pregnant</b>   | Office visits                             | No charge   | Not covered  | Cost sharing does not apply to routine prenatal and postnatal-care and certain <u>preventive services</u> . Depending on the type of services <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|  | Childbirth/delivery professional services | 30% <u>coinsurance</u> after <u>deductible</u>  | Not covered  |   |
|  | Childbirth/delivery facility services     | 30% <u>coinsurance</u> after <u>deductible</u>  | Not covered  |   |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 30% <u>coinsurance</u> after <u>deductible</u>  | Not covered  | Prior authorization required. Limited to 40 visits per calendar year.   |
|  | <u>Rehabilitation services</u>            | \$10 <u>copay</u> / office visit and 30% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | Not covered  | Office visit <u>copay</u> covers evaluation.<br>Therapies are subject to <u>deductible</u> / <u>coinsurance</u> .<br>Limited to 30 visits per calendar year.  |
|  | <u>Habilitation services</u>              | \$10 <u>copay</u> / office visit and 30% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | Not covered  | Office visit <u>copay</u> covers evaluation.<br>Therapies are subject to <u>deductible</u> / <u>coinsurance</u> .<br>Limited to 30 visits per calendar year.  |
|  | <u>Skilled nursing care</u>               | 30% <u>coinsurance</u> after <u>deductible</u>  | Not covered  | Prior authorization required. Limited to 30 days in any consecutive 12-month period.  |
|  | <u>Durable medical equipment</u>          | 30% <u>coinsurance</u> after <u>deductible</u>  | Not covered  | Prior authorization may be required.  |
|  | <u>Hospice services</u>                   | 30% <u>coinsurance</u> after <u>deductible</u>  | Not covered  | None  |

| Common Medical Event                   | Services You May Need      | What You Will Pay                              |  | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------|--|--|--|
|  |                            | Network provider<br>(You will pay the least)   | Out-of-network provider<br>(You will pay the most) |  |
| If your child needs dental or eye care | Children's eye exam        | No charge                                      | Not covered  | Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19.   |
|  | Children's glasses         | 30% <u>coinsurance</u> after <u>deductible</u> | Not covered  | Limited to 1 frame every other year. Lenses or contact lenses limited to 1 item annually. Benefit ends at the end of the month when the member turns 19.   |
|  | Children's dental check-up | No charge                                      | Not covered  | Limited to 2 routine check-up visits per calendar year. Preventive, emergency, and routine coverage available for members up to age 19. See your plan document for eligible services. Certain dental services may require authorization (pre-approval) by the plan. For a list of services, see the Prior Authorization list at <a href="http://sanfordhealthplan.com">sanfordhealthplan.com</a> . |

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                       |                         |  |
|-----------------------|-------------------------|--|
| • Acupuncture         | • Infertility treatment | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery    | • Long-term care        | • Routine eye care (Adult)                           |
| • Dental care (Adult) |                         | • Weight loss programs                               |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                     |  |  |
|---------------------|--|--|
| • Bariatric Surgery | • Hearing aids (except for gradual deterioration of hearing that occurs with aging and/or other lifestyle factors) | • Private-duty nursing                   |
| • Chiropractic Care |  | • Routine foot care (for diabetics only) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: North Dakota Insurance Department at 1-800-247-0560. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Appeals & Complaints at 1-800-752-5863 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-0675 (*toll-free*).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-0675 (*toll-free*).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-0675 (*toll-free*).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-892-0675 (*toll-free*).

