


**!** 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, call 1-800-447-8255. 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 1-800-447-8255 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-Network:</b> \$4,600 individual / \$9,200 family.	Generally, you must pay all 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 care</a> and telemedicine are covered before you meet your <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. For example, 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?	There are no other specific <a href="#">deductibles</a> .	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> ?	For participating <a href="#">providers</a> \$9,450 individual / \$18,900 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be 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.EmblemHealth.com">www.EmblemHealth.com</a> or call 1-800-447-8255 for a list of participating <a href="#">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 a non-participating <a href="#">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 <a href="#">out-of-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> ?	Yes	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services, but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), \$50 not subject to <a href="#">deductible</a> .
	<a href="#">Specialist</a> visit	\$75 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Referral required. First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), \$75 not subject to <a href="#">deductible</a> .
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No Charge	Not Covered	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Xray: \$75 <a href="#">copayment</a> after <a href="#">deductible</a> , Lab: \$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> may be required.
	Imaging (CT/PET scans, MRIs)	\$175 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<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.EmblemHealth.com">www.EmblemHealth.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copayment</a> after <a href="#">deductible</a> (retail); \$25 <a href="#">copayment</a> after <a href="#">deductible</a> (mail order)	Not Covered (retail); Not Covered (mail order)	<a href="#">Preauthorization</a> is not required for a covered prescription drug used to treat a substance use disorder, including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. Your cost may be higher if you select a brand name drug when a generic medicine is available. This plan has a Preferred Pharmacy Network.
	Preferred brand drugs (Tier 2)	\$35 <a href="#">copayment</a> after <a href="#">deductible</a> (retail); \$87.50 <a href="#">copayment</a> after <a href="#">deductible</a> (mail order)	Not Covered (retail); Not Covered (mail order)	
	Non-preferred brand drugs (Tier 3)	\$70 <a href="#">copayment</a> after <a href="#">deductible</a> (retail); \$175 <a href="#">copayment</a> after <a href="#">deductible</a> (mail order)	Not Covered (retail); Not Covered (mail order)	
	<a href="#">Specialty drugs</a> (Tier 4)	After <a href="#">deductible</a> : Tier 1: \$10 copay/30 day supply Tier 2: \$35 copay/30 day supply Tier 3: \$70 copay/30 day supply (specialty retail only)	Not Covered (specialty retail only)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	None
	Physician/surgeon fees	\$150 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 <a href="#">copayment</a> after <a href="#">deductible</a>	\$500 <a href="#">copayment</a> after <a href="#">deductible</a>	Waived if admitted to Hospital.
	<a href="#">Emergency medical transportation</a>	\$300 <a href="#">copayment</a> after <a href="#">deductible</a>	\$300 <a href="#">copayment</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,500 <a href="#">copayment</a> after <a href="#">deductible</a> , per admission	Not Covered	<a href="#">Preauthorization</a> required, except for emergency admissions.
	Physician/surgeon fees	\$150 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> required.

\* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com](http://www.emblemhealth.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: \$50 <a href="#">copayment</a> after <a href="#">deductible</a> All Other Outpatient Services: \$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	First 3 visits (any combination of PCP, Specialist, ABA, MH/SUD), \$50 not subject to <a href="#">deductible</a> . Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling.
	Inpatient services	\$1,500 <a href="#">copayment</a> after <a href="#">deductible</a> , per admission	Not Covered	<a href="#">Preauthorization</a> required, except for emergency admissions.
If you are pregnant	Office visits	No Charge	Not Covered	Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA will use the cost sharing for the appropriate service.
	Childbirth/delivery professional services	\$150 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> required.
	Childbirth/delivery facility services	\$1,500 <a href="#">copayment</a> after <a href="#">deductible</a> , per admission	Not Covered	Limited to forty-eight (48) hours for natural delivery and ninety-six (96) hours for caesarean delivery. One (1) home care visit covered in full if discharged early. <a href="#">Preauthorization</a> required.

\* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com](http://www.emblemhealth.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Forty (40) visits per plan year. <a href="#">Preauthorization</a> required.
	<a href="#">Rehabilitation services</a>	Inpatient: \$1,500 <a href="#">copayment</a> after <a href="#">deductible</a> , per admission Outpatient: \$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. <a href="#">Preauthorization</a> required for Inpatient services.
	<a href="#">Habilitation services</a>	Inpatient: \$1,500 <a href="#">copayment</a> after <a href="#">deductible</a> , per admission Outpatient: \$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. <a href="#">Preauthorization</a> required for Inpatient services.
	<a href="#">Skilled nursing care</a>	\$1,500 <a href="#">copayment</a> after <a href="#">deductible</a> , per admission	Not Covered	200 days per plan year. <a href="#">Preauthorization</a> required.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	<a href="#">Hospice services</a>	Inpatient: \$1,500 <a href="#">copayment</a> after <a href="#">deductible</a> Outpatient: \$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	210 days per plan year. Five (5) visits for family bereavement counseling. <a href="#">Preauthorization</a> required for Inpatient services.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	One (1) exam per twelve (12) month period.
	Children's glasses	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	One (1) prescribed lenses and frames per twelve (12)-month period.
	Children's dental check-up	\$50 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	One (1) dental exam & cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays.

