



EmblemHealth VIP Premier (HMO) Group

2022 Cost Sharing Guide for Medicare Members residing in Albany, Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Saratoga, Schenectady, Suffolk, Sullivan, Ulster, Warren, Washington, and Westchester counties

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)	Days 1-90: \$0 / day
Skilled Nursing Facility	Days 1-100: \$0 / day
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/Virtual)	\$0
Specialist (In-office/Virtual)	\$5 (referral may be required)

Outpatient Services	What you pay
Preventive Services (Includes annual physical exam, screenings, and some Part B immunizations)	Covered in full
Emergency Care (Worldwide coverage)	\$25 \$0 if admitted within 1 day
Urgently Needed Services	\$5
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
Hearing Aid	Up to \$500 allowance every 36 months
Vision Services	What you pay
Medicare-Covered Eye Exam	\$5
Routine Eye Exam	\$5
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)	\$5/\$0
Opioid Treatment	\$0
Partial Hospitalization	\$0
Dental Services	What you pay
Preventive Dental Care	\$5 per exam every 6 months \$10 per visit every 6 months for prophylaxis
Comprehensive Dental Care	Not covered Discounts available
Rehabilitation Services	What you pay
Cardiac Rehabilitation	\$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	\$0
Air Ambulance	\$0
Routine Transportation	Not covered
Outpatient Services	What you pay
Acupuncture (For chronic lower back pain)	\$5
Chiropractic Services (Medicare-covered only)	\$5
Podiatry	\$5

Part B Drugs	What you pay
Medicare Part B drugs (In the home)	\$0
Medicare Part B drugs (Dispensed at a retail pharmacy, mail order pharmacy, physician office, and outpatient facility)	\$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 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

Prescription Drug Coverage

Initial Coverage Limit (ICL) and Coverage Gap

You pay the following until your total yearly drug costs exceed \$7,050	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: Generic	\$0	\$5	\$0	\$0
Tier 2: Preferred Brand	\$0	\$5	\$0	\$0
Tier 3: Non-Preferred*	\$45	\$45	\$67.50	\$67.50

Catastrophic Coverage

You pay the following once your true yearly out-of-pocket drug costs exceed \$7,050	Retail Pharmacy and Mail Order What you pay
Generic/Preferred Multi-Source Drugs	The greater of 5% or \$3.95
All Other Drugs	The greater of 5% or \$9.85

*Tier 3 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 2022 Medicare Plan Evidence of Coverage (EOC). In the event of a discrepancy between the information contained in the guide and the provisions of your 2022 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 Member Services 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**.*