EmblemHealth

EmblemHealth VIP Premier (HMO) Group Plan
2022 Cost Sharing guide for Medicare members residing in Bronx, Kings, New York, and Queens counties

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 Hospital Services*	**$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 up to **$150** benefit limit **OR $0** for one pair of contact lenses up to **$110** benefit limit

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 - $4,430 30-day supply**		**Coverage Gap $4,431 - $7,050**	**Catastrophic Over $7,050**
	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	**$3.95** or **5%** of the cost
Tier 2: Generic	**$10**	**$15**	**$10** at preferred pharmacies; or **$15** at standard pharmacies	**$3.95** or **5%** of the cost
Tier 3: Preferred Brand	**$40**	**$47**	**$40** at preferred pharmacies; or **$47** at standard pharmacies	**$9.85** 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	**$3.95**, **$9.85** or **5%** of the cost
Tier 5: Specialty	**33%** of the cost	**33%** of the cost	**25%** of the cost at preferred or standard pharmacies	**$3.95**, **$9.85** 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**.*