EmblemHealth HIP VIP Premier (HMO) Group

2025 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/Telehealth)	**$0**
Specialist (In-office/Telehealth)	**$5**

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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 and 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 (Referral may be required)	**$5**
Routine Hearing Exam (Referral may be required)	**$5** One exam every year
Hearing Aid	Up to **$500** allowance every 36 months
Vision Services	**What you pay**
Medicare-covered Eye Exam	**$5**
Routine Eye Exam	**$5** One exam every year
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 Use Disorder (Individual session in-person/Telehealth)	$5
Opioid Treatment	$5
Partial Hospitalization	$0
Dental Services	**What you pay**
Dental Discount	Not covered
Rehabilitation Services	**What you pay**
Cardiac Rehabilitation (In-office/Telehealth)	$0
Intensive Cardiac Rehabilitation	$0
Occupational Therapy	$5
Physical Therapy (Referral may be required)	$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 low back pain)	$5
Chiropractic Services (Medicare-covered only)	$5
Podiatry (Referral may be required)	$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 and Training	**$0**
Diabetic Supplies	**$5**
Durable Medical Equipment and Prosthetics/Medical Supplies	**$0**
Home Health Agency Care	**$0**

Prescription Drug Coverage				
Initial Coverage Stage				
You pay the following until your out-of-pocket drug costs reach $2,000	**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 Drug*	**$45**	**$45**	**$67.50**	**$67.50**
Tier 4: Select Care Drugs	**$0**	**$0**	**$0**	**$0**
Catastrophic Coverage				
You pay for all formulary drugs after your out-of-pocket drug costs reach $2,000.	**You pay $0 for Retail Pharmacy and Mail Order drugs.**			

*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 2025 Medicare Plan Evidence of Coverage (EOC). In the event of a discrepancy between the information contained in the guide and the provisions of your 2025 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 EmblemHealth Medicare Connect Concierge at **877-344-7364** (TTY: **711**). From Oct. 1 to March 31, you can call us from 8 a.m. to 8 p.m., seven days a week. From April 1 to Sept. 30, you can call us from 8 a.m. to 8 p.m., Monday through Saturday. Or visit us at **emblemhealth.com/medicare**.*