EmblemHealth

EmblemHealth VIP Premier (HMO) Group Plan
2020 Cost Sharing guide for Medicare members residing in Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester, Orange, and Rockland 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.	**$6,700** 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	**$0** per visit
Specialist	**$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 **$0** if admitted within 1 day Worldwide coverage
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	**$500** based on your plan coverage 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

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

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

Prescription Drug Coverage				
Tier Level	**Initial Coverage $0 - $4,020 30-day supply**		**Coverage Gap $4,020 - $6,350**	**Catastrophic Over $6,350**
	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	**$3.60** or **5%** of the cost
Tier 2: Generic	**$10**	**$15**	**$10** at preferred pharmacies; or **$15** at standard pharmacies	**$3.60** or **5%** of the cost
Tier 3: Preferred Brand	**$40**	**$47**	**25%** of the cost	**$8.95** 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	**$3.60**, **$8.95** or **5%** of the cost
Tier 5: Specialty	**33%** of the cost	**33%** of the cost	**33%** of the cost for generics at preferred or standard pharmacies; or **25%** of the cost for brand	**$3.60**, **$8.95** or **5%** of the cost

Other Benefits	
Durable medical equipment (DME)*	**10%** of the cost
Home health care (non-custodial) *	**$0**
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. For an actual description of your benefits, including exclusions, limitations, or specific conditions, see your 2020 Medicare Plan EOC. In the event of a discrepancy between the information contained in the guide and the provisions of your 2020 Medicare EOC, the specific provisions of the EOC shall prevail over the cost-sharing guide.

*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**.*