Summary of Gold Classic *Benefits*

Benefit	In-Network	Out-of-Network
General Provisions		
Benefit Period	Plan Year	
Provider Network	WNY HMO/POS 200 Network	
Deductible Individual Family	 $600 $1,200	 $5,000 $10,000
Coinsurance	0% after deductible	50% after deductible
Out-of-Pocket Maximum Individual Family	 $5,500 $11,000	 $10,000 $20,000
Deductible & Out-of-Pocket Max Administration	Embedded	
Domestic Partner and Children	Includes coverage for Domestic Partner and Children	
Office Visits		
Primary Care Provider Office & Telehealth Visits	$25 copay after deductible	50% after deductible
Specialist Office & Telehealth Visits	$40 copay after deductible	50% after deductible
Telemedicine (Well360 Virtual Health)	$0 copay	Not Covered
Allergy Testing & Injections	$25 copay after deductible / $40 copay after deductible	50% after deductible
Prenatal and Postnatal Care Cost-share applies to initial visit only	$25 copay after deductible	50% after deductible
Preventive Care		
Immunizations	Covered in full	50% after deductible
Colorectal cancer screening	Covered in full	50% after deductible
Mammograms	Covered in full	50% after deductible
Routine Physical exams	Covered in full	Not Covered
Routine Gynecological exams	Covered in full	50% after deductible
Routine Diagnostic services	Covered in full	50% after deductible
Well Child Visits	Covered in full	Not Covered
Hospital Services		
Inpatient Hospital	$1000 copay after deductible	50% after deductible
Inpatient Maternity	$1000 copay after deductible	50% after deductible
Outpatient Surgery Facility	$250 copay after deductible	50% after deductible
Skilled Nursing Facility	$1000 copay after deductible Limit: None	50% after deductible
Emergency & Urgent Care Services		
Emergency Room	$150 copay after deductible (waived if admitted)	Covered as In-Network
Ambulance	$150 copay after deductible	Covered as In-Network
Urgent Care Center	$60 copay after deductible	Covered as In-Network
Therapy, Rehabilitative and Habilitative Services		
Chiropractic Care	$25 copay after deductible	50% after deductible
Physical, Occupational, & Speech Therapies Rehabilitative and Habilitative	$25 copay after deductible	50% after deductible

Benefit	In-Network	Out-of-Network
Therapies Benefit Maximum	60 combined PT/OT/ST Visits per condition per plan year	
Respiratory Therapy	$25 copay after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health	$1000 copay after deductible	50% after deductible
Inpatient Substance Abuse Detoxification & Rehabilitation	$1000 copay after deductible	50% after deductible
Outpatient Mental Health	$25 copay after deductible	50% after deductible
Outpatient Substance Abuse Detoxification & Rehabilitation	$25 copay after deductible	50% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	$80 copay after deductible	50% after deductible
Radiology (X-ray, Diagnostic testing)	$40 copay after deductible	50% after deductible
Laboratory Testing & Pathology	$40 copay after deductible	50% after deductible
Other Services		
Diabetic Drugs, Equipment, & Supplies Includes Test strips, Syringes, etc	$25 copay after deductible	50% after deductible
Diabetes Care Management Program	Covered in full	Not Covered
Insulin Cap Mandate	Yes Cost-sharing for Prescription Insulin Drugs is $0	
Dialysis	$40 copay after deductible	50% after deductible
Outpatient Chemotherapy	$25 copay after deductible / $40 copay after deductible	50% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible
Orthotics & Prosthetics	20% after deductible	50% after deductible
Home Health Care	$25 copay after deductible / $40 copay after deductible	50% after deductible
	Limit: 40 aggregate visits per year Aggregate of Visiting Nurse/Home Infusion/Home Health	
Hospice	$40 copay after deductible	50% after deductible
	limit: none	
Wellness Card	$250 per contract	
	Benefit allowance accessible through the use of a debit card, at participating providers for exercise centers, fitness clubs, & gyms	
Prescription Drugs		

Benefit	In-Network	Out-of-Network
Prescription Drug	**Retail Drugs (30-day Supply)** $10 $35 $105 **Mail Order Drugs (90-day Supply)** $25 $87.50 $262.50	
Pediatric Vision Services - Davis Vision National Network		
Exam	Covered in full	Not Covered
Pediatric frame selection	Covered in full	Not Covered
Standard eyeglass lenses (per pair)	Covered in full	Not Covered
Pediatric Dental Services - United Concordia Elite Prime Network		
Preventive Services	$25 copay	Not Covered
Basic Services	50%	Not Covered
Major Services	50%	Not Covered
Medically Necessary Orthodontics	50%	Not Covered

Discrimination is Against the Law

The Claims Administrator/Insurer 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 stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- 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, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。
ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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