



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 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>\$1,400</b> individual / <b>\$2,800</b> family. <b>No out of network coverage.</b> <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 plan begins to pay. If you have other family members on the plan, 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 plan 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 plan 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>\$2,900</b> individual / <b>\$5,800</b> family. <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 plan, 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 for this plan?</b>	<u>Premium</u> , <u>balance-billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<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 plan uses a <u>provider network</u> . You will pay less if you use a provider in the plan's <u>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 plan pays (balance billing). 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
		Network provider (You will pay the least)	Out-of-network provider (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	\$5 <u>copay</u> / office visit	Not covered	None
	Chiropractic care	\$5 <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> .
	Specialist visit	\$25 <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)	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	None
<b>If you need drugs to treat your illness or condition</b> 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.
	Generic drugs greater or equal to \$6	\$5 <u>copay</u> / prescription		
	Preferred brand drugs	\$30 <u>copay</u> / prescription	Not covered	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> .
	Non-preferred brand drugs	\$70 <u>copay</u> / prescription	Not covered	
<u>Specialty drugs</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	If the cost of the prescription falls under the copay amount, you will pay the least.  Refer to your <u>Formulary</u> to determine which benefit applies to your medication.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network provider</u> (You will pay the least)	<u>Out-of-network provider</u> (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <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	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	\$20 <u>copay</u> / office visit	\$20 <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)	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$5 <u>copay</u> / office visit and 20% <u>coinsurance</u> for other outpatient services after <u>deductible</u>	Not covered	None
	Inpatient services	20% <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	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required.
	<u>Rehabilitation services</u>	\$5 <u>copay</u> / office visit and 20% <u>coinsurance</u> for other outpatient services after <u>deductible</u>	Not covered	Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> .
	<u>Habilitation services</u>	\$5 <u>copay</u> / office visit and 20% <u>coinsurance</u> for other outpatient services after <u>deductible</u>	Not covered	Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required. Limited to 90 days in any consecutive 12 month period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	None
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	20% <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 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 (excludes treatment of gradual hearing loss that occurs with aging 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: South Dakota Department of Labor at 1-605-773-3101. 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 how 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 might cover costs for a sample medical situation, see the next section.* —————

## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ The plan's overall deductible	\$1,400
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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Deductibles	\$1,400
Copayments	\$10
Coinsurance	\$1,400

<i>What isn't covered</i>	
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Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$2,870</b>
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### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,400
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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Deductibles	\$40
Copayments	\$600
Coinsurance	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$660</b>
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### Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,400
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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Deductibles	\$1,400
Copayments	\$80
Coinsurance	\$100

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,580</b>
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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 ຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີຄໍາຖາມກ່ຽວກັບ Sanford Health Plan, ທ່ານມີສິດທິທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທາງເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ.

ການໂອ້ນລັກບັນຍາຍພາສາ, ໃຫ້ໂທຫາ 1-800-752-5863.

**Arabic:** نإنا ناك كيديل وأيدل صخش مدعاست فلهأ صوصخب ، Sanford Health Plan ، كيذلك قحلا تاملعمللو فيرورضلا كغلب نم نود قيا فذلك. تشرحلال عم مجرتم لصنا ب 1-844-923-3511 ين لوصحلال عل ع قدعاسمل

**Karen:** တၢ်ကွဲးနီၣ်ဆဲးအဲၤန့ၣ်ဆိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ဂၢၤလၢဆရ့ၣ်တဖၣ်န့ၣ်လီၤ.တၢ်ကွဲးနီၣ်ဆဲးအဲၤဆိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ဂၢၤလၢဆရ့ၣ်န့ၣ်သးဒီးန့ၣ်လီၤပတံၤထီၣ်မ့တမ့ၢ်တၢ်ကျၢၢ်ဘၢဆီၣ်စီၣ် Sanford Health Plan န့ၣ်လီၤ.လုၢ်ကွဲးနီၣ်မ့ၢ်ဆိၣ်ဒီးန့ၣ်သ့ၣ်လၢတၢ်ကွဲးနီၣ်ဆဲးအဲၤတက့ၢ်.ဘၣ်သ့ၣ်ဘၣ်န့ၣ်သ့ၣ်န့ၣ်မ့ၢ်လၢမ့ၢ်နီၣ်မ့ၢ်ဒီးလၢတၢ်ဆၢတံၢ်ယၢ်လၢနကဟ်ယၢ်နတၢ်ဆိၣ်ဒီးန့ၣ်သ့ၣ်အဲၤတၢ်ကျၢၢ်ဘၢမ့တမ့ၢ်တၢ်မၤစၢၤလၢနကဘၣ်ဟ့ၣ်အဲၤပှၢၤန့ၣ်လီၤ.န့ၣ်ဆိၣ်ဒီးတၢ်ခွဲးတၢ်ယၢ်လၢနကဒီးန့ၣ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ဂၢၤလၢနကန့ၣ်အဲၤလၢတၢ်လီၤဟ့ၣ်အဲၤပှၢၤဘၣ်န့ၣ်လီၤ.နံး 1-844-923-3522တက့ၢ်.

**Amharic:** እርስዎ፣ ወይም እርስዎ የሚረዳዎት ግለሰብ፣ ስለ Sanford Health Plan ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አለችዎ። ከእስተርጓሚ ጋር ለመነጋገር፣ ደ.ደ.ው.አ.። 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 ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអ្វីៗ ក្នុងទំនាក់ទំនងរបស់អ្នក ទាក់ទងនឹង Sanford Health Plan ឬប្រសិនបើអ្នកមិនសូវស្រាវជ្រាវ យើងនឹងជួយអ្នកស្រាវជ្រាវ តាមរយៈការប្រកាស 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 आवेकिनको 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 िनुुपरे 1-844-927-2961 मा फोन िनुुहोस् ।

**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  
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Please call (855) 305-5060 (toll-free) | TTY: 711