EmblemHealth

EmblemHealth VIP Premier (HMO) Group Plan 2027 Cost Sharing Guide

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)	**$3,400**

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	**$0** per day Unlimited Days
Inpatient Hospital – Mental Health Services (No limit in a general hospital; 190-day lifetime limit in a psychiatric facility)	**$0** per day Days 1-90
Skilled Nursing Facility	**$0** per day Days 1-100
Outpatient Hospital Coverage	**What You Pay**
Outpatient Hospital Services (Includes surgery, observation, clinic)	**$0**
Ambulatory Surgery Centers	**$0**
Renal (Kidney) Dialysis	**$0**
Doctor Visits	**What You Pay**
Primary Care Provider (PCP) (In-office/telehealth)	**$0**
Specialist (In-office/telehealth)	**$5**

Outpatient Services	What You Pay
Preventive Services (Includes annual physical exam, screenings, and some Part B immunizations)	**Covered in Full**
Emergency Care (Within USA / Worldwide)	**$25** $0 if admitted within one day ($50,000 annual limit on Emergency Care, Urgent Care and Ground Ambulance outside of the USA)
Urgently Needed Services (Within USA / Worldwide)	**$5 / $25** ($50,000 annual limit on Emergency Care, Urgent Care and Ground Ambulance outside of the USA)
Diagnostic Services	**What You Pay**
Diagnostic Procedures & Tests	**$0**
Diagnostic Radiology (High-tech radiology including PET scans, MRIs, MRAs, CAT scans, etc.)	**$0**
Lab Services	**$0**
Radiation Therapy	**$0**
X-Ray	**$0**
Hearing Services	**What You Pay**
Medicare-Covered Hearing Exam	**$5**
Routine Hearing Exam	**$5** (1 exam every year)
Hearing Aid	Up to **$500** benefit limit every 3 years
Vision Services	**What You Pay**
Medicare-Covered Eye Exam	**$5**
Routine Eye Exam	**$5** (1 exam every 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-office/telehealth)	**$5**
Opioid Treatment	**$5**
Partial Hospitalization / Intensive Outpatient Services	**$0**

Rehabilitation Services	What You Pay
Cardiac Rehabilitation (In-office/telehealth)	**$0**
Intensive Cardiac Rehabilitation	**$0**
Occupational Therapy	**$5**
Physical Therapy	**$5**
Pulmonary Rehabilitation	**$0**
Speech Therapy	**$5**
Supervised Exercise Therapy (SET) (For symptomatic peripheral artery disease)	**$0**
Transportation Services	**What You Pay**
Ground Ambulance (Within USA / Worldwide)	**$0** ($50,000 annual limit on Emergency Care, Urgent Care and Ground Ambulance outside of the USA)
Air Ambulance	**$0**
Routine Transportation	Not Covered
Outpatient Services	**What You Pay**
Acupuncture (Medicare-covered) (For chronic lower back pain)	**$5**
Chiropractic Services	**$5**
Podiatry (includes up to 4 routine visits per year)	**$5**
Part B Drugs	**What You Pay**
Medicare Part B drugs	**$0**
Other Services and Supplies	**What You Pay**
Diabetes Self-Monitoring & Training	**$0**
Diabetic Supplies	**$5**
Durable Medical Equipment and Prosthetics / Medical Supplies	**$0**
Fitness Benefits with SilverSneakers®*	Not Covered
Home Health Agency Care	**$0**
Home Infusion Therapy	**$0**
Teladoc®** (Virtual care for non-urgent conditions)	Not Covered

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Prescription Drug Coverage		
Initial Coverage Stage		
You pay the following until your out-of-pocket drug costs reach $2,400	**30-day supply Retail Pharmacy**	**90-day supply Mail order Pharmacy**
	What You Pay	**What You Pay**
Tier 1: Generic	**$5**	**$0**
Tier 2: Preferred Brand	**$5** (insulin: lesser of $5 or 25%)	**$0**
Tier 3: Non-Preferred Drug*	**$45** (insulin: lesser of $35 or 25%)	**$67.50** (insulin: lesser of $67.50 or 25%)
Tier 4: Select Care Drugs	**$0**	**$0**

*Tier 3: Specialty Drugs (brand and generic) are available only for 30-day supply.

Catastrophic Coverage Stage	
You pay the following after your out-of-pocket drug costs reach $2,400	**Retail Pharmacy and Mail Order**
	What You Pay
All Covered Part D 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 2027 Medicare Plan Evidence of Coverage (EOC). In the event of a discrepancy between the information contained in the guide and the provisions of your 2027 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, October 1 to March 31, and 8 a.m. to 8 p.m., Monday through Saturday, April 1 to September 30. Or visit us at **emblemhealth.com/medicare.**