



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, visit

[www.sanfordhealthplan.com/sbcfinder](http://www.sanfordhealthplan.com/sbcfinder) or call 1-800-752-5863 (toll-free) | TTY/TDD: 711 (toll-free). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://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><br><b>\$3,000</b> individual / <b>\$6,000</b> family<br><b>No <u>out-of-network</u> coverage.</b><br><b>Copays do not apply to deductible.</b> | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                               |
| <b>Are there services covered before you meet your deductible?</b>  | Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .                                                                                   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">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 <u>out-of-pocket limit</u> for this <u>plan</u>?</b> | For <u>network providers</u><br><b>\$8,500</b> individual / <b>\$17,000</b> family<br><b>No <u>out-of-network</u> coverage.</b>                                             | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                                     |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>      | <u>Premiums</u> , <u>balance-billing</u> charges (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover.                                   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Will you pay less if you use a <u>network provider</u>?</b>      | Yes. See <a href="http://www.sanfordhealthplan.com">www.sanfordhealthplan.com</a> or call 1-800-752-5863 for a list of <u>network providers</u> .                           | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> 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 <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>    | 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                            | What You Will Pay                                                                                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                 | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                                             | Primary care visit to treat an injury or illness | \$35 <u>copay</u> / visit                                                                                    | Not covered                                        | First 5 office visits covered at 100% in the combined categories of Primary Care, Chiropractic, Habilitation, or Rehabilitation.                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                           | Chiropractic Visit                               | \$35 <u>copay</u> / visit                                                                                    | Not covered                                        | First 5 office visits covered at 100% in the combined categories of Primary Care, Chiropractic, Habilitation, or Rehabilitation.                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                           | <u>Specialist</u> visit                          | \$65 <u>copay</u> / visit<br>\$35 <u>copay</u> / visit for mental health and substance use primary diagnoses | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                           | <u>Preventive care/screening/immunization</u>    | No charge                                                                                                    | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed 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)       | \$35 <u>copay</u>                                                                                            | Not covered                                        | Certain services may be subject to <u>deductible</u> / <u>coinsurance</u> . For full details, refer to your plan document.                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                     | 30% <u>coinsurance</u> after <u>deductible</u>                                                               | Not covered                                        | Prior authorization may be required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.sanfordhealthplan.com/pharmacy">www.sanfordhealthplan.com/pharmacy</a> | Generic drugs less than \$6                      | \$0 <u>copay</u> / prescription                                                                              | Not covered                                        | Covers up to a 30-day supply. Brand drugs with generic equivalents or biosimilar alternatives require additional cost share. Difference in cost does not apply to deductible or out-of-pocket limit. There are no limitations or restrictions for use of manufacturer coupons that apply toward cost-sharing obligations if used in conjunction with our current benefit offering. If the drug cost is less than the copay, you will pay the lower amount. Refer to your Formulary for coverage details – drug listings and tier placements are subject to change with prior notice. |
|                                                                                                                                                                                                                                           | Generic drugs greater than \$6                   | \$15 <u>copay</u> / prescription                                                                             | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                           | Preferred brand drugs                            | \$30 <u>copay</u> / prescription                                                                             | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                           | Non-preferred brand drugs                        | \$125 <u>copay</u> / prescription                                                                            | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                           | Generic specialty drugs                          | \$15 <u>copay</u> / prescription                                                                             | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                           | Preferred specialty drugs                        | 30% <u>coinsurance</u> after <u>deductible</u>                                                               | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                           | Non-preferred specialty drugs                    | 50% <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<br>(You will pay the least)                                                                         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                         |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | Certain outpatient services may require authorization (pre-approval) by the <u>plan</u> . For a list of services, see the Prior Authorization list at <a href="http://www.sanfordhealthplan.com">www.sanfordhealthplan.com</a> .                                                                        |
|                                                                           | Physician/surgeon fees                         | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | None                                                                                                                                                                                                                                                                                                    |
| If you need immediate medical attention                                   | Emergency room care                            | \$450 <u>copay</u> / visit                                                                                           | \$450 <u>copay</u> / visit                         | Emergency Room <u>copay</u> waived if directly admitted.                                                                                                                                                                                                                                                |
|                                                                           | <u>Emergency medical transportation</u>        | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | 30% <u>coinsurance</u> after <u>deductible</u>     | None                                                                                                                                                                                                                                                                                                    |
|                                                                           | <u>Urgent care</u>                             | \$50 <u>copay</u> / visit<br>\$35 <u>copay</u> / visit for mental health and substance use primary diagnoses         | 50% <u>coinsurance</u> after <u>deductible</u>     | Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> .                                                                                                                                                                                                                          |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)             | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | Prior authorization required.                                                                                                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                         | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | None                                                                                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                            | Office Visit: \$35 <u>copay</u> / visit<br>Other Outpatient Services: 30% <u>coinsurance</u> after <u>deductible</u> | Not covered                                        | First 5 office visits covered at 100% in the combined categories of Mental/Behavioral Health and SUD.                                                                                                                                                                                                   |
|                                                                           | Inpatient services                             | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | Prior authorization required.                                                                                                                                                                                                                                                                           |
| If you are pregnant                                                       | Office visits                                  | No charge                                                                                                            | Not covered                                        | <u>Cost-sharing</u> does not apply to routine prenatal and postnatal-care and certain <u>preventive services</u> . Depending on the type of services <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                           | Childbirth/delivery professional services      | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        |                                                                                                                                                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services          | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        |                                                                                                                                                                                                                                                                                                         |

