

### Central Rivers AEA Plan 1 PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <u>www.wellmark.com</u> or call 1-800-524-9242. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: \$1,500 person/\$3,000 family per calendar year. Out-of-Network: \$3,000 person/\$6,000 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Well-child care, in-network services for preventive care/ independent labs/prosthetic limbs/ outpatient mental health/substance abuse and services subject to health and drug card copayments (except inpatient facility copay) are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive 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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductible</u> s.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Health In-Network: \$3,000 person/ \$6,000 family per calendar year. Health Out-Of-Network: \$6,000 person/\$12,000 family per calendar year. Drug Card: \$2,600 person/\$5,200 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See <a href="https://www.wellmark.com">www.wellmark.com</a> or call 1-800-524-9242 for a list of <a href="https://www.network.com">network</a> <a href="https://www.network.com">providers</a> .	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</u> 's <u>network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an out-of- <u>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> .



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> per <u>provider</u> per date of service	40% coinsurance	Primary Care Provider (PCP) types can be found in the What You Pay section of your plan document.
	Specialist visit	\$35 <u>copay</u> per <u>provider</u> per date of service	40% coinsurance	Applies to Non-PCP <u>providers</u> . \$20 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> chiropractic services. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	Not covered	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. Out-of-network mammograms and well-child care is subject to deductible and 40% coinsurance. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	40% coinsurance	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in- <u>network</u> outpatient services for mental health/substance abuse.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Tier 1	\$10 copay per prescription	\$10 copay per prescription	Refer to your Blue Rx Complete Drug List to determine the	
If you need drugs to	Tier 2	\$30 <u>copay</u> per prescription	\$30 copay per prescription	tier that applies to a covered drug.  For out-of-network prescription drugs, you may be balance billed.	
treat your illness or condition	Tier 3	\$50 <u>copay</u> per prescription	\$50 copay per prescription	1 copay for 30-day supply.	
More information about prescription drug coverage is available at www.wellmark.com/prescriptions.	Tier 4	\$50 <u>copay</u> per prescription	\$50 <u>copay</u> per prescription	3 <u>copays</u> for 90-day supply (retail). 2 <u>copays</u> for 90-day supply (mail order).	
	Specialty drugs	Generic: \$40 copay per prescription Preferred: \$85 copay per prescription Non-Preferred: \$170 copay per prescription	Not covered	Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program.  See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.	
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse.	
outpatient surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse.	

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Emergency room care	20% coinsurance	20% coinsurance	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Waive cost-share on in-network ambulance services for mental health/substance abuse. For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$20 copay per provider per date of service for facility and physician(s) combined	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	\$500 copay per admission and 40% coinsurance	Reduction for failure to precertify out-of-network services is 25% and will not exceed \$2,000 per calendar year.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	40% coinsurance	None
	Inpatient services	20% coinsurance	Practitioner: 40% coinsurance Facility: \$500 copay per admission and 40% coinsurance	Reduction for failure to precertify out-of-network services is 25% and will not exceed \$2,000 per calendar year.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Reduction for failure to precertify out-of-network services is 25% and will not exceed \$2,000 per calendar year.
	Rehabilitation services	Office: \$20 PCP/\$35 Non-PCP copay per provider per date of service Facility: 20% coinsurance	Inpatient Facility: \$500 copay per admission and 40% coinsurance Other services: 40% coinsurance	Office PCP <u>copay</u> applies to IN office services from Physical and Occupational Therapists and Speech Language Pathologists. \$35 <u>copay</u> per date of service applies to in- <u>network</u> outpatient physical, occupational and speech therapies. Waive <u>coinsurance</u> on in- <u>network</u> outpatient services for mental health/substance abuse.
	Habilitation services	Office: \$20 PCP/\$35 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Inpatient facility: \$500 copay per admission and 40% coinsurance Other services: 40% coinsurance	Office PCP <u>copay</u> applies to IN office services from Physical and Occupational Therapists and Speech Language Pathologists. \$35 <u>copay</u> per date of service applies to in- <u>network</u> outpatient physical, occupational and speech therapies. Waive <u>coinsurance</u> on in- <u>network</u> outpatient services for mental health/substance abuse.
	Skilled nursing care	20% coinsurance	Practitioner: 40% coinsurance Facility: \$500 copay per admission and 40% coinsurance	Reduction for failure to precertify out-of-network services is 25% and will not exceed \$2,000 per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse.
If was a hild was de	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
domai or eye oure	Children's dental check-up	Not covered	Not covered	None

