

Summary of Benefits and Coverage (SBC)

Frequently Asked Questions

Q: What is the SBC?

A: The SBC is a standardized document required by federal law that summarizes your health insurance plan's key features, including covered benefits, cost-sharing requirements, and coverage limitations. It helps you easily compare different health plans.

Q: Why did I receive an SBC?

A: The SBC can help you understand your New York City Employees PPO (NYCE PPO) medical plan, effective January 1, 2026. It's mailed to all eligible employees as part of federal requirements.

Q: Why do the coverage examples on page 8 of the SBC not match NYCE PPO benefits exactly?

A: Federal law requires the coverage examples ("Having a Baby," "Managing Diabetes," "Simple Fracture") to be included on all SBCs for all health insurance plans. They are designed to help you compare different plans, not to reflect the specific benefits or costs of NYCE PPO.

Q: Can the coverage examples in the SBC be changed to match our plan?

A: No. Federal guidelines require that these examples be presented exactly as shown in the SBC template. We are not permitted to modify the wording, numbers, or scenarios.

Q: What should I do if I find the examples confusing?

A: Please remember that the examples are shown for illustration only. Your actual costs and coverage may be different. For details about your specific benefits, deductibles, and out-of-pocket maximums, refer to pages 1-6 of your SBC, or call EmblemHealth Customer Service at **212-501-4444** (TTY: **711**) from 8 a.m. to 6 p.m., Monday through Friday.

Q: Why are these examples included?

A: The federal government requires all insurance companies to include these examples in SBCs. They help people compare coverage for similar situations across different insurance plans.

Q: Where can I find information that applies directly to my plan?

A: Pages 1-6 of your SBC provide specific information about your plan's deductibles, copays, coinsurance, and out-of-pocket limits. You can also visit **nyceppo.com** or call EmblemHealth Customer Service at **212-501-4444** (TTY: **711**) from 8 a.m. to 6 p.m., Monday through Friday.

Q: Who can I contact if I have questions about my coverage?

A: For questions about your coverage, visit **nyceppo.com** or call EmblemHealth Customer Service at **212-501-4444** (TTY: **711**) from 8 a.m. to 6 p.m., Monday through Friday.



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 www.nyceppo.com or call 1-212-501-4444. 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/glossary or call 1-212-501-4444 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$0 person / \$0 family in-network \$200 person / \$500 family out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. See durable medical equipment and private-duty nursing.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$200 person participating / \$2,000 person out-of-network annual coinsurance out-of-pocket maximum \$1,250 person out-of-network annual copay out-of-pocket maximum \$7,150 person / \$14,300 family in-network Unlimited out-of-network annual total out-of-pocket maximum	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Penalties, premiums , balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.nyceppo.com or call 1-212-501-4444 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .
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	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$15 copay per visit	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	None
	Specialist visit	No charge	\$30 copay per visit		None
	Preventive care / screening / immunization	No charge	No charge		You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	\$20 copay per visit for x-ray and \$20 copay per visit for blood work	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	None
	Imaging (CT / PET scans, MRIs)	\$25 copay per visit H+H; \$50 copay per visit	\$100 copay per visit		Preauthorization is required for certain Imaging services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.emblemhealth.com .	Base benefit – ACA mandated and diabetic	Not applicable	Insulin: \$0; Diabetic supply only: generic \$5, brand \$15; Opioid withdrawal medication: Tier 1 20% coinsurance w/ \$5 min charge, Tier 2 40% coinsurance w/ \$25 min charge, Tier 3 50% coinsurance w/ \$40 min charge	Not covered	ACA prescription drugs covered at \$0. Cost share for each prescription up to 30-day supply (up to 90-day supply for home delivery). Cost share will only apply to the total out-of-pocket maximum.
	Optional drug rider generic drugs (Tier 1)	Not applicable	Retail: 20% coinsurance with min charge of \$5 or actual cost, if less; Home delivery: \$12.50	Not covered	Prescriptions will not be filled at retail after 2 fills.
	Optional drug rider Preferred Brand drugs (Tier 2)	Not applicable	Retail: 40% coinsurance with min charge of \$25 or actual cost, if less; Home delivery: \$50	Not covered	PICA Specialty prescription drugs not covered. Non-PICA specialty drugs must be dispensed by the specialty pharmacy.
	Optional drug rider Nonpreferred Brand drugs (Tier 3)	Not applicable	Retail: 50% coinsurance with min charge of \$40 or actual cost, if less; Home delivery: \$75	Not covered	Rider coverage only available to those who have selected the optional prescription rider.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	\$500 copay per occurrence; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	Preauthorization is required for certain surgeries.
	Physician / surgeon fees	No charge	No charge	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	See page 1 for out-of-pocket limits .
If you need immediate medical attention	Emergency room care	\$150 copay per visit	\$150 copay per visit	\$150 copay per visit; Deductible waived	Copay waived if admitted within 24 hours
	Emergency medical transportation	No charge air and ground; Not covered nonemergency ground	No charge air and ground; Not covered nonemergency ground	No charge; Deductible waived air and ground; Not covered nonemergency ground	Preauthorization is required for nonemergency air services.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
	Urgent care	\$25 copay per visit H+H; \$50 copay per visit Preferred	\$50 copay per visit	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	\$100 copay per visit CityMD and ProHealth for downstate New York service area
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$300 copay per admission not to exceed \$750 per calendar year combined with skilled nursing care	\$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$250 per day up to a \$500 maximum of the total cost of the service for out-of-network only. See page 1 for out-of-pocket limits .
	Physician / surgeon fees	No charge	No charge	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$15 copay per office visit; No charge other outpatient services	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	Preauthorization is required for partial hospitalization .
	Inpatient services	No charge	\$300 copay per admission not to exceed \$750 per calendar year combined with skilled nursing care; No charge physician	\$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$250 per day up to a \$500 maximum of the total cost of the service for out-of-network only. See page 1 for out-of-pocket limits .
If you are pregnant	Office visits	No charge	No charge	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	Cost sharing does not apply to certain preventive services . Depending on the type of services, deductible , copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). See page 1 for out-of-pocket limits .
	Childbirth / delivery professional services	No charge	No charge		

