



**Benefit Summary:**  
**Effective on or after 1/1/2022**

	WNY Gold Classic (2022)		
	In-Network	Out-of-Network	Additional Information
<b>General Information</b>			
Provider Network	200 Network		
Deductible	\$600 single / \$1,200 family	\$5,000 single / \$10,000 family	
Deductible Administration Type	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	Embedded deductible - once any individual has met the individual deductible, subsequent medical costs will be covered for that individual, even if the family deductible has not been satisfied	
Coinsurance	N/A	50% coinsurance after deductible	
Out of Pocket Maximum	\$4,000 single / \$8,000 family	\$10,000 single / \$20,000 family	
Out of Pocket Administration Type	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	Embedded OOP Max - once any individual has met the individual OOP Max, subsequent medical costs will be covered for that individual, even if the family OOP Max has not been satisfied	
Benefit Administration Date	Plan year		
<b>Dependent Coverage</b>			
Dependent Age	26/26		
Dependent Coverage Ends	End of birth month		
Domestic Partner and Children	Includes coverage for domestic partner and children		
<b>Prescription Drug Coverage</b>			
Prescription Drugs	\$10/\$35/\$70 not subject to deductible	Not Covered	
Mail Order	2.5 copays per 90 day supply	Not Covered	
Is Rx subject to Medical Deductible?	No		

	WNY Gold Classic (2022)		
	In-Network	Out-of-Network	Additional Information
<b>Physician and Other Services</b>			
Primary Office Visit	\$25 copayment after deductible	50% coinsurance after deductible	
Specialist Office Visit	\$40 copayment after deductible	50% coinsurance after deductible	
Telemedicine	Covered in full not subject to deductible	Not covered	
Allergy Injections	\$25 copayment/\$40 copayment after deductible	50% coinsurance after deductible	
Allergy Testing	\$25 copayment/\$40 copayment after deductible	50% coinsurance after deductible	
Outpatient Surgical Procedures (in physician's office)	\$25 copayment/\$40 copayment after deductible	50% coinsurance after deductible	
<b>Emergency and Urgent Care Services</b>			
Emergency Room	\$150 copayment after deductible	Covered as in-network	Cost-share waived if admitted
Ambulance	\$150 copayment after deductible	Covered as in-network	
Urgent Care Center	\$60 copayment after deductible	Covered as in-network	
<b>Preventive Services</b>			
Bone mineral density measurement or test	Covered in full not subject to deductible	50% coinsurance after deductible	
Cholesterol Test (lipid panel)	Covered in full not subject to deductible	50% coinsurance after deductible	
Immunizations	Covered in full not subject to deductible	50% coinsurance after deductible	
Prostate Test (Prostate Specific Antigen "PSA")	Covered in full not subject to deductible	50% coinsurance after deductible	
Routine Physical Exam	Covered in full not subject to deductible	Not covered	
Well Child Visits	Covered in full not subject to deductible	50% coinsurance after deductible	
<b>Hospital Services</b>			
Inpatient Hospital	\$1,000 copayment after deductible	50% coinsurance after deductible	
Outpatient Surgical Procedure (Facility)	\$100 copayment after deductible	50% coinsurance after deductible	
Skilled Nursing Facility	\$1,000 copayment after deductible	50% coinsurance after deductible	
<b>Diagnostic Testing Services</b>			
Laboratory Tests	\$40 copayment after deductible	50% coinsurance after deductible	
Radiology	\$40 copayment after deductible	50% coinsurance after deductible	

