



**EmblemHealth VIP Premier (HMO) Group Plan
2021 Cost Sharing guide for Medicare members**

Benefits	Your Cost-Sharing
Deductible - The amount you pay before your plan starts to pay.	\$0
Maximum out-of-pocket - The most you will have to pay for services. This does not include prescription drugs.	\$7,550 per year. This includes copays and deductibles

Inpatient Hospital Coverage	
Inpatient hospital coverage* - You pay this amount if you are admitted to a hospital.	\$50 per day 1-5 \$0 per day 6-90 Unlimited days
Outpatient Hospital Coverage	
Ambulatory Surgery Center*	\$50
Outpatient Surgery Center*	\$150
Renal (Kidney) dialysis	10% of the cost
Doctor Visits	
Primary care provider (In person/telehealth)	\$0 per visit
Specialist (In person/telehealth)	\$10 per visit (referral may be required)
Foot care	\$10 per visit (includes 4 routine visits per year)
Chiropractic care*	\$10 per visit
Preventive care (e.g., annual physical exam, flu, and pneumonia vaccines)	Covered in full
Emergency Care	\$90 per visit \$50 Worldwide coverage \$0 if admitted within 1 day
Urgently Needed Services	\$10 per visit
Diagnostic Services/Labs/Imaging*	
Diagnostic services including EKG	\$0
Hi-tech radiology including MRI, MRA, CAT scans, Pet scans	\$50
Lab tests	\$0
X-ray	\$10
Radiation therapy	\$50

Hearing Services	
Medicare-covered hearing exam	\$10
Routine hearing exam	\$10 per yearly visit
Hearing aid	Plan pays up to \$500 toward the purchase of a hearing aid every 36 months

Dental Services	
Preventive dental care	Not Covered
Comprehensive dental care	Not Covered
Dental discount	\$5 per exam every 6 months \$10 per visit every 6 months for prophylaxis Additional services provided at a discounted rate subject to fee schedule

Vision Services	
Routine eye exam	\$15 per yearly visit
Medicare-covered eyewear	\$0 if you get a new prescription as a result of cataract surgery
Routine eyewear	\$0 for one pair of eyeglasses or contact lenses

Mental Health Services*	
Inpatient: no limit in a general hospital; 190- day lifetime limit in a psychiatric facility.	\$50 per day for days 1-5 \$0 per day for days 6-90
Outpatient mental health therapy	\$10 per visit Individual sessions in person/telehealth

Skilled Nursing Facility*	
Nursing home following hospital stay up to 100 days per benefit period	\$0 per day for days 1-20 \$50 per day for days 21-100 Prior hospital stay not required

Substance Abuse Services*	
Outpatient alcohol and substance abuse therapy	\$10 per visit Individual sessions in person/telehealth

Transportation	
Ground ambulance	\$50 per trip
Ambulance air	20% per trip
Routine transportation	Not Covered

Rehabilitation – Therapies*	
Physical therapy	\$10 per visit
Speech therapy	\$10 per visit
Occupational therapy	\$10 per visit
Cardiac rehabilitation	\$10 per visit
Intensive cardiac rehabilitation	\$10 per visit
Pulmonary rehabilitation	\$10 per visit
Supervised exercise therapy for symptomatic peripheral artery disease	\$10 per visit

Part B Drugs*	10% of the cost Step therapy may apply.
----------------------	---

Prescription Drug Coverage				
Tier Level	Initial Coverage \$0 - \$4,130 30-day supply		Coverage Gap \$4,131 - \$6,550	Catastrophic Over \$6,550
	At Preferred Pharmacies	At Standard Pharmacies	You Pay	You Pay
Tier 1: Preferred Generic	\$0	\$5	\$0 at preferred pharmacies; or \$5 at standard pharmacies	\$3.70 or 5% of the cost
Tier 2: Generic	\$10	\$15	\$10 at preferred pharmacies; or \$15 at standard pharmacies	\$3.70 or 5% of the cost
Tier 3: Preferred Brand	\$40	\$47	\$40 at preferred pharmacies; or \$47 at standard pharmacies	\$9.20 or 5% of the cost
Tier 4: Non- Preferred Drug	23% of the cost	25% of the cost	23% of the cost for generics at preferred pharmacies; or 25% of the cost for generics at standard pharmacies or brand	\$3.70, \$9.20 or 5% of the cost
Tier 5: Specialty	33% of the cost	33% of the cost	33% of the cost at preferred or standard pharmacies	\$3.70, \$9.20 or 5% of the cost

Other Benefits	
Durable medical equipment (DME)*	10% of the cost
Home health care (non-custodial) *	\$0
Acupuncture (for chronic low back pain)*	\$10 per visit for up to 20 visits every year
Fitness benefit - SilverSneakers®	Not Covered
Over-the-counter health items (OTC)	Not Covered
Teladoc® - virtual visit to get care for non-urgent conditions	Not Covered
Opioid treatment	\$10 per visit

IMPORTANT INFORMATION

You can find a full list of the preventive services in your Evidence of Coverage (EOC) at emblemhealth.com/Medicare.

** Prior authorization rules may apply.*

All services covered in this Cost Sharing Guide are subject to medical necessity review.

*This information is not a complete description of benefits. Call **877-344-7364 (TTY: 711)** for more information.*

*If you have questions, or want to request a copy of the EOC, call Customer Service at **877-344-7364 (TTY: 711)**. Our hours are 8 a.m. to 8 p.m., seven days a week. Or, visit us at emblemhealth.com/medicare.*