SANF: RD Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services HEALTH PLAN TRUE Individual Gold \$1,750 (Limited Cost Sharing) | North Dakota | Alaska Native/American Indian

Coverage Period Beginning on or after: 01/01/2023

Coverage for: Individual + Family | Plan Type: HMO | Non-Grandfathered

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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, visit <u>sanfordhealthplan.com/sbcfinder</u> or call 1-800-752-5863 (toll free) | TTY/TDD: 711. For general definitions of common terms, such as <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms see the Glossary. You can view the Glossary at <u>https://www.healthcare.gov/sbc-glossary/</u> or call 1-800-752-5863 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>network providers</u> \$1,750 individual / \$3,500 family. No <u>out of network</u> coverage. <u>Copays</u> do not apply to <u>deductible</u> .	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> .
Are there services covered before you meet your <u>deductible</u> ?	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</u> <u>services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$8,450 individual / \$16,900 family. No <u>out of network</u> coverage.	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.
What is not included in the <u>out-of-pocket</u> limit?	<u>Premiums, 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.
Will you pay less if you use a <u>network</u> <u>provider</u> ?	Yes. See www.sanfordhealthplan.com 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</u> 's charge and what your <u>plan</u> pays (<u>balance-</u> <u>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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the in-network <u>specialist</u> you choose without a <u>referral.</u>



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	Wha <u>Network provider</u> (You will pay the least)	t You Will Pa <u>Indian</u> <u>Health</u> <u>Care</u> <u>Provider</u> (IHCP)	ay <u>Out-of-</u> <u>network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$15 <u>copay</u> / office visit	No charge	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
If you visit a health care <u>provider's</u> office or	Chiropractic visit	ctic visit \$15 <u>copay</u> / office No charge Not cove		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.	
clinic	<u>Specialist</u> visit	\$25 <u>copay</u> / office visit	No charge	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
	Preventive care/screening/ immunization	No charge	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.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	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. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance</u> <u>billing</u>).	
	Imaging (CT/PET scans, MRIs)	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). Prior authorization may be required.	

		Wha	t You Will Pa	ay		
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Indian</u> <u>Health</u> <u>Care</u> <u>Provider</u> (IHCP)	<u>Out-of-</u> <u>network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Generic drugs less than \$6	\$0 <u>copay</u> / prescription	No charge	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	
If you need drugs to treat your illness or condition More information about	Generic drugs greater or equal to \$6	\$20 <u>copay</u> / prescription	No charge	Not covered	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	
prescription drug coverage is available at	Preferred brand drugs	\$40 <u>copay</u> / prescription	No charge	Not covered	offering. If the cost of the prescription falls under the copay amount, you will pay the least. Refer to your <u>Formulary</u> to determine	
sanfordhealthplan.com/ pharmacy	Non-preferred brand drugs	\$100 <u>copay</u> / prescription	No charge	Not covered	which benefit applies to your medication. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the	
	Specialty drugs	\$250 <u>copay</u> / prescription	No charge	Not covered	difference (<u>balance billing</u>).	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance</u> <u>billing</u>).	
	Physician/ surgeon fees	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
	Emergency room care	35% <u>coinsurance</u> after <u>deductible</u>	No charge	35% <u>coinsurance</u> after <u>deductible</u>	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-</u> <u>network provider</u> charges more than the <u>allowed amount</u> , you may	
If you need immediate medical attention	Emergency medical transportation	35% <u>coinsurance</u> after <u>deductible</u>	No charge	35% <u>coinsurance</u> after <u>deductible</u>	have to pay the difference (<u>balance billing</u>).	
	Urgent care	\$25 <u>copay</u> / office visit	No charge	\$25 <u>copay</u> / office visit	Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> . <u>Cost</u> <u>sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-</u> <u>network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	