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section. —————

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|  |                |
|--|----------------|
| ■ <b>The plan's overall deductible</b>   | <b>\$1,500</b> |
| ■ <b>Specialist copayment</b>            | <b>\$35</b>    |
| ■ <b>Hospital (facility) coinsurance</b> | <b>30%</b>     |
| ■ <b>Other coinsurance</b>               | <b>30%</b>     |

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,500        |
| Copayments                        | \$10           |
| Coinsurance                       | \$2,100        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,670</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|  |                |
|--|----------------|
| ■ <b>The plan's overall deductible</b>   | <b>\$1,500</b> |
| ■ <b>Specialist copayment</b>            | <b>\$35</b>    |
| ■ <b>Hospital (facility) coinsurance</b> | <b>30%</b>     |
| ■ <b>Other coinsurance</b>               | <b>30%</b>     |

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$40           |
| Copayments                        | \$1,200        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,260</b> |

### Mia's Simple Fracture

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

|  |                |
|--|----------------|
| ■ <b>The plan's overall deductible</b>   | <b>\$1,500</b> |
| ■ <b>Specialist copayment</b>            | <b>\$35</b>    |
| ■ <b>Hospital (facility) coinsurance</b> | <b>30%</b>     |
| ■ <b>Other coinsurance</b>               | <b>30%</b>     |

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles*                      | \$1,500        |
| Copayments                        | \$100          |
| Coinsurance                       | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,800</b> |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Sanford Wellness at 1-877-305-5463.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

## Non-discrimination notice

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions.

### 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, or 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, contact Sanford Health Plan at (800) 752-5863 | TTY: 711.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator at 300 Cherapa Place #201, Sioux Falls, SD 57103, call (800) 325-9402 | TTY: 711, fax (605) 328-6812, or e-mail [compliancehotline@sanfordhealth.org](mailto:compliancehotline@sanfordhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the US 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: US Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TTY/TDD (800) 537-7697. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

## Free help in other languages

For help in any language other than English, please call **1-800-752-5863** | TTY: 711.

If you have any questions, for example, about your benefits, a document, or how Sanford Health Plan pays for your care, please call us.

**Spanish:** Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sanford Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-927-2969.

**Hmong:** Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Sanford Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-923-3519.

**Cushite:** Isin yookan namni biraa isin deeggartan Sanford Health Plan irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-927-2968 tiin bilbilaa.

**Vietnamese:** Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sanford Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-927-2973.

**Chinese (Mandarin):** 如果您, 或您正在幫助的人, 有關於 Sanford Health Plan 方面的問題, 您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話, 請致電 1-844-923-3524。

**German:** Falls Sie oder jemand, dem Sie helfen, Fragen zum Sanford Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-923-3517 an.



**Russian:** Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sanford Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-927-2967.

**Laotian:** ຖ້າທ່ານ, ຫຼື ຄົນທ່ານກໍ່ ກຳລັງ ຈຳລອງ ວຍເຫຼືອ, ມີ ຄຳ ຖາມ ຫຼື ບັນຫາ ບໍ່ ສາມາດ ສອບຮູ້ ດ້ານ ສັນຍາ ສະໜອງ ສະບັບ Sanford Health Plan, ທ່ານ ມີ ສິດ ດິນ ຈະ ໄດ້ ຮັບ ການ ຈຳລອງ ວຍເຫຼືອ ແລະ ຂໍ້ ມູນ ຂ່າວ ສານ ທ່ານ ເປັນ ພາສາ ຂອງ ທ່ານ ບໍ່ ມີ ຄ່າ ຈ່າ ຈ່າຍ.

ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ ໂທຫາ 1-800-752-5863.

**Arabic:**  
نا ناك لكي يد وأ يد صخش مدعاست فاشراً صوصخب ، Sanford Health Plan ، كي ذلك قحلا  
تامولعملاو فيرورضلا كغلب نم نود قيا فلك. ثدحتل عم مجرتم لصنا ب 1-844-923-3511  
ين لوصحلا لى ع قدعاسمل