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<b>Maternity Services</b>			
Physician Services: Prenatal and Postnatal Care (initial visit)	\$25 copayment after deductible	50% coinsurance after deductible	
Inpatient Maternity	\$1,000 copayment after deductible	50% coinsurance after deductible	
<b>Mental Health and Substance Abuse</b>			
Inpatient Mental Health	\$1,000 copayment after deductible	50% coinsurance after deductible	
Outpatient Mental Health	\$25 copayment after deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Rehab	\$1,000 copayment after deductible	50% coinsurance after deductible	
Inpatient Substance Abuse - Detox	\$1,000 copayment after deductible	50% coinsurance after deductible	
Outpatient Substance Abuse	\$25 copayment after deductible	50% coinsurance after deductible	Up to 20 visits a year may be used for family counseling
<b>Diabetic Supplies and Services</b>			
Diabetic Equipment	\$25 copayment after deductible	50% coinsurance after deductible	Additional benefits available through Livongo.
Insulin and Other Oral Agents	\$25 copayment after deductible	50% coinsurance after deductible	Diabetic drugs and supplies rendered at pharmacy will be covered as a medical benefit. Diabetic drugs rendered at pharmacy are only covered in-network.
Diabetic Medical Supplies (Test strips, Syringes, etc)	\$25 copayment after deductible	50% coinsurance after deductible	Additional benefits available through Livongo.
<b>Rehabilitation Services</b>			
Chiropractic Care	\$25 copayment after deductible	50% coinsurance after deductible	
Physical - Occupational - Speech Therapies	\$25 copayment after deductible	50% coinsurance after deductible	60 combined PT/OT/ST visits per condition per plan year
Pulmonary Rehabilitation	\$40 copayment after deductible	50% coinsurance after deductible	
<b>Additional Services</b>			
Durable Medical Equipment	20% coinsurance after deductible	50% coinsurance after deductible	
Prosthetics and Appliances	20% coinsurance after deductible	50% coinsurance after deductible	Shoe inserts are not covered. For children, the cost of replacements is also covered but only if the previous device has been outgrown.
Home Health Care	\$40 copayment after deductible	50% coinsurance after deductible	40 aggregate visits per year; Home Infusion counts toward home health care visit limit.

	WNY Gold Classic (2022)		
	In-Network	Out-of-Network	Additional Information
<b>Additional Services</b>			
Hospice	\$40 copayment after deductible	50% coinsurance after deductible	
Chemotherapy - Outpatient Facility	\$25 copayment/\$40 copayment after deductible	50% coinsurance after deductible	
Dialysis	\$25 copayment/\$40 copayment after deductible	50% coinsurance after deductible	
Wellness Card	\$250 per contract	N/A	Benefit allowance accessible through the use of a debit card, at participating providers for exercise centers, fitness clubs, gyms, and recreational or sports camps.
<b>Pediatric Vision Services</b>			
Routine Exam	Covered in full not subject to deductible	Not covered	One routine exam every calendar year; coverage up to Age 19
Medical Eye Exam	\$40 copayment after deductible	50% coinsurance after deductible	
<b>Adult Vision Services</b>			
Routine Exam	Covered in full not subject to deductible	Not covered	One routine exam every calendar year
Medical Eye Exam	\$40 copayment after deductible	50% coinsurance after deductible	
<b>Pediatric Dental Services</b>			
Preventive Dental Care	\$25 copayment not subject to deductible	Not covered	2 per calendar year
Major Dental Care	50% coinsurance not subject to deductible	Not covered	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals

\*Cost share may vary based on place of service for services listed above.

\*\*For a list of Medicare Part D creditable coverage prescription drug plans, please refer to our website.

\*\*\*This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.



