
 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 [wpshealth.com](https://wpshealth.com) or call 1-800-223-6048. 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 <https://www.healthcare.gov/sbc-glossary> /or call 1-800-223-6048 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For preferred <u>providers</u> : \$300 / Covered Person or \$900 / Family; For non-preferred <u>providers</u> : \$900 / Covered Person or \$2,700 / 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> services, office visits and prescription drugs purchased from a pharmacy 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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For preferred providers: \$800 / Covered Person or \$2,400 / Family; (excludes <u>copayments</u> ), up to a maximum out-of-pocket (includes <u>copayments</u> ) of \$7,350 Person / \$14,700 Family. For non-preferred providers: \$2,400 / Covered Person or \$7,200 / 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, 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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do">https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do</a> or call 1-800-223-6048 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 <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 <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.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u> / office visit ( <u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	\$25 <u>copayment</u> / office visit ( <u>deductible</u> waived) and 30% <u>coinsurance</u> for other outpatient services	\$10 <u>copayment</u> / Teladoc <sup>®</sup> visit charge  \$20 <u>copayment</u> / office visit charge for a preferred convenient care clinic visit  \$20 <u>copayment</u> / visit for a preferred chiropractor
	<u>Specialist</u> visit	\$35 <u>copayment</u> / office visit ( <u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	\$45 <u>copayment</u> / office visit ( <u>deductible</u> waived) and 30% <u>coinsurance</u> for other outpatient services	None
	<u>Preventive care/screening/immunization</u>	No charge	\$25 <u>copayment</u> / office visit ( <u>deductible</u> waived) and 30% <u>coinsurance</u> for other outpatient services	You may have to pay for services that aren't <u>preventive care</u> . Ask your <u>provider</u> if the services you need are <u>preventive care</u> . Then check what your plan will pay for. You also have no charge for immunizations provided by a non-preferred <u>provider</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> , <u>deductible</u> does not apply if provided in an office or outpatient	30% <u>coinsurance</u> , <u>deductible</u> does not apply if provided in an office or outpatient	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> , <u>deductible</u> does not apply if provided in an office or outpatient	30% <u>coinsurance</u> , <u>deductible</u> does not apply if provided in an office or outpatient	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b><u>prescription drug coverage</u></b> is available at <a href="https://wpshealth.com/resources/files/32053_2024-preferred-drug-guide.pdf">https://wpshealth.com/resources/files/32053_2024-preferred-drug-guide.pdf</a></p>	Generic drugs	Retail: \$10 <u>copayment</u> / prescription & \$20 <u>copayment</u> / prescription for home delivery	Retail: \$10 <u>copayment</u> / prescription & \$20 <u>copayment</u> / prescription for home delivery	<p><u>Deductible</u> does not apply to prescription drugs purchased from a pharmacy.</p> <p>Covers up to a 90-day supply.</p> <p>Retail <u>copayments</u> applied as follows:  1-30-day supply = one <u>copayment</u>  31-60-day supply = two <u>copayments</u>  61-90-day supply = three <u>copayments</u></p> <p>If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which does not count toward your <u>out-of-pocket limit</u>. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization.</p> <p><u>Specialty drugs</u> are always limited to a 30-day supply. <u>Specialty drugs</u> require prior authorization. Benefits may not be payable if you do not obtain prior authorization.</p>
	Preferred brand drugs	Retail: \$20 <u>copayment</u> / prescription & \$40 <u>copayment</u> / prescription for home delivery	Retail: \$20 <u>copayment</u> / prescription & \$40 <u>copayment</u> / prescription for home delivery	
	Non-preferred brand drugs	Retail: \$30 <u>copayment</u> / prescription & \$60 <u>copayment</u> / prescription for home delivery	Retail: \$30 <u>copayment</u> / prescription & \$60 <u>copayment</u> / prescription for home delivery	
	<u>Specialty drugs</u>	Retail: \$40 <u>copayment</u> / prescription & \$40 <u>copayment</u> / prescription for home delivery	Retail: \$40 <u>copayment</u> / prescription & \$40 <u>copayment</u> / prescription for home delivery	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<p><b>If you need immediate medical attention</b></p>	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<p><u>Urgent care</u> services from a non-preferred <u>provider</u> for treatment of a condition which does not require immediate medical attention will be subject to the non-preferred <u>provider deductible</u> and <u>coinsurance</u>.</p> <p><u>Urgent care</u> billed from a clinic location (a location outside of the hospital emergency room or any other facility as an extension of a</p>
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
				hospital emergency room) maybe be subject to the \$20 primary care office <u>copayment</u> or \$35 <u>specialist</u> office visit <u>copayment</u> depending on the specialty of the physician providing treatment.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u> / therapy office visit ( <u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	\$25 <u>copayment</u> / therapy office visit ( <u>deductible</u> waived) and 30% <u>coinsurance</u> for other outpatient services	\$10 <u>copayment</u> / Teladoc ® visit charge  All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you are pregnant	Office visits	\$20 <u>copayment</u> / office visit ( <u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	\$25 <u>copayment</u> / office visit ( <u>deductible</u> waived) and 30% <u>coinsurance</u> for other outpatient services	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to 100 visits in a 12 month period
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to 30 days per confinement in a skilled nursing facility. All non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior authorization required for: <ul style="list-style-type: none"> <li>• All CPAP purchases</li> <li>• Purchases over \$1,000</li> <li>• All other rentals as stated on our website</li> </ul> Benefits may not be payable if you do not obtain prior authorization.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Hospice services require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If your child needs dental or eye care	Children's eye exam	No charge	30% <u>coinsurance</u>	None
	Children's glasses	Not covered	Not covered	Not Covered
	Children's dental check-up	Not covered	Not covered	Not Covered

