



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 1-800-624-2414. 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.emblemhealth.com](http://www.emblemhealth.com) or call 1-800-624-2414 to request a copy.

| Important Questions  | Answers   | Why this Matters:  |
|--|---|--|
| <u>What is the overall deductible?</u>                             | \$0   | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.   |
| <u>Are there services covered before you meet your deductible?</u> | In network medical and hospital services are not subject to a deductible.   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| <u>Are there other deductibles for specific services?</u>          | No  | You don't have to meet <u>deductibles</u> for specific services.   |
| <u>What is the out-of-pocket limit for this plan?</u>              | For in network providers \$3,300 Individual / \$6,600 Family.   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <u>What is not included in the out-of-pocket limit?</u>            | Premiums, penalties, balanced-bill charges, and health care this plan doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <u>Will you pay less if you use a network provider?</u>            | Yes. See <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> or call 1-800-447-8255 for a list of participating providers. | 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 charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). <b>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.</b> |
| <u>Do you need a referral to see a specialist?</u>                 | Yes, written approval is required to see a specialist.  | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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   |
|---|--|---|--|--|
|   |  | Network Provider<br>(You will pay the least)                    | Out-of-Network Provider<br>(You will pay the most) |  |
| If you visit a health care <u>provider's</u> office or clinic   | Primary care visit to treat an injury or illness | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  | -----None-----   |
|   | <u>Specialist</u> visit                          | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  | Referral required  |
|   | <u>Preventive care/screening/</u> immunization   | No charge   | Not covered  | Applies to Well Child Visits; Adult Annual Physical Exams; Well Woman Exams; Bone Density Testing. |
| If you have a test  | <u>Diagnostic test</u> (x-ray, blood work)       | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  | Referral required for Specialist Office and Outpatient Hospital.                                   |
|   | Imaging (CT/PET scans, MRIs)                     | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  | Referral required  |
| If you need drugs to treat your illness or condition<br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> . | Generic drugs (Tier 1)                           | Not covered   | Not covered  |  |
|   | Preferred brand drugs (Tier 2)                   | Not covered   | Not covered  |  |
|   | Non-preferred brand drugs (Tier 3)               | Not covered   | Not covered  |  |
|   | <u>Specialty drugs</u> (Tier 4)                  | Not covered   | Not covered  |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | \$50 co-pay   | Not covered  | Preauthorization required  |
|   | Physician/surgeon fees                           | No charge   | Not covered  | Preauthorization required  |
| If you need immediate medical attention   | <u>Emergency room care</u>                       | \$150 co-pay  | \$150 co-pay                                       | Applies to facility charge, waived if admitted.  |
|   | <u>Emergency medical transportation</u>          | No charge   | No charge  | -----None-----   |
|   | <u>Urgent care</u>                               | \$50 co-pay visit   | Not covered  | -----None-----   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | \$100 per admission   | Not covered  | Preauthorization required  |
|   | Physician/surgeon fee                            | No charge   | Not covered  | Preauthorization required  |

| Common Medical Event  | Services You May Need                     | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|---|---|---|--|---|
|   |   | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit   | Not covered  | Unlimited visits. For Substance Abuse care, up to 20 visits per calendar year may be used for family counseling   |
|   | Inpatient services                        | \$100 per admission   | Not covered  | Preauthorization required. However, Preauthorization is not required for emergency admissions.  |
| If you are pregnant   | Office visits                             | No charge   | Not covered  | -----None-----  |
|   | Childbirth/delivery professional services | No charge   | Not covered  | Preauthorization required   |
|   | Childbirth/delivery facility services     | \$100 per admission   | Not covered  | Limited to 48 hours for natural delivery and 96 hours for caesarean delivery. Preauthorization required   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | No charge   | Not covered  | 200 visits per plan year. Preauthorization required.  |
|   | <a href="#">Rehabilitation services</a>   | Inpatient: \$100 per admission<br>Outpatient: Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  | Inpatient: 90 days per plan year combined therapies. Preauthorization required.<br>Outpatient: 90 visits per plan year combined therapies. Preauthorization required. |
|   | <a href="#">Habilitation services</a>     | Inpatient: \$100 per admission<br>Outpatient: Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit | Not covered  |   |
|   | <a href="#">Skilled nursing care</a>      | No charge   | Not covered  | Unlimited days. Preauthorization required.  |
|   | <a href="#">Durable medical equipment</a> | Not covered   | Not covered  |   |
|   | <a href="#">Hospice services</a>          | No charge   | Not covered  | 210 days per plan year. Preauthorization required.  |

| Common Medical Event                   | Services You May Need      | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information                |
|--|----------------------------|--|--|---|
|  |                            | Network Provider<br>(You will pay the least)                                     | Out-of-Network Provider<br>(You will pay the most) |   |
| If your child needs dental or eye care | Children's eye exam        | Preferred: \$0 co-pay visit<br>Participating: \$10 co-pay visit                  | Not covered  | Refractive eye exam   |
|  | Children's glasses         | Frames: \$80 allowance; Standard single, bifocal or trifocal lenses: \$35 co-pay | Not covered  | Available every 24 months through participating EyeMed/ CPS providers |
|  | Children's dental check-up | Not covered  | Not covered  |   |