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                                                                                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                          |
|-----------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                  | Network Provider<br>(You will pay the least)                                                                         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                 |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | Prior authorization may be required.                                                                                                                                                                                                            |
|                                                                       | <u>Rehabilitation services</u>   | Office Visit: \$35 <u>copay</u> / visit<br>Other Outpatient Services: 30% <u>coinsurance</u> after <u>deductible</u> | Not covered                                        | First 5 office visits covered at 100% in the combined categories of Primary Care, Chiropractic, Habilitation, or Rehabilitation. Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> . |
|                                                                       | <u>Habilitation services</u>     | Office Visit: \$35 <u>copay</u> / visit<br>Other Outpatient Services: 30% <u>coinsurance</u> after <u>deductible</u> | Not covered                                        | First 5 office visits covered at 100% in the combined categories of Primary Care, Chiropractic, Habilitation, or Rehabilitation. Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> . |
|                                                                       | <u>Skilled nursing care</u>      | 30% <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> | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | Prior authorization may be required.                                                                                                                                                                                                            |
|                                                                       | <u>Hospice services</u>          | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | 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.                                                                            |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | No charge                                                                                                            | Not covered                                        | Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19.                                                                                                                                            |
|                                                                       | Children's glasses               | 30% <u>coinsurance</u> after <u>deductible</u>                                                                       | Not covered                                        | Limited to 1 frame every other year. Lenses or contact lenses limited to 1 item annually. Benefit ends at the end of the month when the member turns 19.                                                                                        |

| Common Medical Event | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                             |
|----------------------|----------------------------|----------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                      |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                    |
|                      | Children's dental check-up | No charge                                    | Not covered                                        | Limited to 2 routine check-up visits per calendar year. Preventive, emergency, and routine coverage available for members up to age 19. See your plan document for eligible services. Certain dental services may require authorization (pre-approval) by the plan. For a list of services, see the Prior Authorization list at <a href="http://sanfordhealthplan.com">sanfordhealthplan.com</a> . |

#### Excluded Services & Other Covered Services:

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

- |                    |                         |                                                      |
|--------------------|-------------------------|------------------------------------------------------|
| • 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 (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 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 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 & Grievances 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 the 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 1-800-752-5863 (*toll-free*).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-5863 (*toll-free*).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-752-5863 (toll-free).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-752-5863 (toll-free).