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Cosmetic Surgery</li><li>• Infertility Treatment</li></ul>	<ul style="list-style-type: none"><li>• Long Term Care</li><li>• Private Duty Nursing</li></ul>	<ul style="list-style-type: none"><li>• Routine Foot Care (unless associated with a specific medical diagnosis)</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Chiropractic Care</li><li>• Acupuncture, limited to adults over age 18 for postoperative nausea and vomiting, nausea and vomiting due to anti-neoplastic agents, and postoperative dental pain</li></ul>	<ul style="list-style-type: none"><li>• Dental Care (adult), limited to certain oral surgical procedures, treatment of an injury, and extraction of teeth and sealants on existing teeth related to treatment of neoplastic disease</li><li>• Bariatric Surgery</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids, limited to the cost of one hearing aid, per ear, for each member under age 18 every three years</li><li>• Routine eye care, limited to eye exams</li></ul>

**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: for the U.S. Department of Labor, Employee Benefits Security Administration 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the Department of Health and Human Services at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: WPS at 1-800-223-6048. You may also contact your state insurance department at 1-800-236-8517 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (888) 915-4001.

Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu (888) 915-4001.

Traditional Chinese (傳統中文): 有關中文協助,請致電 (888) 915-4001.

German (Deutsch): Für Hilfe in deutscher Sprache rufen (888) 915-4001.

-----*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>	\$300
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$50
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Peg would pay is</b>	<b>\$580</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>	\$300
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$1,000
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,210</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copayment</u>	\$35
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$80
Coinsurance	\$180
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$560</b>

## Nondiscrimination and Language Access Policy

Wisconsin Physicians Service Insurance Corporation/WPS Health Plan, Inc./The EPIC Life Insurance Company (WPS/EPIC) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. WPS/EPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### WPS/EPIC:

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 us at the phone number on the attached correspondence, your ID card, or the number listed on [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan), or [epiclifec.com](http://epiclifec.com).

If you believe that WPS/EPIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

WPS/EPIC  
Nondiscrimination Grievance Coordinator  
P.O. Box 7458 Madison, WI 53707  
Email: [WPSNondiscrimination@wpsic.com](mailto:WPSNondiscrimination@wpsic.com)

You can file a grievance in person, by mail, or by email. If you need help filing a grievance, the Nondiscrimination Grievance 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 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf); by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, D.C., 20201; or by phone at 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

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Albanian VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Na telefononi në numrin e telefonit që gjendet në korrespondencën e bashkëngjitur, në pjesën e përparme të kartës suaj ID ose në numrin e renditur në adresën [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) or [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

بالهجة العربية: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بنا على رقم الهاتف الموجود بالرسالة المرفقة أو بالهجة الأمامية لبطاقة تعريف الهوية الخاصة بك أو على الرقم المدرج بالمواقع الإلكترونية التالية [wpshealth.com/healthplan](http://wpshealth.com/healthplan) أو [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

French À NOTER : Si vous parlez le français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez-nous au numéro de téléphone indiqué sur le courrier joint, au recto de votre carte d'identité ou au numéro indiqué sur le site Internet [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) ou [epiclifecare.com](http://epiclifecare.com) (ATS : 711).

