EmblemHealth®

VIP® PREMIER MEDICARE PLAN
2016 Summary of Benefits
For Medicare-Eligible Retirees Residing in Manhattan, Brooklyn, Bronx, Staten Island, Queens, Nassau, Suffolk & Westchester Counties

➢ PROFESSIONAL SERVICES	2016 Medicare Plan
PCP office visits	Covered in full
Specialist office visits	$10 copay per visit
Annual physical exam/preventive care	Covered in full
Physical, Speech & Occupational Therapy	$10 copay per visit
Cardiac/Pulmonary Rehab	$10 copay per visit
Flu & Pneumonia Vaccinations	Covered in full
Diagnostic Services including X-ray, Lab Tests, EKG's	Covered in full
Routine Foot Care (Up to 4 visit per year)	$10 copay per visit
Chiropractic Care	$10 copay per visit

➢ INPATIENT HOSPITAL SERVICES	2016 Medicare Plan
Surgeon & physician fees	Covered in full
Semi-private room and board	Covered in full
Anesthesia	Covered in full
Nursing care (hospital provided)	Covered in full
X-ray & Lab tests (inpatient)	Covered in full
Prescribed drugs	Covered in full
Operating & recovery room fees	Covered in full
Intensive Care Unit	Covered in full
Therapy (physical, speech and occupational therapy)	Covered in full

➢ OUTPATIENT FACILITY SERVICES	2016 Medicare Plan
Ambulatory surgery	$50 copay per visit
Emergency room fees	$50 copay per visit (waived if admitted within 1 day)
Ambulance service to the hospital (Non-emergent ambulance transportation requires authorization)	$50 copay per service
Renal dialysis	Covered in full
X-ray & Lab tests (outpatient)	Covered in full
Diagnostic Services including MRI's, MRA's, PET, and CAT Scans	Covered in full
Radiation Therapy	Covered in full

➢ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	2016 Medicare Plan
Mental Health Care	
• Inpatient: no limit in a general hospital; 190-day lifetime limit in a psychiatric facility	Covered in full
• Outpatient therapy	Covered in full
Alcohol and Substance Abuse Care	
• Inpatient: based on medical necessity, up to Medicare limits	Covered in full
• Inpatient Detoxification	Covered in full
• Outpatient therapy	Covered in full

➢ PRESCRIPTION DRUGS	2016 Medicare Plan
When prescribed by a Participating Provider and filled by a participating pharmacy	Deductible: $0 Initial Coverage Limit (ICL): $3,310 Preferred Generic: $10 copay per 30-day supply, $20 copay per 60-day supply, $30 copay per 90-day supply Generic: $10 copay per 30-day supply, $20 copay per 60-day supply, $30 copay per 90-day supply Preferred Brand: $40 copay per 30-day supply, $80 copay per 60-day supply, $120 copay per 90-day supply Non-Preferred Brand: 33% coinsurance Specialty: 33% coinsurance
When prescribed by a Participating Provider and filled by a participating mail order vendor.	Mail Order: Preferred Generic: $10 copay per 30-day supply, $20 copay per 60-day supply, $20 copay per 90-day supply Generic: $10 copay per 30-day supply, $20 copay per 60-day supply, $20 copay per 90-day supply

	Preferred Brand: $40 copay per 30-day supply, $80 copay per 60-day supply, $80 copay per 90-day supply Non-Preferred Brand: 33% coinsurance Specialty: 33% coinsurance **Coverage Gap:** Member pays copays and coinsurance listed above until reaching a benefit limit of $4,850. **Catastrophic Coverage:** When a member reaches $4,850 of true out-of-pocket (TrOOP) costs for the calendar year, the member will pay the greater of $2.95 copay for generic, $7.40 copay for brand, or 5% coinsurance.
➢ **PART B DRUGS**	Covered in full