[To see examples of how this plan might cover costs for a sample medical situation, see the next section.](#)

## About these Coverage Examples:



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

### Peg is Having a Baby

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$3,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$65    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

This **EXAMPLE** event includes services like:

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

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

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$3,000        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$1,600        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,670</b> |

### Managing Joe's type 2 Diabetes

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$3,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$65    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

This **EXAMPLE** event includes services like:

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

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

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$100          |
| <u>Copayments</u>                 | \$1,200        |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,320</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$3,000 |
| ■ <u>Specialist</u> <u>copayment</u>          | \$65    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

This **EXAMPLE** event includes services like:

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

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

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,100        |
| <u>Copayments</u>                 | \$800          |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

# Non-discrimination notice

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Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law.

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, 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, call (800) 752-5863 (TTY: 711)

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator  
2301 E. 60th Street, Sioux Falls, SD 57103  
Telephone number: (877) 473-0911 (TTY: 711)  
Fax: (605) 312-9886  
Email: [shpcompliance@sanfordhealth.org](mailto:shpcompliance@sanfordhealth.org)

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. 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:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at:  
<http://www.hhs.gov/ocr/office/file/index.html>.

## Help in Other Languages

For help in any language other than English, call (800) 752-5863 (TTY: 711).

### Arabic –

خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم  
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن  
(رقم هاتف الصم والبكم: 711) (800) 752-5863

**Amharic** – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም  
ክርዳታ ድርጅቶችማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም  
ክርዳታ ድርጅቶች: በነጻ ሊያገዝዎት ተዘጋጅተዋል: ወደ ሚከተለው  
ቁጥር ይደውሉ (800) 752-5863 (መስማት ለተሳናቸው: 711).

**Chinese** – 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 (800) 752-5863 (TTY: 711)。

**Cushite (Oromo)** – XIYYEEFFANNAA: Afaan dubbattu  
Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala,  
ni argama. Bilbilaa (800) 752-5863 (TTY: 711).

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen  
Ihnen kostenlos sprachliche Hilfsdienstleistungen zur  
Verfügung. Rufnummer: (800) 752-5863 (TTY: 711).

**Hmong** – LUS CEEV: Yog tias koj hais lus Hmoob, cov  
kev pab txog lus, muaj kev pab dawb rau koj. Hu rau  
(800) 752-5863 (TTY: 711).

**Karen** – ဟံသာဝတီသား- နမ့်ကတိၤ ကညိ ကျိာ်အသိ. နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ  
တလၢာ်ဘျုးလၢာ်စ့ၤ နီတမံၤဘျုးသ့န့ၢ်လီၤ. ကိး (800) 752-5863 (TTY: 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를  
무료로 이용하실 수 있습니다. (800) 752-5863 (TTY: 711) 번으로  
전화해 주십시오.

**Laotian** – ໄປດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ  
ພາສາ, ໄດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (800) 752-5863 (TTY: 711).

**French** – ATTENTION : Si vous parlez français, des services  
d'aide linguistique vous sont proposés gratuitement.  
Appelez le (800) 752-5863 (TTY: 711).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском  
языке, то вам доступны бесплатные услуги перевода.  
Звоните (800) 752-5863 (телетайп: 711).

**Spanish** – ATENCIÓN: si habla español, tiene a su  
disposición servicios gratuitos de asistencia lingüística.  
Llame al (800) 752-5863 (TTY: 711).

**Tagalog** – PAUNAWA: Kung nagsasalita ka ng Tagalog,  
maaari kang gumamit ng mga serbisyo ng tulong sa wika  
nang walang bayad. Tumawag sa (800) 752-5863 (TTY: 711).

**Thai** – เรียน: ถ้า คุณพูดภาษาไทยคุณสามารถใช้ บริการช่วยเหลือ  
ทางภาษาได้ ฟรี โทร (800) 752-5863 (TTY: 711).

**Vietnamese** – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ  
hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 752-5863  
(TTY: 711).