\* For more information about limitations and exceptions, see the plan or policy document at [www.emblemhealth.com](http://www.emblemhealth.com).

## 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                                     | • Routine foot care     |
| • Cosmetic Surgery    | • Non-emergency care when traveling outside the U.S. | • Routine hearing tests |
| • Dental Care (Adult) | • Private-duty nursing                               | • Weight loss programs  |

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

- |   |  |   |
|---|--|---|
| • Abortion Services                           | • Chiropractic care                      | • Infertility treatment (Prior Approval required) |
| • Bariatric Surgery (Prior Approval required) | • Hearing aids (Prior Approval required) | • Routine eye care                                |

**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: New York State Department of Financial Services at 1-800-342-3736 or [www.dfs.ny.gov](http://www.dfs.ny.gov) U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/contactEBSA/consumerassistance.html](http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html) 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 or NY State of Health Marketplace at 1-855-355-5777 or [www.nystateofhealth.ny.gov](http://www.nystateofhealth.ny.gov).

**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:

#### **EmblemHealth**

##### **By Phone:**

Please call the number on your ID card.

##### **In writing:**

EmblemHealth  
Grievance and Appeals Department  
P.O. Box 2801  
New York, NY 10116-2807  
Website: [www.emblemhealth.com](http://www.emblemhealth.com)

#### **For All Coverage Types**

##### **New York State Department of Financial Services**

**By Phone:** 1-800-342-3736

##### **In writing:**

New York State Department of Financial Services  
Consumer Assistance Unit  
One Commerce Plaza  
Albany, NY 12257  
Website: [www.dfs.ny.gov](http://www.dfs.ny.gov)

**For HMO Coverage****New York State Department of Health****By Phone:** 1-800-206-8125**In writing:**

New York State Department of Health

Office of Health Insurance Programs

Bureau of Consumer Services - Complaint Unit

Coming Tower - OCP Room 1607

Albany, NY 12237

Email: [managedcarecomplaint@health.ny.gov](mailto:managedcarecomplaint@health.ny.gov)Website: [www.health.ny.gov](http://www.health.ny.gov)**Consumer Assistance Program****New York State Consumer Assistance Program****By Phone:** 1-888-614-5400**In writing:**

Community Health Advocates

633 Third Avenue, 10th Floor

New York, NY 10017

Email: [cha@cssny.org](mailto:cha@cssny.org)Website: [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org)**For Group Coverage:****U.S. Department of Labor****Employee Benefits Security Administration** at 1-866-444-EBSA (3272)Website: [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 Coverage Meet the Minimum Value Standard? 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 1-888-447-8255.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-447-8255.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-447-8255.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-447-8255.

\_\_\_\_\_ *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 [plan's](#) overall [deductible](#) \$4600
- [Specialist copayment](#) \$75
- Hospital (facility) [copayment](#) \$1500
- Other [copayment](#) \$0

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>
---------------------------	-----------------

In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$4,600
<a href="#">Copayments</a>	\$1,800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,460</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$4600
- [Specialist copayment](#) \$75
- Hospital (facility) [copayment](#) \$1500
- Other [copayment](#) \$0

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>
---------------------------	----------------

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$4,600
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,740</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$4600
- [Specialist copayment](#) \$75
- Hospital (facility) [copayment](#) \$1500
- Other [copayment](#) \$0

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>
---------------------------	----------------

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</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: 1-800-390-3522.

\*Note: This [plan](#) may have other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services





**ATTENTION:** Language assistance services, free of charge, are available to you. Call **1-877-411-3625**. TTY/TDD: **711**.

**Español (Spanish)**

ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

**中文 (Traditional Chinese)**

注意：我們免費提供相關的語言協助服務。請致電 **1-877-411-3625** (TTY/TDD: **711**)。

**Русский (Russian)**

ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона TTY/TDD: **711**).

**Kreyòl Ayisyen (Haitian Creole)**

ATANSYON: Gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

**한국어 (Korean)**

주의: 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625**(TTY/TDD: **711**)번으로 전화하십시오.

**Italiano (Italian)**

ATTENZIONE: sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero **1-877-411-3625** (TTY/TDD: **711**).

**אידיש (Yiddish)**

אכטונג: שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625** (TTY/TDD: **711**).

**বাংলা (Bengali)**

মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

**Polski (Polish)**

UWAGA: dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

**العربية (Arabic)**

يُرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجاناً، اتصل على الرقم **1-877-411-3625** أو (TTY/TDD: **711**).

**Français (French)**

ATTENTION : une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le

**1-877-411-3625** (TTY/TDD : **711**).

**اردو (Urdu)**

توجہ دیں: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ **1-877-411-3625** (TTY/TDD: **711**) پر کال کریں۔

**Tagalog (Tagalog)**

NANANAWAGAN NG PANSIN: Mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

**Ελληνικά (Greek)**

ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το **1-877-411-3625** (για άτομα με προβλήματα ακοής (TTY/TDD): **711**).

**Shqip (Albanian)**

VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

## NOTICE OF NONDISCRIMINATION POLICY

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

### EmblemHealth:

- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at **1-877-411-3625** (TTY/TDD: **711**).

If you believe that EmblemHealth 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 EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](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, DC 20201; 1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).