		What You Will Pay				
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Indian</u> <u>Health</u> <u>Care</u> <u>Provider</u> (IHCP)	<u>Out-of-</u> <u>network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hospital	Facility fee (e.g., hospital room)	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	Prior authorization required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network</u> <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance</u> <u>billing</u>).	
stay	Physician/ surgeon fees	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	Cost sharing waived at non-IHCP with IHCP referral. If an out-of-	
If you need mental health, behavioral	Outpatient services	\$15 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u>	No charge	Not covered	<u>network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
health, or substance abuse services	Inpatient services	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	Prior authorization required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network</u> <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance</u> <u>billing</u>).	
	Office visits	No charge	No charge	Not covered	Cost sharing does not apply to routine prenatal and postnatal-care	
If you are pregnant	Childbirth/delivery professional services	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	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). <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an out-of-network provider charges more than the allowed	
	Childbirth/delivery facility services	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	<u>amount</u> , you may have to pay the difference (<u>balance billing</u>).	

		What You Will Pay				
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Indian</u> <u>Health</u> <u>Care</u> <u>Provider</u> (IHCP)	<u>Out-of-</u> <u>network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Home health care	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	Prior authorization required. Limited to 40 visits per calendar year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-</u> <u>network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
	<u>Rehabilitation</u> <u>services</u>	\$15 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u>	No charge	Not covered	Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 30 visits per calendar year. <u>Cost sharing</u> waived at non-	
If you need help recovering or have other special health needs	<u>Habilitation</u> <u>services</u>	\$15 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u>	No charge	Not covered	IHCP with IHCP <u>referral</u> . If an <u>out-of-network</u> <u>provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
	<u>Skilled nursing</u> <u>care</u>	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	Prior authorization required. Limited to 30 days in any consecutive 12- month period. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed</u> <u>amount</u> , you may have to pay the difference (<u>balance billing</u>).	
	Durable medical equipment	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	Prior authorization may be required. <u>Cost sharing</u> waived at non- IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
	Hospice services	35% <u>coinsurance</u> after <u>deductible</u>	No charge	Not covered	<u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	

	Services You May Need	What You Will Pay				
Common Medical Event		<u>Network provider</u> (You will pay the least)	Indian <u>Health</u> <u>Care</u> <u>Provider</u> (IHCP)	<u>Out-of-</u> <u>network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (balance billing).	
	Children's glasses	35% <u>coinsurance</u> after <u>deductible</u>	No charge	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. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	
	Children's dental check-up	No charge	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 sanfordhealthplan.com. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of- network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>).	

Excluded Services & Other Covered	d Services:	
Services Your <u>Plan</u> Generally Does	NOT Cover (Check your policy or plan document for	r more information and a list of any other excluded services.)
Abortion	 Dental care (Adult) 	 Non-emergency care when traveling outside the U.S.
Acupuncture	 Infertility treatment 	 Routine eye care (Adult)
Cosmetic surgery	Long-term care	 Weight loss programs
Other Covered Services (Limitation	s may apply to these services. This isn't a complete	e list. Please see your <u>plan</u> document.)
Bariatric Surgery	 Hearing aids 	 Private-duty nursing
 Chiropractic Care 		 Routine foot care

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Appeals & Complaints at 1-800-752-5863 or contact the North Dakota Insurance Department at 1-800-247-0560.

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? Not Applicable.

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, kwiijigo holne' 1-800-892-0675 (toll-free).

————To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Bab (9 months of in-network pre-natal of hospital delivery)		Managing Joe's type 2 Dia (a year of routine in-network care of controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)		
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> <u>copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,750 \$25 35% 35%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,750 \$25 35% 35%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$1,750 \$25 35% 35%	
This EXAMPLE event includes service Specialist office visits (prenatal care) Childbirth/Delivery Professional Service Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood Specialist visit (anesthesia)	es	This EXAMPLE event includes service <u>Primary care physician</u> office visits (includes and disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose medical equipment)	uding	This EXAMPLE event includes ser Emergency room care (including me supplies) Diagnostic test (x-ray) Durable medical equipment (crutche Rehabilitation services (physical the	dical s)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800	
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:		
Cost Sharing		Cost Sharing		Cost Sharing		
<u>Deductibles</u>	\$1,750	<u>Deductibles</u>	\$40	<u>Deductibles</u>	\$1,750	
<u>Copayments</u>	\$10	<u>Copayments</u>	\$1,200	<u>Copayments</u>	\$200	
Coinsurance	\$1,700	Coinsurance	\$0	<u>Coinsurance</u>	\$80	
What isn't covered		What isn't covered		What isn't covered		
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0	
The total Peg would pay is	\$3,520	The total Joe would pay is	\$1,260	The total Mia would pay is	\$2,030	

The <u>plan</u> 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:
 - o 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
 - o 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 <u>compliancehotline@sanfordhealth.org</u>. 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.

