#### SANF **BRD** Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services HEALTH PLAN Simplicity Small Group Silver \$3,000 HSA Qualified | Minnesota Coverage Period B

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

Coverage for: Individual + Family | Plan Type: PPO | 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>www.sanfordhealthplan.com/sbcfinder</u> or call 1-800-752-5863 (toll free) | TTY/TDD: 711. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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 <u>deductible</u> ?	For <u>network providers</u> <b>\$3,000</b> individual / <b>\$6,000</b> family. For <u>out-of-network providers</u> <b>\$6,000</b> individual / <b>\$12,000</b> family.	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 deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>network providers</u> <b>\$6,000</b> individual / <b>\$12,000</b> family. For <u>out-of-network providers</u> <b>\$12,000</b> individual / <b>\$24,000</b> family.	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 out-of-pocket limit?	<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.
Will you pay less if you use a <u>network provider?</u>	Yes. See <u>www.sanfordhealthplan.com</u> or call 1-800-752-5863 for a list of <u>network providers</u> .	You will pay the least if you use a provider in the Sanford Preferred <u>network</u> . You pay more if you use a provider in the Affiliated network. You will pay the most if you use an <u>out-of-network</u> <u>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 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> Provider Network: Broad	No.	You can see the in-network <u>specialist</u> you choose without a <u>referral.</u>

Provider Network: Broad Previous: HP-2787 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies. Sanford Preferred Provider: Sanford Health Practitioners and/or Facilities. With Sanford Preferred Providers, you will pay Tier-1 In-Network Benefits. Sanford Affiliated Provider: All other In-Network Practitioners and/or facilities. With Affiliated Providers, you will pay Tier-2 In-Network Benefits.

		What You Will	Pay	
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Out-of-network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	Sanford Preferred: 20% coinsurance after deductible Affiliated: 40% coinsurance after deductible	50% <u>coinsurance</u> after <u>deductible</u>	None
If you visit a boalth care	Chiropractic visit	Sanford Preferred or Affiliated: 20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	Sanford Preferred: 20% coinsurance after deductible Affiliated: 40% coinsurance after deductible	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive</u> <u>care/screening</u> / immunization	No charge	50% <u>coinsurance</u> after <u>deductible</u>	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)	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization may be required.

		What You Will Pay		
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Out-of-network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat	Preventive drugs	\$5 <u>copay</u> / prescription. <u>Copay</u> does not apply to <u>deductible</u> .	Not covered	Covers up to a 30-day supply. Brand name drugs with generic equivalents require
your illness or condition More information about	Generic drugs	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	additional cost share. Difference in cost does not apply to <u>deductible</u> or <u>out-of-pocket limit</u> .
prescription drug coverage is available at	Preferred brand drugs	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	There are no limitations or restrictions for use of manufacturer coupons if used in conjunction with our
www.sanfordhealthplan.com/ pharmacy	Non-preferred brand drugs	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	current benefit offering. Refer to your <u>Formulary</u> to determine which benefit applies
	Specialty drugs	30% <u>coinsurance</u> after <u>deductible</u>	Not covered	to your medication.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Certain outpatient services may require authorization (pre- approval) by the Plan. For a list of services, see the Prior Authorization list at <u>www.sanfordhealthplan.com</u> .
surgery	Physician/surgeon fees	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Emergency room care	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	None
If you need immediate medical attention	Emergency medical transportation	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	None

		What You Will	Pay		
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Out-of-network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hospital stay	Facility fee (e.g., hospital room)	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.	
n you nave a nospital stay	Physician/surgeon fees	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
If you need mental health,	Outpatient services	Sanford Preferred or Affiliated: 20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
behavioral health, or substance abuse services	Inpatient services	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.	
	Office visits	No charge	50% <u>coinsurance</u> after <u>deductible</u>		
If you are pregnant	Childbirth/delivery professional services	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Cost sharing does not apply to routine prenatal and postnatal-care and certain preventive services. 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.	
	Childbirth/delivery facility services	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	ultrasound).	

		What You Will	Pay	
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Out-of-network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required. Limited to 120 visits per calendar year.
	Rehabilitation services	Sanford Preferred or Affiliated: 20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you need help recovering or have other special health needs	Habilitation services	Sanford Preferred or Affiliated: 20% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Skilled nursing care	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required. Limited to 120 days per episode in any consecutive 12 month period.
	<u>Durable medical</u> equipment	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization may be required.
	Hospice services	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None

		What You Will	Pay		
Common Medical Event	Services You May Need	<u>Network provider</u> (You will pay the least)	<u>Out-of-network</u> <u>provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Children's eye exam	No charge	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19.	
Marana da	Children's glasses	Sanford Preferred or Affiliated: 30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	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.	
If your child needs dental or eye care	Children's dental check- up	No charge	50% <u>coinsurance</u> after <u>deductible</u>	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 <u>www.sanfordhealthplan.com</u> .	

<b>Excluded Services &amp; Other Covered</b>	d 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.)
<ul><li> Abortion</li><li> Acupuncture</li><li> Cosmetic surgery</li></ul>	<ul> <li>Dental care (Adult)</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul> <li>Non-emergency care when traveling outside the U.S.</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitation	is may apply to these services. This isn't a complete	list. Please see your <u>plan</u> document.)
Bariatric Surgery	<ul> <li>Hearing Aids</li> </ul>	<ul> <li>Private-duty nursing</li> </ul>
Chiropractic Care		<ul> <li>Routine eye care (Adult)</li> </ul>
		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: Minnesota Department of Health at 1-651-201-5100/1-800-657-3916, or the U.S.Department of Labor's Employee Benefits Security Administration at 1-866-444-3272. Other coverage options may be available to you too, including buying individual insurance coverage through MNsure. For more information about MNsure, visit <a href="https://www.mnsure.org">https://www.mnsure.org</a> or call 1-855-366-7873.

Your <u>Grievance</u> 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 Minnesota Department of Health at 1-651-201-5100/1-800-657-3916.

#### 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, 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 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.

<b>Peg is Having a Baby</b> (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well- controlled condition)		<b>Mia's Simple Fracture</b> (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$3,000	The plan's overall deductible	\$3,000	■ The <u>plan's</u> overall <u>deductible</u>	\$3,000
Specialist copayment	<u>Coinsurance</u>	Specialist copayment	<u>Coinsurance</u>	Specialist copayment	<u>Coinsurance</u>
Hospital (facility) <u>coinsurance</u>	30%	Hospital (facility) <u>coinsurance</u>	30%	Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%
This EXAMPLE event includes serv	vices like:	This EXAMPLE event includes ser	vices like:	This EXAMPLE event includes se	rvices like:

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

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,660

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

Total Example Cost	\$5,600		
In this example, Joe would pay:			
Cost Sharing			
Deductibles*	\$3,000		
Copayments	\$0		
Coinsurance	\$700		
What isn't covered			
Limits or exclusions	\$20		
The total Joe would pay is	\$3,720		

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

Total Example Cost

**#0.000** 

lotal Example Cost	\$2,800		
In this example, Mia would pay:			
Cost Sharing			
Deductibles*	\$2,800		
Copayments	\$0		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$2,800		

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:
  - 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, 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 <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>

# 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
រស់អ្នក បទោយមិនអនុស់ប្ទាក់ ។ ២៩មែបនេះយាយជាមួយអនុតាករប្រ 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