



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 [emblemhealth.com](http://emblemhealth.com) or call 1-888-447-7703. 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-888-447-7703 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0                                                                                                                                                      | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> is 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                            |
| 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> ?       | \$200                                                                                                                                                    | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 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 <a href="http://emblemhealth.com/findcare">http://emblemhealth.com/findcare</a> or call 1-888-447-7703 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 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<br>(You will pay the least)                                                          | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                   | Primary care visit to treat an injury or illness          | No charge                                                                                                   | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                 | <a href="#">Specialist</a> visit                          | No charge                                                                                                   | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                 | <a href="#">Preventive care/screening/immunization</a>    | No charge                                                                                                   | Not covered                                           | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. 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)       | No charge                                                                                                   | Not covered                                           | Preauthorization may be required                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                 | Imaging (CT/PET scans, MRIs)                              | No charge                                                                                                   | Not covered                                           | Preauthorization required                                                                                                                                                                                                                                                                                                                                           |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.emblemhealth.com">www.emblemhealth.com</a> | Tier 1 (Generic drugs)                                    | \$1 <a href="#">copay</a> /prescription (retail)<br>\$2.50 <a href="#">copay</a> /prescription (mail order) | Not covered                                           | Preauthorization 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. |
|                                                                                                                                                                                                                 | Tier 2 (Preferred brand drugs or Formulary brand)         | \$3 <a href="#">copay</a> /prescription (retail)<br>\$7.50 <a href="#">copay</a> /prescription (mail order) | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                 | Tier 3 (Non-preferred brand drugs or Non-formulary brand) | \$3 <a href="#">copay</a> /prescription (retail)<br>\$7.50 <a href="#">copay</a> /prescription (mail order) | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a>                           | Tier 1: \$1 copay/30 day supply<br>Tier 2: \$3 copay/30 day                                                 | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                 |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                           |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Participating Provider<br>(You will pay the least)                | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                  |
|                                                                           |                                                  | supply<br>Tier 3: \$3 copay/30 day supply (specialty retail only) |                                                       |                                                                                                                                                                                                  |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | No charge                                                         | Not covered                                           | None                                                                                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | No charge                                                         | Not covered                                           | Preauthorization required                                                                                                                                                                        |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge                                                         | No charge                                             | Waived if admitted to Hospital                                                                                                                                                                   |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                                         | No charge                                             | None                                                                                                                                                                                             |
|                                                                           | <a href="#">Urgent care</a>                      | No charge                                                         | Not covered                                           |                                                                                                                                                                                                  |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                                         | Not covered                                           | Preauthorization required, except for emergency admissions.                                                                                                                                      |
|                                                                           | Physician/surgeon fees                           | No charge                                                         | Not covered                                           | Preauthorization required                                                                                                                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge                                                         | Not covered                                           | Unlimited visits                                                                                                                                                                                 |
|                                                                           | Inpatient services                               | No charge                                                         | Not covered                                           | Preauthorization 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        | No charge                                                         | Not covered                                           | Preauthorization required                                                                                                                                                                        |
|                                                                           | Childbirth/delivery facility services            | No charge                                                         | 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. Preauthorization required. |
| If you need help recovering or have                                       | <a href="#">Home health care</a>                 | No charge                                                         | Not covered                                           | 40 visit limit. Preauthorization required.                                                                                                                                                       |
|                                                                           | <a href="#">Rehabilitation services</a>          | No charge                                                         | Not covered                                           | 60 visit limit per condition, applied to all                                                                                                                                                     |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information           |
|-----------------------------------------------|-------------------------------------------|----------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------|
|                                               |                                           | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                  |
| <b>other special health needs</b>             |                                           |                                                    |                                                       | therapies combined.                                              |
|                                               | <a href="#">Habilitation services</a>     | No charge                                          | Not covered                                           | 60 visit limit per condition, applied to all therapies combined. |
|                                               | <a href="#">Skilled nursing care</a>      | No charge                                          | Not covered                                           | 200 day limit. Preauthorization required.                        |
|                                               | <a href="#">Durable medical equipment</a> | No charge                                          | Not covered                                           | Preauthorization required                                        |
|                                               | <a href="#">Hospice services</a>          | No charge                                          | Not covered                                           | 210 day limit. Preauthorization required for Inpatient services. |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | Not covered                                        | Not covered                                           | None                                                             |
|                                               | Children's glasses                        | Not covered                                        | Not covered                                           |                                                                  |
|                                               | Children's dental check-up                | Not covered                                        | Not covered                                           |                                                                  |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                             |                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Long-term care</li> </ul>                                                                                   | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>                          | <ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>           |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                             |                                                                                                             |  |
| <ul style="list-style-type: none"> <li>Abortion</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> </ul>                                                                                  | <ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Hearing aids (One purchase every three years)</li> <li>Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Over-the-Counter Credit</li> </ul> |  |

