
 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-447-8255. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-447-8255 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In-Network:</b> \$100 individual / \$200 family. <b>Out-of-Network:</b> \$4,000 individual / \$8,000 family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , primary care visits, generic drugs and telemedicine are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/#preventive-care-benefits/">https://www.healthcare.gov/coverage/#preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 Individual / \$200 Family for drug coverage.	You must pay all the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In-Network:</b> \$2,300 individual / \$4,600 family. <b>Out-of-Network:</b> \$10,000 individual / \$20,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a> or call 1-800-447-8255 for a list of participating <a href="#">providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use a non-participating <a href="#">provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copayment</a> not subject to <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	First 3 In-Network visits (any combination of PCP, ABA, MH/SUD), covered in full.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copayment</a> not subject to <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No Charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Xray: (Performed at PCP/ Freestanding/Specialist/ Outpatient) \$10 <a href="#">copayment</a> / \$10 <a href="#">copayment</a> /\$35 <a href="#">copayment</a> /\$125 <a href="#">copayment</a> , all after <a href="#">deductible</a> , Lab: (Performed at PCP/ Freestanding/Specialist/ Outpatient) \$10 <a href="#">copayment</a> / \$10 <a href="#">copayment</a> /\$35 <a href="#">copayment</a> /\$125 <a href="#">copayment</a> , all not subject to <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> may be required. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.
	Imaging (CT/PET scans, MRIs)	Performed in a Freestanding Facility or Specialist Office: \$35 <a href="#">copayment</a> after <a href="#">deductible</a> Performed in an Outpatient Facility: \$75 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.EmblemHealth.com">www.EmblemHealth.com</a>	Generic drugs (Tier 1)	\$5 <a href="#">copayment</a> not subject to <a href="#">deductible</a> (retail); \$12.50 <a href="#">copayment</a> not subject to <a href="#">deductible</a> (mail order)	Not Covered (retail); Not Covered (mail order)	<a href="#">Preauthorization</a> is not required for a covered prescription drug used to treat a substance use disorder, including a prescription drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. Your cost may be higher if you select a brand name drug when a generic medicine is available. This plan has a Preferred Pharmacy Network.
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copayment</a> after <a href="#">deductible</a> (retail); \$75 <a href="#">copayment</a> after <a href="#">deductible</a> (mail order)	Not Covered (retail); Not Covered (mail order)	
	Non-preferred brand drugs (Tier 3)	\$65 <a href="#">copayment</a> after <a href="#">deductible</a> (retail); \$162.50 <a href="#">copayment</a> after <a href="#">deductible</a> (mail order)	Not Covered (retail); Not Covered (mail order)	
	<a href="#">Specialty drugs</a> (Tier 4)	Tier 1: \$5 copay/30 day supply After <a href="#">deductible</a> : Tier 2: \$30 copay/30 day supply Tier 3: \$65 copay/30 day supply (specialty retail only)	Not Covered (specialty retail only)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	\$250 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Waived if admitted to Hospital.
	<a href="#">Emergency medical transportation</a>	\$250 <a href="#">copayment</a> after <a href="#">deductible</a>	\$250 <a href="#">copayment</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$100 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission	<a href="#">Preauthorization</a> required, except for emergency admissions. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.
	Physician/surgeon fees	\$250 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visits: \$10 <a href="#">copayment</a> not subject to <a href="#">deductible</a> All Other Outpatient Services: \$10 <a href="#">copayment</a> not subject to <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	First 3 In-Network visits (any combination of PCP, ABA, MH/SUD), covered in full. Unlimited visits. For Substance Abuse care, up to twenty (20) visits per plan year may be used for family counseling.
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission	<a href="#">Preauthorization</a> required, except for emergency admissions. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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	\$250 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> required. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission	Limited to forty-eight (48) hours for natural delivery and ninety-six (96) hours for caesarean delivery. One (1) home care visit covered in full if discharged early. <a href="#">Preauthorization</a> required. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$35 <a href="#">copayment</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Forty (40) visits per plan year. <a href="#">Preauthorization</a> required. If you do not get <a href="#">Preauthorization</a> for Out-of-Network services, we will reduce your benefit by \$500 or 50%, whichever is less for you.
	<a href="#">Rehabilitation services</a>	Inpatient: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission Outpatient: \$10/\$35 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. <a href="#">Preauthorization</a> required for Inpatient services.
	<a href="#">Habilitation services</a>	Inpatient: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission Outpatient: \$10/\$35 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. <a href="#">Preauthorization</a> required for Inpatient services.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> , per admission	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	None
	<a href="#">Hospice services</a>	Inpatient: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> Outpatient: \$35 <a href="#">copayment</a> after <a href="#">deductible</a>	Not Covered	210 days per plan year. Five (5) visits for family bereavement counseling. <a href="#">Preauthorization</a> required for Inpatient services.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	One (1) exam per twelve (12) month period.
	Children's glasses	10% <a href="#">coinsurance</a> not subject to <a href="#">deductible</a>	Not Covered	One (1) prescribed lenses and frames per twelve (12)-month period.
	Children's dental check-up	\$10 <a href="#">copayment</a> not subject to <a href="#">deductible</a>	Not Covered	One (1) dental exam & cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays.

