



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 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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 <u>providers</u> : \$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 <u>providers</u> : \$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 https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do 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	\$35 <u>copayment</u> / office visit (<u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u>	\$10 <u>copayment</u> / Teladoc ® visit charge \$35 <u>copayment</u> / office visit charge for a preferred convenient care clinic visit \$35 <u>copayment</u> / visit for a preferred chiropractor
	<u>Specialist</u> visit	\$50 <u>copayment</u> / office visit (<u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	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)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://wpshealth.com/resources/files/32053_2025-preferred-drug-guide.pdf	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	<u>Deductible</u> does not apply to prescription drugs purchased from a pharmacy. Covers up to a 90-day supply.
	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	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>
	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	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.
	<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	<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.
If you have outpatient surgery	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
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Urgent care</u> services from a non-preferred provider 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>. <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
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Urgent care</u>	\$35 <u>copayment</u> / office visit (<u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	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 \$35 primary care office <u>copayment</u> or \$50 <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	\$35 <u>copayment</u> / therapy office visit (<u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u>	\$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	\$35 <u>copayment</u> / office visit (<u>deductible</u> waived) and 10% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u>	<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>	Massage therapy provided by a physical therapist or occupational therapist is limited to six visits/year.
	<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: • All CPAP purchases • Purchases over \$1,000 • All other rentals as stated on our website 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> .)		
• Cosmetic Surgery • Infertility Treatment • Acupuncture	• Long Term Care • Private Duty Nursing	• Routine Foot Care (unless associated with a specific medical diagnosis) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Chiropractic Care	• 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 • Bariatric Surgery, limited to one (1) per lifetime with a BMI (body mass index) of 35 or greater	• Hearing aids, limited to the cost of one hearing aid, per ear, for each member under age 18 every three years • Routine eye care, limited to eye exams

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, or the Department of Health and Human Services at 1-877-267-2323 x 61565 or 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 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.

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>	\$50
■ 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$50
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$30
The total Peg would pay is	\$880

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>	\$50
■ 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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$150
Copayments	\$1,150
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,310

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>	\$50
■ 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*)

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

Cost Sharing	
Deductibles	\$300
Copayments	\$250
Coinsurance	\$190
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$740

Nondiscrimination and Language Access Policy

Discrimination Is Against the Law

Wisconsin Physicians Service Insurance Corporation (WPS)/The EPIC Life Insurance Company (collectively, 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 (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). WPS/EPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

WPS/EPIC:

Provides people with disabilities reasonable modifications and free auxiliary aids and services 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 assistance services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need any these services, contact us at the phone number on the attached correspondence, your ID card, or the number listed on wpshealth.com/contact.

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

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 <https://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 <http://www.hhs.gov/ocr/office/file/index.html>.

**The EPIC Life
Insurance Company[®]**
A WPS Company
Medicare Supplement Insurance Plans



Notice of Availability of Language Assistance Services and Auxiliary Aids

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the number on your Member ID card or speak to your provider.

SPANISH: ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al número que figura en la tarjeta de identificación de miembro o hable con su proveedor.

HMONG: NCO NTSOOV: Yog hais tias koj hais lus Hmoob, peb yeej muaj kev pab txhais lus dawb rau koj. Peb los kuj tseem muaj cov khoom siv thiab cov kev pab los npaj lwm yam ntaub ntawv uas yuav muab tau koj los saib dawb. Hu xov tooj mus rau tus xov tooj nyob ntawm koj daim ID Ua Tswv Cuab los sis nrog koj tus kws kho mob tham.

TRADITIONAL CHINESE: 請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電您的會員 ID 卡上的電話號碼或聯絡您的提供者。

GERMAN: HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie die Nummer auf Ihrer Versichertenkarte an oder sprechen Sie mit Ihrem Dienstleister.

ARABIC: إذا كنت تتحدث بالعربية فستتوفر لك خدمات المساعدة اللغوية والخدمية مجاناً. أيضاً، تتوفر أدوات وخدمات المساعدة اللغوية والخدمية مجاناً. يمكنك الحصول على معلومات إضافية عن هذه الخدمات من خلال الاتصال بالرقم الموجود على بطاقة ID. يمكنك أيضاً الاتصال بالرقم الموجود على بطاقة ID للحصول على معلومات إضافية عن هذه الخدمات.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также можно получить бесплатно. Позвоните по номеру, указанному на вашей идентификационной карточке участника плана, или обратитесь к своему врачу.

KOREAN: 주의 사항: 한국어를 구사하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 액세스 가능한 형식으로 정보를 제공하기 위해 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 가입자 ID 카드에 기재된 전화번호로 연락하시거나 귀하의 의료 제공자에게 문의하시길 바랍니다.

VIETNAMESE: CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho quý vị. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy gọi số trên thẻ ID Thành viên của quý vị hoặc nói chuyện với nhà cung cấp của quý vị.

PENNSYLVANIA DUTCH: WICHDICH: Wann du Deitsch schwetzst un hoscht Druwwel fer Englisch verschtehe, kenne mer epper beigrige fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf die Nummer uff dei Member ID Card uff odder schwetz mit dei Provider.

LAO: ຂໍຄວນໃສ່ໃຈ: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີໃຫ້ແກ່ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມທີ່ເໝາະສົມ ເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ ແມ່ນມີໃຫ້ແບບບໍ່ໄດ້ເສຍຄ່າອີກດ້ວຍ. ໂທຫາເບີທີ່ຢູ່ໃນບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ ຫຼື ມົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

FRENCH: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro figurant sur votre carte d'adhérent ou parlez à votre prestataire.

POLISH: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie materiały pomocnicze i usługi zapewniające informacje w dostosowanych formatach są również dostępne bezpłatnie. Należy zadzwonić pod numer podany na karcie członkowskiej lub porozmawiać z lekarzem prowadzącym.

HINDI: ध्यान दें: यदि आप हिंदी में बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। अपने सदस्य आईडी कार्ड पर दिए गए नंबर पर कॉल करें या अपने प्रदाता से बात करें।

ALBANIAN: KINI PARASYSH: Nëse flisni shqip, ofrohen shërbime falas të ndihmës gjuhësore. Ndihamat dhe shërbimet e përshtatshme ndihmëse për të ofruar informacion në formate të aksesueshme janë gjithashtu të disponueshme pa pagesë. Telefononi numrin në kartën tuaj të identitetit të Anëtarit ose flisni me ofruesin tuaj të shërbimit.

TAGALOG: BIGYANG-PANSIN: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang mga naaangkop na pantulong na suporta at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang libre. Tawagan ang numero sa iyong card ng Member ID o makipag-usap sa iyong provider.