German HINWEIS: Wenn Sie Deutsch sprechen, stehen für Sie kostenlos Sprachassistenzen zur Verfügung. Sie finden die entsprechende Telefonnummer auf dem beigefügten Schreiben, auf der Vorderseite Ihrer ID-Karte oder unter [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) oder [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

Hindi ध्यान दें अगर आप हिन्दी बोलते हैं तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। हमें संलग्न पत्राचार पता, आपके पहचान पत्र (आईडी कार्ड) के सामने के पृष्ठ पर

दिए गए फ़ोन नंबर या [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan), [epiclifecare.com](http://epiclifecare.com) पर दिए गए नंबर पर कॉल करें (TTY: 711)।

Hmong TSHWJ XEEB: Yog hais tias koj hais lus Hmoob, peb muaj cov kev pab cuam hais ua koj hom lus pub rau koj yam tsis xam tus nqi hlo li. Hu rau peb tus nab npawb xov tooj nyob rau ntawm daim ntawv, sab hauv ntej ntawm koj daim id lossis nab npawb xov tooj nyob rau hauv [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) lossis [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

Korean 주목해 주세요: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 첨부된 서신, ID 카드 앞면 또는 [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan), [epiclifecare.com](http://epiclifecare.com) 에 나와 있는 전화번호로 연락해 주십시오(TTY: 711).

Polish UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany w załączonej korespondencji, z przodu karty identyfikacyjnej lub numer podany na stronie [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) lub [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

Russian ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться услугами переводчика. Позвоните по любому номеру, указанному: в прикреплённом письме, на лицевой стороне Вашей идентификационной карты или на сайте [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) и [epiclifecare.com](http://epiclifecare.com) (телетайп: 711).

Spanish ATENCIÓN: Si habla español, los servicios de asistencia de idioma están disponibles para usted, sin costo. Llámennos al número de teléfono que se encuentra en la correspondencia adjunta, en la parte de adelante de su tarjeta de identificación o al número indicado en [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) o [epiclifecare.com](http://epiclifecare.com)(TTY: 711).

Tagalog BIGYANG-PANSIN: Kung Tagalog ang ginagamit mong wika, may mga serbisyong tulong sa wika na makukuha mo nang walang babayaran. Tawagan kami sa numero ng telepono na nasa nakalalip na sulat, nasa harapang bahagi ng iyong id card o nakalintang numero sa [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) o [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

Traditional 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。請撥打隨附之通訊上、ID 卡正面或以下網址：  
[wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) 或 [epiclifecare.com](http://epiclifecare.com) 列出的電話號碼與我們聯絡 (TTY: 711)。

Vietnamese CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi cho chúng tôi theo số điện thoại có trên thư từ đính kèm, mặt trước thẻ id của quý vị hoặc số điện thoại được niêm yết trên [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) hoặc [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

Pennsylvania Dutch GEB ACHT: Wann du Deitsch schwetzst, du kannst Schprooch Services griege, mitaus Koschd. Ruf uns mit der Nummer uff die attached correspondence, die vonne Seide vun der ID Kaarde odder die Nummer uff [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) or [epiclifecare.com](http://epiclifecare.com) (TTY: 711).

Lao ສໍາລັບທ່ານທີ່ຄົນໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຄິດຄ່າໃຊ້ຈ່າຍ ສໍາລັບທ່ານ.

ທ່ານສາມາດໂທຫາພວກເຮົາໄດ້ຜ່ານພາສາເລກຢູ່ເທິງຈົດໝາຍຕິດຕັ້ງດ້ວຍຕົວເອງ, ດ້ານໜ້າປັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໝາຍເລກທີ່ໝາຍໄວ້ໃນ [wpshealth.com](http://wpshealth.com), [wpshealth.com/healthplan](http://wpshealth.com/healthplan) or [epiclifecare.com](http://epiclifecare.com) (TTY: 711).