**Karen:**  
တၢ်ကွဲးနီၣ်ဆဲးအံၤန့ၣ်ဆီၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ဂျီၤလၢဆၢဒုၣ်တဖၣ်န့ၣ်လီၤ.တၢ်ကွဲးနီၣ်ဆဲးအံၤဆီၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ဂျီၤ  
လၢဆၢဒုၣ်တဖၣ်န့ၣ်လီၤဒီးန့ၣ်လီၤပတံၤထီၣ်တဖၣ်တၢ်ကျၢၢ်ဘၢဆီၣ် Sanford Health Plan  
န့ၣ်လီၤ.လူကွၢ်မ့ၢ်န့ၢ်မ့ၢ်သီဆီၣ်သ့ၣ်လၢတၢ်ကွဲးနီၣ်ဆဲးအံၤတက့ၢ်.ဘၣ်သ့ၣ်သ့ၣ်နကဘၣ်ဟံၣ်န့ၢ်မ့ၢ်အီၤလၢမ့ၢ်န့ၢ်မ့ၢ်  
ဒီသီလၢတၢ်ဆၢတၢ်ယၢ်လၢနကဟံၣ်န့ၢ်တၢ်ဆီၣ်ဆူၣ်ဆီၣ်ဆူၣ်တၢ်ကျၢၢ်ဘၢမ့ၢ်တဖၣ်မၤစၢၤလၢနကဘၣ်ဟံၣ်ဆ  
ပူၤန့ၣ်လီၤ.န့ၣ်ဆီၣ်ဒီးတၢ်န့ၣ်တၢ်ယၢ်လၢနကဒီးန့ၣ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ဂျီၤလၢနကန့ၣ်န့ၣ်လၢတလိၣ်ဟံၣ်ဆ  
ပူၤဘၣ်န့ၣ်လီၤ.ကိး 1-844-923-3522တက့ၢ်.

**Amharic:**  
እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Sanford Health Plan  
ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣  
ደደውሉ። 1-800-752-5863

**Korean:** 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sanford Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-923-3523로 오.

**French:** Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Sanford Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-923-3516.

**Serbo-Croatian:** Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Sanford Health Plan, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da

biste razgovarali sa prevodiocem, nazovite 1-800-752-5863.

**Cambodian, Mon-Khmer:** ប្រសិនបើអ្នក ឬនរណាម្នាក់ កំពុងរងការជំនួយ មិនសំណើ អ្នកពី Sanford Health Plan ឬ អ្នកមិនសំណើ ចូលជំនួយនិងព័ត៌មាន

ស្រុកនៃអ្នក ឬអ្នកមិនសំណើ ១ ឬ ព័ត៌មានយោងជាមួយអ្នកសុំ 1-844-923-3512។

**Bantu:** Nimba wewe canke umuntu uriko urafasha afise ibibazo vyerekeye Sanford Health Plan, utegerezwa kugira uburenganzira bwo kuronka ubufasha n'amakuru arambuye mu rurimi gwawe ataco utanze canke kurihira. Hamagara 1-800-752-5863 uhamagara umusobanuzi.

**Swahili:** Kama wewe, au mtu unaye mpa usaidizi ana maswali kuhusu Sanford Health Plan, Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Kuzungumza na mkalimani, piga nambari hii: 1-844-927-2970.

**Japanese:** ご本人様、またはお客様の身の回りの方でも、Sanford Health Plan についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合、1-844-923-3521 までお電話ください。

**Tagalog:** Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Sanford Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-752-5863.

**Nepali:** यदि तपाईं आफ्ना लादि आफैं आवेनिको काम िि, वा कसैलाई मदत िि हुनुहुन्छ, Sanford Health Plan बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा दन : शुल्क सहायता वा जानकारी पाउने अधिकार छ । िोभाषे ( इन्टरप्रेटर ) सँ कुरा िनुपरे 1-844-927-2961 मा फोन िनुहोस् ।

**Norwegian:** Hvis du, eller noen du hjelper, har spørsmål om Sanford Health Plan, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring 1-800-752-5863.

**Help understanding your health insurance is free.**  
If you would like something in another format (for example, a larger font size of a file for use with assistive technology, like a screen reader), please call us at: (800) 752-5863 (toll-free) | TTY: 711  
**North Dakota Medicaid Expansion:**  
Please call (855) 305-5060 (toll-free) | TTY: 711