## 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         | • Hearing aids                                       | • Private-duty nursing |
| • Cosmetic surgery    | • Long-term care                                     | • Routine foot care    |
| • Dental care (Adult) | • Most coverage provided outside the United States   | • Weight loss programs |
|                       | • Non-emergency care when traveling outside the U.S. |                        |

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

|   |   |                            |
|---|---|----------------------------|
| • Bariatric surgery (Prior Approval required) | • Infertility treatment (Prior Approval required) | • Routine eye care (Adult) |
| • Chiropractic 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.

**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 right, 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)

|   |  |
|---|--|
| <p><b><u>For HMO Coverage</u></b></p> <p><b>New York State Department of Health</b></p> <p><b>By Phone:</b> 1-800-206-8125</p> <p><b>In writing:</b></p> <p>New York State Department of Health<br/>Office of Health Insurance Programs<br/>Bureau of Consumer Services – Complaint Unit<br/>Corning Tower – OCP Room 1607<br/>Albany, NY 12237<br/>Email: <a href="mailto:managedcarecomplaint@health.ny.gov">managedcarecomplaint@health.ny.gov</a><br/>Website: <a href="http://www.health.ny.gov">www.health.ny.gov</a></p> | <p><b><u>Consumer Assistance Program</u></b></p> <p><b>New York State Consumer Assistance Program</b></p> <p><b>By Phone:</b> 1-888-614-5400</p> <p><b>In writing:</b></p> <p>Community Health Advocates<br/>633 Third Avenue, 10<sup>th</sup> Floor<br/>New York, NY 10017<br/>Email: <a href="mailto:cha@cssny.org">cha@cssny.org</a><br/>Website: <a href="http://www.communityhealthadvocates.org">www.communityhealthadvocates.org</a></p> <p><b><u>For Group Coverage:</u></b></p> <p><b>U.S. Department of Labor</b></p> <p><b>Employee Benefits Security Administration</b> at 1-866-444-EBSA (3272)<br/>Website: <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a></p> |
|---|--|

### **Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### **Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-2414

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-2414

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-624-2414

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-624-2414

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



**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</a> ( <a href="#">cost sharing</a> )   | \$10  |
| ■ <a href="#">Hospital (facility) cost sharing</a>              | \$100 |
| ■ <a href="#">Other cost sharing</a>                            | \$96  |

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> | \$12,800 |
|---------------------------|----------|

In the example, Peg would pay:

#### Cost Sharing

|                                   |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$300        |
| <u>Coinsurance</u>                | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$96         |
| <b>The total Peg would pay is</b> | <b>\$396</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</a> ( <a href="#">cost sharing</a> )   | \$10  |
| ■ <a href="#">Hospital (facility) cost sharing</a>              | \$100 |
| ■ <a href="#">Other cost sharing</a>                            | \$55  |

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> | \$7,400 |
|---------------------------|---------|

In the example, Joe would pay:

#### Cost Sharing

|                                   |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$780        |
| <u>Coinsurance</u>                | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$55         |
| <b>The total Joe would pay is</b> | <b>\$835</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</a> ( <a href="#">cost sharing</a> )   | \$10 |
| ■ <a href="#">Hospital (facility) cost sharing</a>              | \$50 |
| ■ <a href="#">Other cost sharing</a>                            | \$37 |

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> | \$1,900 |
|---------------------------|---------|

In the example, Mia would pay:

#### Cost Sharing

|                                   |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$0          |
| <u>Copayments</u>                 | \$130        |
| <u>Co-insurance</u>               | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$37         |
| <b>The total Mia would pay is</b> | <b>\$167</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 1-800-318-2596.

\*Note: This plan has 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.

PHTBP1005

7 of 10

### Getting Help in a Language Other than English

ATTENTION: This is an important document. If you need help to understand it, please call the telephone number marked "customer service" on the back of your member ID card [TTY/TDD: 711]. We can give you an interpreter for free in the language you speak.

#### Español (Spanish)

ATENCIÓN: Este es un documento importante. Si necesita ayuda para entenderlo, llame al número telefónico marcado "customer service" que se encuentra en el dorso de su tarjeta de identificación de miembro [TTY/TDD: 711]. Le podemos proporcionar un intérprete que habla su idioma sin ningún costo.

#### 中文 (Traditional Chinese)

注意：這是重要的文件。如果您需要協助來瞭解文件內容，請致電您會員卡背面標記為"customer service"的電話號碼[TTY/TDD : 711]。我們可以為您免費提供您所使用語言的翻譯人員。

#### Русский (Russian)

ВНИМАНИЕ! Это важный документ. Если у Вас возникли трудности с пониманием этого документа и Вам необходима помочь, позвоните по телефону отдела обслуживания клиентов (customer service), указанному на обратной стороне Вашей идентификационной карточки [служба текстового телефона (TTY/TDD): 711]. Мы можем бесплатно предоставить Вам переводчика, который говорит на Вашем языке.