**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: emblemhealth.com or 1-888-447-7703, New York State Department of Financial Services at [www.dfs.ny.gov](http://www.dfs.ny.gov) or call 1-800-342-3736, Community Service Society of New York at [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org) or call 1-888-614-5400, or NY State of Health: <https://nystateofhealth.ny.gov> or 1-855-355-5777. 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: New York State Department of Financial Services at [www.dfs.ny.gov](http://www.dfs.ny.gov) or call 1-800-342-3736. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Community Service Society of New York at [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org) or call 1-888-614-5400.

**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? Not Applicable**

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 1-888-447-7703

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-447-7703

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-447-7703

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-447-7703

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0 |
| ■ Other <a href="#">copayment</a>                               | \$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:

| Cost Sharing                      |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$0         |
| <a href="#">Coinsurance</a>       | \$0         |
| What isn't covered                |             |
| Limits or exclusions              | \$60        |
| <b>The total Peg would pay is</b> | <b>\$60</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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0 |
| ■ Other <a href="#">copayment</a>                               | \$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:

| Cost Sharing                      |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$10        |
| <a href="#">Coinsurance</a>       | \$0         |
| What isn't covered                |             |
| Limits or exclusions              | \$20        |
| <b>The total Joe would pay is</b> | <b>\$30</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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$0 |
| ■ Other <a href="#">copayment</a>                               | \$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:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English ATTENTION:** If you speak another language, 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 **877-411-3625** (TTY: **711**) or speak to your provider.

**Español (Spanish) ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al **877-411-3625** (TTY: **711**) o hable con su proveedor.

**中文 (Simplified Chinese) 注意:** 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 **877-411-3625** (文本电话: **711**) 或咨询您的服务提供商。

**РУССКИЙ (Russian) ВНИМАНИЕ:** Если вы говорите на русском, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону **877-411-3625** (TTY: **711**) или обратитесь к своему поставщику услуг.

**Kreyòl Ayisyen (Haitian Creole) ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksèsib yo disponib gratis tou. Rele nan **877-411-3625** (TTY: **711**) oswa pale avèk founisè w la.

**한국어 (Korean) 주의:** [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. **877-411-3625** (TTY: **711**) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Italiano (Italian) ATTENZIONE:** se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l' **877-411-3625** (tty: **711**) o parla con il tuo fornitore.

**יידיש (Yiddish) נאטיץ:** אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַיִס און באַדינונגס פֿאַר פּראָוויידינג אינפֿאָרמאַציע אין צוטריטלעך פֿאַרמאַטירונגען זענען אויך בנימצא פריי. רופן **877-411-3625** (TTY: **711**) אָדער רעדן מיט דיין טרעגער.

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

**বাংলা (Bengali)** মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। **877-411-3625 (TTY: 711)** নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

**POLSKI (Polish)** UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer **877-411-3625 (TTY: 711)** lub porozmawiaj ze swoim dostawcą.

### العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم **877-411-3625 (711)** أو تحدث إلى مقدم الخدمة.

**Français (French)** ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le **877-411-3625 (TTY: 711)** ou parlez à votre fournisseur.

### اردو (Urdu)

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ **877-411-3625 (TTY: 711)** پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

**Tagalog (Tagalog)** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **877-411-3625 (TTY: 711)** o makipag-usap sa iyong provider.

**Ελληνικά (Greek)** ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το **877-411-3625 (TTY: 711)** ή απευθυνθείτε στον πάροχό σας.

**SHQIP (Albanian)** VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi **877-411-3625 (TTY: 711)** ose bisedoni me ofruesin tuaj të shërbimit.



## NOTICE OF NONDISCRIMINATION POLICY

### Discrimination is Against the Law

EmblemHealth complies with 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.

EmblemHealth does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

### EmblemHealth:

- 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, and 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 contact the Civil Rights Coordinator by calling Customer Service at **877-411-3625** (TTY: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator by writing to the EmblemHealth Grievance and Appeals Department, P.O. Box 2844, New York, NY 10116-2844; faxing them at **212-510-5320**; or calling Customer Service at **877-411-3625**. (Dial **711** for TTY services.) You can file a grievance in person, by mail, by fax, or through your secure member portal. 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 for Civil Rights electronically through the Office for 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; 800-368-1019** (TTY: **800-537-7697**).

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

This notice is available on EmblemHealth's website at [emblemhealth.com/legal/nondiscrimination](https://emblemhealth.com/legal/nondiscrimination).