EmblemHealth

EmblemHealth VIP Premier (HMO) Group
2024 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	**$50** per day for days 1-5; **$0** per day for each additional day
Inpatient Hospital – Mental Health Services (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
Skilled Nursing Facility	Days 1-20: **$0** per day Days 21–100: **$50** per day
Outpatient Hospital Coverage	**What you pay**
Outpatient Hospital Services (Includes surgery, observation, clinic)	**$150**
Ambulatory Surgery Centers	**$50**
Renal (Kidney) Dialysis	**10%** of the cost
Doctor visits	**What you pay**
Primary Care Provider (PCP) (In office/Telehealth)	**$0**
Specialist (referral may be required) (In office/Telehealth)	**$10**

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** copay waived if admitted within 1 day
Urgently Needed Services	**$10**
Diagnostic Services	**What you pay**
Diagnostic Procedures & Tests	**$0**
Diagnostic Radiology (High-tech radiology including PET scans, MRIs, MRAs, CAT scans etc.)	**$50**
Lab Services	**$0**
Radiation therapy	**$50**
X-Ray	**$10**
Hearing Services	**What you pay**
Medicare-Covered Hearing Exam (referral may be required)	**$10**
Routine Hearing Exam (referral may be required)	**$10**
Hearing Aid	Up to **$500** allowance every 36 months
Vision Services	**What you pay**
Medicare-Covered Eye Exam	**$15**
Routine Eye Exam	**$15**
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	**What you pay**
Mental Health & Substance Abuse (Individual session in-person/telehealth)	**$10**
Opioid Treatment	**$10**
Partial Hospitalization	**$10**

Dental Services	What you pay
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
Rehabilitation Services	**What you pay**
Cardiac Rehabilitation (In office/Telehealth)	**$10**
Intensive Cardiac Rehabilitation	**$10**
Occupational Therapy	**$10**
Physical Therapy (referral may be required)	**$10**
Pulmonary Rehabilitation	**$10**
Speech Therapy	**$10**
Supervised Exercise Therapy (SET) (For symptomatic peripheral artery disease)	**$10**
Transportation Services	**What you pay**
Ground Ambulance	**$50** (one-way)
Air Ambulance	**20%** of the cost (one-way)
Routine Transportation	**Not Covered**
Outpatient Services	**What you pay**
Acupuncture (For chronic lower back pain)	**$10**
Chiropractic Services (Medicare-covered only)	**$10**
Podiatry (referral may be required) (includes up to 4 routine visits per year)	**$10**

Part B Drugs	What you pay
Medicare Part B drugs (In the home)	**0% to 10%** of the cost (up to $35 one-month supply of insulin)
Medicare Part B drugs (Dispensed at a retail pharmacy, mail order pharmacy, physician office, and outpatient facility)	**0% to 10%** of the cost (up to $35 one-month supply of insulin)
Other Services and Supplies	**What you pay**
Diabetes Self-Monitoring & Training	**$0**
Diabetic Supplies	**$0**
Durable Medical Equipment and Prosthetics/Medical Supplies	**10%** of the cost
Fitness benefit with SilverSneakers®	**Not Covered**
Home Health Agency Care	**$0**
Over-the-Counter Health Items (OTC)	**Not covered**
Teladoc® (Virtual visit to get care for non-urgent conditions)	**Not covered**

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Prescription Drug Coverage				
Initial Coverage Limit (ICL)				
You pay the following until your total yearly drug costs reach $5,030	**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*	**33%** of the drug cost	**33%** of the drug cost	**n/a**	**n/a**
Tier 6: Select Care Drugs	**$0**	**$0**	**$0**	**$0**
Coverage Gap				
You pay the following after your total yearly drug costs exceed $5,030	**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*	**25%** of the drug cost	**25%** of the drug cost	**n/a**	**n/a**
Tier 6: Select Care Drugs	**$0**	**$0**	**$0**	**$0**
Catastrophic Coverage				

You pay the following once your true yearly out-of-pocket drug costs exceed $8,000	Retail Pharmacy and Mail Order What you pay
All Covered Drugs	**$0**

*Tier 5 specialty drugs (brand and generic) are available only for 30-day supply.

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 2024 Medicare Plan Evidence of Coverage (EOC). In the event of a discrepancy between the information contained in the guide and the provisions of your 2024 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. Or, visit us at **emblemhealth.com/medicare.***