EmblemHealth

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2026 to 12/31/2026

EmblemHealth : **Gold Premier**

Coverage for: Individual + Family | Plan Type: POS

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 deductible?	**In-Network:** $500 individual / $1,000 family. **Out-of-Network:** $6,000 individual / $12,000 family	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, primary care visits, generic drugs and telemedicine 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. $150 Individual / $300 Family for drug coverage.	You must pay all 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?	**In-Network:** $8,650 individual / $17,300 family. **Out-of-Network:** $12,000 individual / $24,000 family	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?	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.EmblemHealth.com or call 1-800-447-8255 for a list of participating 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 a non-participating 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.

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	$25 copayment not subject to deductible	50% coinsurance after deductible	First 3 In-Network visits (any combination of PCP, ABA, MH/SUD), covered in full.
	Specialist visit	$50 copayment not subject to deductible	50% coinsurance after deductible	None
	Preventive care / screening / immunization	No Charge	50% coinsurance after deductible	None
If you have a test	Diagnostic test (x-ray, blood work)	Xray: (Performed at PCP/ Freestanding/Spec./ Outpatient) $25 copayment/ $15 copayment/$50 copayment/$150 copayment, all after deductible , Lab: (Performed at PCP/ Freestanding/Spec./ Outpatient) $25 copayment/ $15 copayment/$50 copayment after deductible/ $150 copayment after deductible	50% coinsurance after deductible	Laboratory procedures performed in PCP office or Freestanding facility are not subject to deductible. Preauthorization may be required. If you do not get Preauthorization 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: $50 copayment after deductible Performed in an Outpatient Facility: $175 copayment after deductible	Not Covered	Preauthorization required. If you do not get Preauthorization 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.EmblemHealth.com	Generic drugs (Tier 1)	$7 copayment not subject to deductible (retail); $17.50 copayment not subject to deductible (mail order)	Not Covered (retail); Not Covered (mail order)	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.
	Preferred brand drugs (Tier 2)	$40 copayment after deductible (retail); $100 copayment after deductible (mail order)	Not Covered (retail); Not Covered (mail order)	
	Non-preferred brand drugs (Tier 3)	$85 copayment after deductible (retail); $212.50 copayment after deductible (mail order)	Not Covered (retail); Not Covered (mail order)	
	Specialty drugs (Tier 4)	Tier 1: $7 copay/30 day supply After deductible: Tier 2: $40 copay/30 day supply Tier 3: $85 copay/30 day supply (specialty retail only)	Not Covered (specialty retail only)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copayment after deductible	50% coinsurance after deductible	None
	Physician/surgeon fees	$350 copayment after deductible	50% coinsurance after deductible	Preauthorization required. If you do not get Preauthorization for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less for you.
If you need immediate medical attention	Emergency room care	40% coinsurance after deductible	40% coinsurance after deductible	Waived if admitted to Hospital.
	Emergency medical transportation	$350 copayment after deductible	$350 copayment after deductible	None
	Urgent care	$100 copayment after deductible	50% coinsurance after deductible	None

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 have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible, per admission	50% coinsurance after deductible, per admission	Preauthorization required, except for emergency admissions. If you do not get Preauthorization for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less for you.
	Physician/surgeon fees	$350 copayment after deductible	50% coinsurance after deductible	Preauthorization required. If you do not get Preauthorization for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less for you.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visits: $25 copayment not subject to deductible All Other Outpatient Services: $25 copayment not subject to deductible	50% coinsurance after deductible	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	30% coinsurance after deductible, per admission	50% coinsurance after deductible, per admission	Preauthorization required, except for emergency admissions. If you do not get Preauthorization 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)	
If you are pregnant	Office visits	No Charge	50% coinsurance after deductible	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	$350 copayment after deductible	50% coinsurance after deductible	Preauthorization required. If you do not get Preauthorization for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less for you.
	Childbirth/delivery facility services	30% coinsurance after deductible, per admission	50% coinsurance after deductible, 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. Preauthorization required. If you do not get Preauthorization 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)	
If you need help recovering or have other special health needs	Home health care	$50 copayment after deductible	50% coinsurance after deductible	Forty (40) visits per plan year. Preauthorization required. If you do not get Preauthorization for Out-of-Network services, we will reduce your benefit by $500 or 50%, whichever is less for you.
	Rehabilitation services	Inpatient: 30% coinsurance after deductible, per admission Outpatient: $25/$50 copayment after deductible	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required for Inpatient services.
	Habilitation services	Inpatient: 30% coinsurance after deductible, per admission Outpatient: $25/$50 copayment after deductible	Not Covered	Inpatient: Sixty (60) days per condition/per plan year, combined therapies. Outpatient: Sixty (60) visits per condition/per plan year, combined therapies. Preauthorization required for Inpatient services.
	Skilled nursing care	30% coinsurance after deductible, per admission	Not Covered	Preauthorization required.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	Preauthorization required.
	Hospice services	Inpatient: 30% coinsurance after deductible Outpatient: $50 copayment after deductible	Not Covered	210 days per plan year. Five (5) visits for family bereavement counseling. Preauthorization required for Inpatient services.

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 your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One (1) exam per twelve (12) month period.
	Children's glasses	20% coinsurance not subject to deductible	Not Covered	One (1) prescribed lenses and frames per twelve (12)-month period.
	Children's dental check-up	$25 copayment not subject to deductible	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 Plan Generally 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 (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Routine hearing tests
- 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 (Prior Approval required)
- Chiropractic care
- Hearing aids (Prior Approval required)
- Infertility treatment (Prior Approval required)
- Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services at 1-800-342-3736 or www.dfs.ny.gov U.S. Department of Health and Human Services at 1-877-267-2323 x1565 or 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 or 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 or call 1-800-318-2596 or NY State of Health Marketplace at 1-855-355-5777 or 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

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
Website: 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

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
Website: 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

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, kwiijigo holne' 1-888-447-8255.

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

* For more information about limitations and exceptions, see the plan or policy document at www.emblemhealth.com.

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** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **30%**
- **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **30%**
- **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,000**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **30%**
- **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services

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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 fòma 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 l' **877-411-3625** (tty: **711**) o parla con il tuo fornitore.

(**Yiddish**) **יידיש** נאטיץ: אויב איר רעדט יידיש, שפראך הילף סערוויסעס זענען בארעכטיגט פאר דיר פריי. צונעמען אַידס און באַדינונגס פֿאַר פֿראַוויידינג אינפֿאָרמאַציע אין צוטריטלעך פֿאָרמאַטירונגען 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۔ (TTY: **711**) **877-411-3625** 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** 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**.