<u>Vietnamese</u>: 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, ຫຼືຄົນທ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມ ຄຳຖາມກ່ຽວກັບ Sanford Health Plan, ທ່ານມ ສິດທ ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທ ່ເປັນພາສາຂອງທ່ານບໍ່ມ ຄ່າໃຊ້ຈ່າຍ.

ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-752-5863.

Arabic:

نا ناك كىچىل و أ ىدل صنخش ەدعاست قائساً صوصخب Sanford Health Plan ، كيىلە قىحلا ت امولعملاو ةير ورضلا كنغلب نىم نود ةيما قالك. شدحىتلل عم مجرتم ل صنا ب 3511-923-844. ي، لوصحلا ىلع قدعاسملا

Karen:

တာ်ကွဲးနီဉ်အဝဲဆံးနှဉ်အိဉ်ဒီးတာ်ကိုတာ်ကိုးလားစာရှဒ်ဉ်တဖဉ်နှဉ်လီး.တာ်ကွဲးနီဉ်အဝဲဆံးအိဉ်ဒီးတာ်ကဲ့တာ်ကိုး လားစာရှဒ်ဉ်ဘဉ်ယးဒီးနင်္လာပတံထီဉ်မှတမ့ာ်တာ်ကျက်ဘာစီဖျို Sanford Health Plan

န္ ဉ်လီး.ယုက္စာ်မှာ်နံးမှာ်သီအခ်ိဉ်သွဉ်လ၊တာ်ကွဲးနီဉ်အံးတက္နာ်.ဘဉ်သွဉ်သွဉ်နကဘဉ်ဟံနွှာ်မူဒါလ၊မှာ်နံးမှ ာ်သီလ၊တစ်ဆာတာ်ယာ်လ၊နကဟာ်ယာ်နတားအိဉ်ဆူဉ်အိဉ်ချုတဉ်ကျ၊ဉ်ဘာမှတမှာ်တာ်မ၊စားလ၊နကဘဉ်ဟ့ဉ်အ ပွားနှဉ်လီး.နအိဉ်ဇီးတာ်ခွဲးတာ်ယာ်လ၊နကဇီးနှာ်ဘဉ်တာ်မ၊စားဇီးတာ်ဂ္ဂါတာ်ကျိုးလ၊နကျိာ်ဧဉ်နဲ့လ၊တလိဉ်ဟ္ဉ်ခ်အ ပွားဘဉ်နှဉ်လီး.ကီး 1-844-923-3522တက္န်.

Amharic:

እርስዎ፣ ወይም እርስዎ የሚያጣዙት ባለሰብ፣ ስለ Sanford Health Plan ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ ይደውሉ። 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.

<u>Serbo-Croatian</u>: 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.

<u>Cambodian, Mon-Khmer</u>: ប្រសិនបររ៉ុែក ឬនវណាមុន កំដ**ែលអ្នកកំពុង**ើេដួយ មួនសុណ**្ឌ រអ**់ពី Sanford Health Plan ប**េ រុមកម្**នសិេធិេល្លលដនួយនិងព័រែ្សមួន

បៅកនុងភាស
រ វរស់អ្នក បទោយមិនអ
ស់ប្ទាក់ ។ ២៩ខែបើនដោយជាមួយអ
នកាករប្រ សូម 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.

<u>Swahili</u>: 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、情報を入手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 tinutulangan, 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 आफें आवेिनको काम िै, वा कसैलाई मद्दत

 िै हुनुहुन्छ, Sanford Health Plan बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा

 दन : शुल्क सहायता वा जानकारी पाउने अदिकार छ । िोभाषे (इन्टरप्रेटर)

 सँि 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

North Dakota Medicaid Expansion:

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