#### Kreyòl Ayisyen (Haitian Creole)

ATANSYON: Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo ki make "customer service" nan do kat ID manm ou [TTY/TDD: 711]. Nou kapab ba ou yon entèpèt gratis nan lang ou pale a.

#### 한국어 (Korean)

주의: 이것은 중요한 문서입니다. 이 문서를 이해하는 데 도움이 필요하시면 회원 ID 카드의 뒷면에 "customer service" 라고 표시된 전화번호[TTY/TDD: 711]로 연락해 주십시오. 저희는 귀하가 사용하는 언어에 대해 무료 통역사를 제공할 수 있습니다.

#### Italiano (Italian)

ATTENZIONE. Questo è un documento importante. Per qualsiasi chiarimento telefoni all "customer service" al numero stampato sul retro della Sua tessera (per i non udenti: 711). Possiamo mettere a disposizione gratis un interprete nella Sua lingua.

#### אידיש (Yiddish)

מעלדונג: דא איז א וויכטיגע דאקסמענט. אויב אויר דארפטע הילפ עס צו פארשטיין, ביטע רופט דעם טעלעפונג נומבער גערופן "customer service" אויף אויער קארטל [TTY/TDD: 711]. מיר קענען אויר געבן אן איבערצעער פרײ אין די שפראך וואו אויר רעדט.

## বাংলা (Bengali)

দৃষ্টি আকর্ষণ করছি: এটি একটি গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয়, তাহলে অনুগ্রহ করে আপনার মেম্বার আইডি কার্ডের উল্টোপিঠে "customer service" চিহ্নিত টেলিফোন নম্বরে [TTY/TDD: 711] কল করুন। আপনি যে ভাষায় কথা বলেন সে-ভাষার জন্য বিনামূল্যে আমরা আপনাকে একজন দোভাসী দিতে পারি।

## Polski (Polish)

UWAGA: To jest ważny dokument. Jeżeli potrzebujesz pomocy w celu zrozumienia jego treści, zadzwoń do „customer service” pod numer telefonu podany na odwrocie karty identyfikacyjnej ubezpieczonego (member ID card) [TTY/TDD: 711]. Możemy bezpłatnie zapewnić usługi tłumacza języka, którym się posługujesz.

## العربية (ARABIC)

انتباه: هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم المشار إليه بـ"customer service" على ظهر بطاقة عضويتك [711:TTY/TDD]. يمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

## Français (French)

ATTENTION : ce document est important. Si vous avez besoin d'aide pour en comprendre le contenu, veuillez composer le numéro «customer service » au dos de votre carte de membre [Sourds et malentendants : 711]. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

## اردو (Urdu)

تو جہ دین: یہ ایک ایم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم "customer service" والے نمبر پر کال کریں جو آپ کے ممبر آئی ڈی کارڈ کی پشت پر درج ہے [ڈی ٹی وائی/ڈی ڈی: 711]۔ آپ جو زبان بولتے ہیں اس میں ہم آپ کو مفت مترجم فرائیم کر سکتے ہیں۔

## Tagalog (Tagalog)

NANAWAGAN NG PANSIN: Ito ay isang mahalagang dokumento. Kung kailangan mo ng tulong para maintindihan ito, pakitawagan ang numero ng telepono na minarkahang "customer service" sa likod ng inyong ID card ng miyembro [TTY/TDD: 711]. Maaari ka naming bigyan ng libreng interpreter sa wikang iyong sinasalita.

## Ελληνικά (Greek)

ΠΡΟΣΟΧΗ: Αυτό το έγγραφο είναι σημαντικό. Εάν χρειάζεστε βοήθεια για να το κατανοήσετε, καλέστε μας στον αριθμό που σημειώνεται ως «customer service» στο πίσω μέρος της κάρτας της συνδρομής σας [αριθμός για άτομα με προβλήματα ακοής (TTY/TDD): 711]. Μπορούμε να σας προσφέρουμε δωρεάν διερμηνεία στη μητρική σας γλώσσα.

## Shqip (Albanian)

VINI RE: Ky është një dokument i rëndësishëm. Nëse ju nevojitet ndihmë për ta kuptuar, ju lutemi telefononi në numrin ku shkruhet "customer service", i cili gjendet ne anen e pasme të kartës tuaj identifikuese të anëtarësisë [Shërbimi rele TTY/TDD: 711]. Ne mund t'ju ofrojmë pa pagesë një përkthyes në gjuhën që flisni ju.

## NOTICE OF NONDISCRIMINATION POLICY

EmblemHealth complies with applicable 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 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, please call the telephone number marked "customer service" on the back of your member ID card.

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 the telephone number marked "customer service" on the back of your member ID card. (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](http://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](http://hhs.gov/ocr/office/file/index.html).