

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

TRUE Individual Enhanced Silver \$3,700 94% | South Dakota

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>allowed amount</u>, <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 <a href="https://www.healthcare.gov/sbc-glossary/">https://www.healthcare.gov/sbc-glossary/</a> 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> \$200 individual / \$400 family.  No <u>out-of-network</u> coverage.	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 deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$1,400 individual / \$2,800 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 out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan 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 network provider?	Yes. See www.sanfordhealthplan.com or call 1-800-752-5863 for a list of network providers.	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-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 specialist you choose without a referral.

Provider Network: Focused

1 of 8

HP-5358 | QHP | COI: HP-4469

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.

Common	Services You May	What You Will Pay Network provider Out-of-network provider		Limitations, Exceptions, & Other Important	
Medical Event	Medical Event Need		Out-of-network provider (You will pay the most)	Information	
	Primary care visit to treat an injury or illness	(You will pay the least)  5% coinsurance after deductible	Not covered	None	
K	Chiropractic visit	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
If you visit a health care provider's office or clinic	Specialist visit	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't part of the preventive health guidelines. Ask your provider if these services you need are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
	Imaging (CT/PET scans, MRIs)	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization may be required.	

Common	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Need	Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	Information	
	Preventive drugs	\$5 copay / prescription. Copay does not apply to deductible.	Not covered	Covers up to a 30-day supply. Generic cost is based on	
If you need drugs to treat your illness or condition	Generic drugs	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	total drug cost per 30-day supply.  Brand name drugs with generic equivalents require additional cost share. Difference in cost does not apply	
More information about prescription drug coverage is available at	Preferred brand drugs	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	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.	
sanfordhealthplan.com/ pharmacy	Non-preferred brand drugs	5% <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 Formulary to determine which benefit applies to your medication.	
	Specialty drugs	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	applied to your medication.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	5% <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 sanfordhealthplan.com.	
surgery	Physician/surgeon fees	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
If you need immediate medical attention	Emergency room care	5% <u>coinsurance</u> after <u>deductible</u>	5% <u>coinsurance</u> after <u>deductible</u>	None	
	Emergency medical transportation	5% <u>coinsurance</u> after <u>deductible</u>	5% <u>coinsurance</u> after <u>deductible</u>	None	
	<u>Urgent care</u>	5% <u>coinsurance</u> after <u>deductible</u>	5% <u>coinsurance</u> after <u>deductible</u>	Additional services may be subject to deductible / coinsurance.	

Common	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Need	Network provider	Out-of-network provider (You will pay the most)	Information	
	Facility fee (e.g., hospital room)	(You will pay the least)  5% coinsurance after deductible	Not covered	Prior authorization required.	
If you have a hospital stay	Physician/surgeon fees	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
If you need mental health, behavioral health, or	Outpatient services	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
substance abuse services	Inpatient services	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required.	
	Office visits	No charge	Not covered	Cost sharing does not apply to routine prenatal and postnatal-care and certain preventive services.  Depending on the type of services copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
If you are pregnant	Childbirth/delivery professional services	5% <u>coinsurance</u> after <u>deductible</u>	Not covered		
	Childbirth/delivery facility services	5% <u>coinsurance</u> after <u>deductible</u>	Not covered		

Common	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Need	Network provider	Out-of-network provider	Information	
	Home health care	5% coinsurance after deductible	(You will pay the most)  Not covered	Prior authorization required.	
	Rehabilitation services	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
If you need help recovering or have other	Habilitation services	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	None	
special health needs	Skilled nursing care	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required. Limited to 90 days in any consecutive 12 month period.	
	Durable medical equipment	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization may be required.	
	Hospice services	5% <u>coinsurance</u> after <u>deductible</u>	Not covered	Hospice respite care limited to 15 inpatient and 15 outpatient days per lifetime. Hospice respite care must be used in increments of not more than 5 days at a time.	

Common	Common Services You May What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Need	Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	Information
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	5% <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 sanfordhealthplan.com.

#### **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.)

- Abortion
   Dental care (Adult)
- Acupuncture Infertility treatment
- Cosmetic surgery Long-term care

- Non-emergency care when traveling outside the U.S.
- Routine eye 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
   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 <a href="Health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> 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 South Dakota Division of Insurance at 605-773-3563...

