



**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
<p>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.</p>	
Inpatient Hospital Coverage	What You Pay
Inpatient Hospital - Acute	Days 1-5: \$50 / day \$0 / additional day
Inpatient Hospital – Mental Health Services (No limit in a general hospital; 190-day lifetime limit in a psychiatric facility)	Days 1-5: \$50 / day Days 6 – 90: \$0 / day
Skilled Nursing Facility	Days 1-20: \$0 / day Days 21–100: \$50 / 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 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 1 exam per 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-person/telehealth)	\$10
Opioid Treatment	\$10
Partial Hospitalization/ Intensive Outpatient Services	\$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 (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)	\$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% - 10% of the cost (\$35 one-month supply of insulin)
Medicare Part B drugs (Dispensed at a retail pharmacy, mail order pharmacy, physician office, and outpatient facility)	0% - 10% 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	10%
Fitness benefits with SilverSneakers®*	Not Covered
Home Health Agency Care	\$0
Over-the-Counter (OTC) Health Items	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		Not available in long-term supply	
Tier 6: Select Care Drugs	\$0	\$0	\$0	\$0
Coverage Gap				
You pay the following once 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		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	
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

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.