➢ **OTHER BENEFITS**	**2016 Medicare Plan**
Skilled Nursing Facility Care Up to 100 days per benefit period	$0 copay per day (days 1-20) $25 copay per day (days 21-100)
Home Health Care (non-custodial)	Covered in full
Hospice Care Provided by Medicare-certified hospice. Covered for 180 days plus unlimited 60-day extension if Medicare guidelines are met.	Covered by Medicare
Urgent Care	$10 copay per visit
Routine Vision Care • One eye exam per calendar year by a Participating Provider. • One pair of eyeglasses per calendar year when chosen from a select group of frames at a participating optical provider.	$15 copay per visit Covered in full
Hearing Exam and Aid • One routine hearing exam per calendar year by a Participating Provider. • Hearing Aid	$10 copay One hearing aid (up to $500) or a $500 credit toward the purchase of a hearing aid every 36 months

Comprehensive Dental **HIP Participating Dentist must be used**	Not Covered
Dental Discount*** (Careington Participating Dentist must be used)	$5 for one examination (comprehensive or periodic) every 6 months. $10 per visit for one prophylaxis (cleaning) every 6 months. Additional services, including but not limited to X-rays, fillings, crowns or dentures will be provided at a discounted rate subject to a fee schedule.
Durable Medical Equipment*	Covered in full
Private Duty Nursing	Not Covered
Dialysis Transportation (For end-stage renal disease/kidney related diseases to/from dialysis centers only)	Not Covered
Transitional Health Care Services (Members will receive home health aide services and personal care services (ADL'S) performed by a home health aide for up to 30 days after their discharge from a hospital.	Not Covered
Over the Counter Medication (OTC) • Cough and Cold • PPI (Proton Pump Inhibitors) Axid, Prilosec, etc. • Analgesics (includes aspirins) • Anti-Acid (Mylanta, Bismuth)	Not Covered

FOOTNOTES

**Durable Medical Equipment must be medically necessary, in accordance with Medicare guidelines and prescribed by a HIP participating medical provider, to be covered. Please note prior approval for customized Durable Medical Equipment must be obtained through the CMP program.*

***Member is eligible for the applicable low income copay and premium subsidy. For further information please contact **1-877 344-7364**. If you have a hearing or speech impairment and use a TDD, call **711**.*

****This is not a plan benefit, this is a discount offered to all enrollees through Careington.*

Maximum Out of Pocket Costs *- $3,400 annual out of pocket maximum. Once met, medical and hospital services have no cost sharing. The out of pocket maximum does not apply to supplemental benefits not covered by Medicare such as hearing aids and preventive dental care.*

Your pharmacy benefit will be made up of two plans

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Your benefit consists of a primary Medicare Advantage plan and a secondary supplemental plan for the Coverage Gap Stage only. Your pharmacy will only need to submit your prescription once to the Emblem Health Premier (HMO) Medicare Plan. During the Coverage Gap Stage, if your prescription is identified as an applicable drug – typically brand-name drugs – the prescription will automatically process under the secondary supplemental coverage. This ensures the correct copayment is applied to your prescription in all stages of the benefit. All of the information needed to process your prescription is included on your member ID card. To ensure your coverage is applied correctly, present your ID card each time you fill a prescription. For more information on the Medicare Coverage Gap Discount Program refer to the benefits description above. This benefit design does not apply if you are receiving Extra Help from Medicare.

HIP Health Plan of New York (HIP) is an HMO plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company. Enrolled members must use HIP participating providers for all medical and hospital services except for emergency care or urgently needed care. If you receive medical or hospital care that is not provided or authorized by HIP (other than emergency care or urgently needed care as defined in your contract) neither HIP nor Medicare will pay for that service and you will be responsible for the full payment for the care you received. This benefit package is subject to change annually at the plan's contracted renewal time with the Centers for Medicare & Medicaid Services. (CMS) (Effective 01-01-16 through 12-31-16).

The information contained in the Summary is intended to provide a general overview of the benefits available in the Medicare HMO Plan. For an actual description of your benefits including exclusions, limitations or specific conditions that may modify the benefits described in this Summary see your 2016 Medicare EOC. In the event of a discrepancy between the information contained in this Summary and the provisions of your 2016 Medicare EOC, the specific provisions of the EOC shall prevail over the overview provided in this Summary.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.