### **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.)

- Acupuncture
- Cosmetic surgery
- Custodial care in home or facility
- Dental care Adult
- Dental check-up
- Extended home skilled nursing
- Eye exam

- Glasses
- Hearing aids
- Long-term care
- Routine eye care Adult
- Routine foot care
- · Weight loss programs

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$15,000 LTM, not covered out-of-network)
- Most coverage provided outside the U.S.

 Private-duty nursing short term intermittent home skilled nursing

**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: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="https://www.detplace">Marketplace</a>. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals</u> <u>Rights</u>: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242.

# 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.

\_\_\_\_\_ To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next page. \_\_\_\_\_

# Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

02/19/2024;07/01/2025;PL001831;RL003838;386464-2;102652-168;00046943;N;NGF

# **About These Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plan</u>s. 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 plan's overall deductible	\$1,500
<ul><li>PCP <u>copayment</u></li></ul>	\$20
<ul> <li>Hospital(facility) <u>coinsurance</u></li> </ul>	20%
<ul><li>Other <u>coinsurance</u></li></ul>	20%

## 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
1000 - 1000	¥ ·—,· · ·

# In this example, Peg would pay:

Cost Sharing				
<u>Deductibles</u>	\$1,500			
<u>Copayments</u>	\$100			
Coinsurance	\$1,400			
What isn't covered				
Limits or exclusions \$60				
The total Peg would pay is	\$3,060			

# Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
<ul><li>Specialist copayment</li></ul>	\$35
<ul> <li>Hospital(facility) <u>coinsurance</u></li> </ul>	20%
<ul><li>Other coinsurance</li></ul>	20%

## This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

# In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
Copayments	\$1,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,270

# Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,500
<ul> <li>Specialist copayment</li> </ul>	\$35
<ul><li>Hospital(facility) <u>coinsurance</u></li></ul>	20%
<ul> <li>Other coinsurance</li> </ul>	20%

### This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

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

Rehabilitation services (physical therapy)

Total Example Cost \$2,800
----------------------------

# In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,500
Copayments	\$200
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,790

The amounts shown in the maternity <u>claim</u> example above are based on amounts using a single per person <u>deductible</u>. Some <u>plans</u> may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

02/19/2024;07/01/2025;PL001831;RL003838;386464-2;102652-168;00046943;N;NGF



# **Wellmark Language Assistance**

### Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

#### Wellmark

- Provides people with disabilities reasonable modifications and free appropriate 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, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark 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: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

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

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意:如果您说普通话,我们可免费为您提供语言协助服务。请拨打800-524-9242或(听障专线:888-781-4262)。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٢٤٢٩-٤٢٥- أو (خدمة الهاتف النصبي: ٢٦٢٤-١٨٧).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົານີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิด ค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တာ်နားသူဉ်ညါ–နမ္မာ်ကတီးကညီကိုဉ်,ကိုဉ်တာမောေးတာ်ဖုံးတာမေးတမဉ်,လာတာာဉ်လက်ဘူးလဲ,အိဉ်လာနဂိုးလီး.ဆဲးကိုးဆူ ၈၀၀–၅၂၄–၅၂၂မှတမှာ(TTY:၈၈၀–၇၈၁–၄၂၆၂)တက္ခု.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) guunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.