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
	Childbirth / delivery facility services	No charge	\$300 copay per admission not to exceed \$750 per calendar year	\$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	\$50 copay per episode; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	200 maximum visits per calendar year preferred and participating; 40 maximum visits per calendar year out-of-network; Preauthorization for certain home health visits is required.
	Rehabilitation services	No charge	\$20 copay per visit	After plan deductible is met, you pay the difference between the plan allowance and the provider's fee.	Preauthorization is required after 25 combined visits occupational therapy / physical therapy. Preauthorization is required after 25 visits speech therapy. Habilitation services for learning disabilities are covered to age 3; Not covered from age 3.
	Habilitation services	No charge	\$20 copay per visit		
	Skilled nursing care	No charge	\$300 copay per admission not to exceed \$750 per calendar year combined with inpatient hospital	\$500 copay per admission; 20% coinsurance; Deductible waived; You pay the difference between the plan allowance and the provider's fee.	90 maximum days per calendar year; Preauthorization is required. If you don't get preauthorization , benefits could be reduced by \$250 per day up to a \$500 maximum of the total cost of the service for out-of-network only. See page 1 for out-of-pocket limits .
	Durable medical equipment (DME)	\$100 deductible, combined w/ DME and prosthetics	\$100 deductible, combined w/ DME and prosthetics	\$100 deductible, combined w/ DME and prosthetics. You pay the difference between the plan allowance and the provider's fee.	\$100 deductible per calendar year; Preauthorization is required for DME in excess of \$500 for rentals or \$1,500 for purchases.
	Hospice service	No charge	No charge	Deductible waived; You pay the difference between the plan allowance and the provider's fee.	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Preferred	Participating	Out-of-network	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
- Acupuncture. - Cosmetic surgery. - Dental care.	- Hearing aids. - Long-term care. Preauthorization - You may have to pay for all or a portion of any test, equipment, service, or procedure that is not preauthorized. Contact us to find out what must be preauthorized and whether preauthorization has been given.	- Routine eye care (adult). - Routine foot care. - Weight loss programs.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
- Bariatric surgery (bariatric program included, preauthorization required). - Chiropractic care.	- Infertility treatment (preauthorization required). - Nonemergency care when traveling outside the U.S.	Private-duty nursing (outpatient care; \$250 deductible per calendar year, preauthorization required).

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 U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at **1-877-267-2323** x61565 or www.cciio.cms.gov. 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 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](#). Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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? 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 **1-212-501-4444**.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 **1-212-501-4444**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-212-501-4444**.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff **1-212-501-4444**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-212-501-4444**.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni **1-212-501-4444**.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye **1-212-501-4444**.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang **1-212-501-4444**.

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 preferred pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist visit](#) (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's Type 2 Diabetes

(a year of routine preferred care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$70
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$90

Mia's Simple Fracture

(preferred emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$300

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 aksesib 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 il **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 פֿאַרמאָטירונגען 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. Ndiheja 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 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.

This notice is available on EmblemHealth's website at emblemhealth.com/legal/nondiscrimination.