### 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>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <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>• Routine hearing tests</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>• Bariatric Surgery (Prior Approval required)</li> <li>• Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (Prior Approval required)</li> <li>• Infertility treatment (Prior Approval required)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care</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: New York State Department of Financial Services at 1-800-342-3736 or [www.dfs.ny.gov](http://www.dfs.ny.gov) U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/contactEBSA/consumerassistance.html](http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596 or NY State of Health Marketplace at 1-855-355-5777 or [www.nystateofhealth.ny.gov](http://www.nystateofhealth.ny.gov).

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

**EmblemHealth****By Phone:**

Please call the number on your ID card.

**In writing:**

EmblemHealth

Grievance and Appeals Department

P.O. Box 2801

New York, NY 10116-2807

Website: [www.emblemhealth.com](http://www.emblemhealth.com)

**For HMO Coverage**

**New York State Department of Health**

**By Phone:** 1-800-206-8125

**In writing:**

New York State Department of Health

Office of Health Insurance Programs

Bureau of Consumer Services - Complaint Unit

Corning Tower - OCP Room 1607

Albany, NY 12237

Email: [managedcarecomplaint@health.ny.gov](mailto:managedcarecomplaint@health.ny.gov)

Website: [www.health.ny.gov](http://www.health.ny.gov)

**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)

**Consumer Assistance Program**

**New York State Consumer Assistance Program**

**By Phone:** 1-888-614-5400

**In writing:**

Community Health Advocates

633 Third Avenue, 10th Floor

New York, NY 10017

Email: [cha@cssny.org](mailto:cha@cssny.org)

Website: [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org)

**For Group Coverage:**

**U.S. Department of Labor**

**Employee Benefits Security Administration** at 1-866-444-EBSA (3272)

Website: [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this Coverage Meet the Minimum Value Standard? Yes.**

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



### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-447-8255.

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

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

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

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

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## About these Coverage Examples



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$820
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$980</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$0

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$820
<a href="#">Coinsurance</a>	\$173
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,148</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$100
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$0

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$1,380
<a href="#">Coinsurance</a>	\$4
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,484</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-390-3522.

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

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



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

**Español (Spanish)**

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

**中文 (Traditional Chinese)**

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

**Русский (Russian)**

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

**Kreyòl Ayisyen (Haitian Creole)**

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

**한국어 (Korean)**

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

**Italiano (Italian)**

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

**אידיש (Yiddish)**

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

**বাংলা (Bengali)**

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

**Polski (Polish)**

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

**العربية (Arabic)**

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

**Français (French)**

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

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

**اردو (Urdu)**

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

**Tagalog (Tagalog)**

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

**Ελληνικά (Greek)**

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

**Shqip (Albanian)**

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

## NOTICE OF NONDISCRIMINATION POLICY

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### EmblemHealth:

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

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

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](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).