## 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.

\$200

Coinsurance

\$5,600

# Peg is Having a Baby

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

■ The	e <u>plan's</u> ove	rall <u>deductible</u>	\$200
_			

■ Specialist copayment

<u>Coinsurance</u>

■ Hospital (facility) coinsurance

5%

■ Other <u>coinsurance</u>

00 ■ The plan's o

■ The <u>plan's</u> overall <u>deductible</u>

■ <u>Specialist copayment</u>
■ Hospital (facility) coinsurance

■ Other <u>coinsurance</u>

## **Mia's Simple Fracture**

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

■ The plan's overal	ll deductible	\$20
Ine plan s overal	ii deductible	<b></b>

■ Specialist copayment Coinsurance

■ Hospital (facility) <u>coinsurance</u> 5°

■ Other coinsurance 5%

#### 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)

In this example, Peg would pay:

in this example, i eg would pay.	
Cost Sharing	
<u>Deductibles</u>	\$200
Copayments	\$0
Coinsurance	\$400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$660

#### This EXAMPLE event includes services like:

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-

controlled condition)

Primary care physician office visits (including

disease education)

**Total Example Cost** 

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

In this example, Joe would pay:			
Cost Sharing			
<u>Deductibles</u>	\$200		
Copayments	\$0		
Coinsurance	\$200		
What isn't covered			
Limits or exclusions	\$20		
The total Joe would pay is	\$420		

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	

Cost Shaning	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$300

#### 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
  - o 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 <a href="mailto:compliancehotline@sanfordhealth.org">compliancehotline@sanfordhealth.org</a>. 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="https://www.hhs.gov/ocr/office/file/index.html">https://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.

<u>Cushite</u>: 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 ສິດທ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບໍ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-752-5863.

## **Arabic:**

#### <u>Karen</u>:

တာ်ကွဲးနီဉ်အဝဲဆံးနှဉ်အိဉ်ဒီးတာ်က်တာ်ကျိုးလာအရှဒိဉ်တဖဉ်နှဉ်လီး တာ်ကွဲးနီဉ်အဝဲဆံးအိဉ်ဒီးတာ်က်တာ်ကျိုး လာအရှဒိဉ်ဘဉ်ယးဒီးနှလံာ်ပတံထိဉ်မှတမှာ်တာ်ကျက်ဘာခ်ီမျို Sanford Health Plan

န္ဉ်လီး.ယုကျွ်မုံနံးမုံသီအခ်ိဉ်သှဉ်လ၊တာ်ကွဲးနီဉ်အာံးတက္ခုံ.ဘဉ်သှဉ်နကဘဉ်ဟံနှုံမူဒါလ၊မုဂံနံးမု ဂ်သီလ၊တာ်ဆာတာ်ယာ်လ၊နကဟ်ယာ်နတာ်အိဉ်ဆူဉ်ဆိုဉ်ချုတဉ်ကျုဉ်ဘာမှတမှာ်တာ်မးစားလာနကဘဉ်ဟှဉ်အ ပူးနှဉ်လီး.နအိဉ်ဇီးတာ်ခွဲးတာ်ယာ်လာနကဇီးနှုံးဘဉ်တာ်မးစားဇီးတာ်က်တာ်ကျိုးလာနကျိုာ်စဉ်နဲ့လ၊တလိဉ်ဟုဉ်အ ပူးဘဉ်နှဉ်လီး.ကီး 1-844-923-3522တက္ခုံ.

## Amharic:

እርስዎ፣ ወይም እርስዎ የሚያባዙት ባለሰብ፣ ስለ Sanford Health Plan ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የጣግኘት 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>: ប្រសិនបរ្មុំគ ឬនរណារួន ក់រ៉ែលអ្នកកំពុងរ៉ែដួយ ម្មុនស់ណ**្ឋ រអ**់ពី Sanford Health Plan ប**េ**,រួមកម្មនសិេធិេ េួលជំនួយនិងព័ែ្ចម្អន

**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。

<u>Tagalog</u>: 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