**See Next Insert for Summary of Benefits and Coverage**

**What this Plan Covers & What You Pay For Covered Services**



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, go to [www.bcbswny.com](http://www.bcbswny.com) or call 1-888-249-2583. 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.bcbswny.com](http://www.bcbswny.com) or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In- <a href="#">network</a> : \$600 individual / \$1,200 family; Out-of- <a href="#">network</a> : \$5,000 individual / \$10,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive services</a> are not subject to the <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. This <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In- <a href="#">network</a> : \$4,000 individual / \$8,000 family; Out-of- <a href="#">network</a> : \$10,000 individual / \$20,000 family	If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbswny.com">www.bcbswny.com</a> or call 1-888-249-2583 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	Covered in full	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$40 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
	Imaging (CT/PET scans, MRIs)	\$40 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbswny.com">www.bcbswny.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copayment</a>	<a href="#">Not covered</a>	Some generic drugs may be subject to non-preferred brand <a href="#">cost share</a> .
	Preferred brand drugs (Tier 2)	\$35 <a href="#">copayment</a>	<a href="#">Not covered</a>	None
	Non-preferred brand drugs (Tier 3)	\$70 <a href="#">copayment</a>	<a href="#">Not covered</a>	None
	<a href="#">Specialty drugs</a> (Tier 4)	See limitations & exceptions	See limitations & exceptions	<a href="#">Specialty drugs</a> could be generic, preferred brand or non-preferred brand. Please visit our website for a copy of our medication guide.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
	Physician/surgeon fees	Covered in full	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copayment</a>	Covered as in- <a href="#">network</a>	None
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copayment</a>	Covered as in- <a href="#">network</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
	<a href="#">Urgent care</a>	\$60 <a href="#">copayment</a>	Covered as in- <a href="#">network</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,000 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required.
	Physician/surgeon fees	Covered in full	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copayment</a> for Mental Health; \$25 <a href="#">copayment</a> for Substance Abuse	50% <a href="#">coinsurance</a> for Mental Health; 50% <a href="#">coinsurance</a> for Substance Abuse	Up to 20 visits a year may be used for family counseling
	Inpatient services	\$1,000 <a href="#">copayment</a> for Mental Health; \$1,000 <a href="#">copayment</a> for Substance Abuse Detox; \$1,000 <a href="#">copayment</a> for Substance Abuse Rehab	50% <a href="#">coinsurance</a> for Mental Health; 50% <a href="#">coinsurance</a> for Substance Abuse Detox; 50% <a href="#">coinsurance</a> for Substance Abuse Rehab	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
If you are pregnant	Office visits	\$25 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	None
	Childbirth/delivery professional services	\$25 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	For participating <a href="#">providers</a> , <a href="#">cost share</a> applies only to initial visit to determine pregnancy.
	Childbirth/delivery facility services	\$1,000 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$40 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details. 40 aggregate visits per year; Home Infusion counts toward <a href="#">home health care</a> visit limit.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	60 combined PT/OT/ST visits per condition per <a href="#">plan</a> year
	<a href="#">Habilitation services</a>	\$25 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	60 combined PT/OT/ST visits per condition per <a href="#">plan</a> year
	<a href="#">Skilled nursing care</a>	\$1,000 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> required on certain procedures. Call the number on the back of your ID card for details.
	<a href="#">Hospice services</a>	\$40 <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's eye exam	Covered in full	<a href="#">Not covered</a>	Member <a href="#">cost share</a> may vary by <a href="#">plan</a> .
	Children's glasses	Covered in full	<a href="#">Not covered</a>	Discounts may apply.
	Children's dental check-up	\$25 <a href="#">copayment</a>	<a href="#">Not covered</a>	2 per calendar year



## 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
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Private-duty nursing
- Custodial care
- Routine foot care

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

- Bariatric surgery
- Elective Abortion
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)
- Dental
- Infertility treatment

**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: 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). 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 on how 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: 1-888-249-2583.

### 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 1-888-249-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.

Chinese (中文):如果需要中文的帮助，请拨打这个号码 1-888-249-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-249-2583.

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600.00
■ <a href="#">Specialist copayment</a>	\$40.00
■ Hospital (facility) <a href="#">copayment</a>	\$1,000.00
■ Other <a href="#">copayment</a>	\$25.00

**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	\$600
Copays	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,060</b>

**Managing Joe's type 2 Diabetes**

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600.00
■ <a href="#">Specialist copayment</a>	\$40.00
■ Hospital (facility) <a href="#">copayment</a>	\$1,000.00
■ Other <a href="#">copayment</a>	\$25.00

**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	\$600
Copays	\$700
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,420</b>

**Mia's Simple Fracture**

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$600.00
■ <a href="#">Specialist copayment</a>	\$40.00
■ Hospital (facility) <a href="#">copayment</a>	\$1,000.00
■ Other <a href="#">copayment</a>	\$25.00

**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	\$600
Copays	\$600
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,250</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Highmark Blue Cross Blue Shield of Western New York at [www.bcbswny.com](http://www.bcbswny.com) or call 1-888-249-2583.

## Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The 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)
- 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, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan 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: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org)

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

**For assistance in English, call the customer service number listed on your member ID card.**

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বর করতে পররবেয় ই-মেইল করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں۔

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لیے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.