EmblemHealth VIP Premier (HMO) Group
2025 Cost Sharing Guide for Medicare Members

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 each year. This includes copays and deductibles. This does not include prescription drugs)	**$8,850**

The information listed below and on the following pages is not a complete description of benefits. You can find the full list of benefits and plan rules in your Evidence of Coverage, available online at emblemhealth.com/medicare

Inpatient Hospital Coverage	What You Pay
Inpatient Hospital - Acute	Days 1-5: **$150** per day **$0** per additional day
Inpatient Hospital – Mental Health Services (No limit in a general hospital; 190-day lifetime limit in a psychiatric facility)	Days 1-5: **$150** per day Days 6-90: **$0** per day
Skilled Nursing Facility	Days 1-20: **$0** per day Days 21-100: **$100** per day
Outpatient Hospital Coverage	**What You Pay**
Outpatient Hospital Services (Includes surgery, observation, clinic)	**$150** ($0 for Diagnostic Colonoscopy)
Ambulatory Surgery Centers	**$50** ($0 for Diagnostic Colonoscopy)
Renal (Kidney) Dialysis	**20%** of the cost
Doctor visits	**What You Pay**
Primary Care Provider (PCP) (In-office/telehealth)	**$10**
Specialist (referral may be required) (In-office/telehealth)	**$20**
Outpatient Services	**What You Pay**
Preventive Services (Includes annual physical exam, screenings, and some Part B immunizations)	**Covered in full**
Emergency Care (Worldwide Coverage)	**$90** waived if admitted within 1 day
Urgently Needed Services	**$10**

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Diagnostic Services	What You Pay
Diagnostic Procedures & Tests	**$0**
Diagnostic Radiology (High-tech radiology including PET scans, MRIs, MRAs, CAT scans etc.)	**$50** ($0 for Diagnostic Mammograms)
Lab Services	**$0**
Radiation Therapy	**$50**
X-Ray	**$20**
Hearing Services	**What You Pay**
Medicare-Covered Hearing Exam (referral may be required)	**$20**
Routine Hearing Exam (referral may be required)	**$20** (1 exam every year)
Hearing Aid	Up to **$500** benefit limit every 3 years
Vision Services	**What You Pay**
Medicare-Covered Eye Exam	**$15**
Routine Eye Exam	**$15** (1 exam every year)
Routine Eyewear	**$0** for one pair of eyeglasses up to **$150** benefit limit **or** **$0** for contact lenses up to **$110** benefit limit
Mental Health Services	**What You Pay**
Mental Health & Substance Abuse (Individual session in-office/telehealth)	**$20**
Opioid Treatment	**$20**
Partial Hospitalization / Intensive Outpatient Services	**$20**
Dental Services	**What You Pay**
Preventive and Comprehensive Dental Care / Dental Discount	**Not Covered**

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Rehabilitation Services	What You Pay
Cardiac Rehabilitation (In-office/telehealth)	**$20**
Intensive Cardiac Rehabilitation	**$20**
Occupational Therapy	**$20**
Physical Therapy (referral may be required)	**$20**
Pulmonary Rehabilitation	**$20**
Speech Therapy	**$20**
Supervised Exercise Therapy (SET) (For symptomatic peripheral artery disease)	**$20**
Transportation Services	**What You Pay**
Ground Ambulance (Within USA/Worldwide)	**$50 / $90** (one-way)
Air Ambulance	**20%** of the cost (one-way)
Routine Transportation	**Not Covered**
Outpatient Services	**What You Pay**
Acupuncture (Medicare-covered) (For chronic lower back pain)	**$20**
Chiropractic Services (Medicare-covered only)	**$15**
Podiatry (referral may be required) (includes up to 4 routine visits per year)	**$20**
Part B Drugs	**What You Pay**
Medicare Part B drugs	**0% - 20%** of the cost ($35 one-month supply of insulin)
Other Service and Supplies	**What You Pay**
Diabetes Self-Monitoring & Training	**$0**
Diabetic Supplies	**$0**
Durable Medical Equipment and Prosthetics/Medical Supplies	**20%** of the cost
Home Health Agency Care	**$0**

Prescription Drug Coverage				
Initial Coverage Stage				
You pay the following until your out-of-pocket drug costs reach $2,000	30-day supply Retail Preferred Pharmacy	30-day supply Retail Standard Pharmacy	90-day supply Mail order Preferred Pharmacy	90-day supply Mail order Standard Pharmacy
	What You Pay	What You Pay	What You Pay	What You Pay
Tier 1: Preferred Generic	**$0**	**$5**	**$0**	**$15**
Tier 2: Generic	**$10**	**$15**	**$30**	**$45**
Tier 3: Preferred Brand	**$40** **$35 insulins**	**$47** **$35 insulins**	**$120** **$105 insulins**	**$141** **$105 insulins**
Tier 4: Non-Preferred Drug	**23%** of the drug cost	**25%** of the drug cost	**23%** of the drug cost	**25%** of the drug cost
Tier 5: Specialty Tier*	**33%** of the drug cost		Not available in long-term supply	
Tier 6: Select Care Drugs	**$0**	**$0**	**$0**	**$0**

*Tier 5: Specialty Drugs (brand and generic) are available only for 30-day supply.

Catastrophic Coverage Stage	
You pay the following after your out-of-pocket drug costs reach $2,000	Retail Pharmacy and Mail Order What You Pay
All Covered Drugs	**$0**

IMPORTANT INFORMATION

All services covered in this Cost Sharing Guide are subject to medical necessity review. For more information about your benefits, including exclusions, limitations, or specific conditions, see your 2025 Medicare Plan Evidence of Coverage (EOC). In the event of a discrepancy between the information contained in the guide and the provisions of your 2025 Medicare EOC, the specific provisions of the EOC shall prevail over the cost-sharing guide.

Please note that prior authorization is required before you receive certain covered services.

*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, October 1 to March 31, and 8 a.m. to 8 p.m., Monday through Saturday, April 1 to September 30. Or visit us at **emblemhealth.com/medicare.***