2023 Summary of Benefits
EmblemHealth VIP Rx Saver (HMO)

January 1, 2023 – December 31, 2023

WHO CAN JOIN?

To join **EmblemHealth VIP Rx Saver (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in the **New York Capital Region:** Albany, Broome, Columbia, Delaware, Greene, Rensselaer, Saratoga, Schenectady, Warren, and Washington.

This plan does not require referrals.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

EmblemHealth VIP Rx Saver (HMO) plan has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan will not pay for these services.

When joining **EmblemHealth VIP Rx Saver (HMO)** plan, you must choose a primary care provider (PCP) in the VIP Bold Network. If you do not select a PCP, one will be selected for you. At any time, you can select a different PCP within the network. This network also includes additional medical providers like specialists, laboratories, and hospitals.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **emblemhealth.com/medicare**. Or, call us and we'll send you a copy.

In most situations you must use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider and pharmacy directories on our website at **emblemhealth.com/medicare**. Or, call us and we'll send you a copy.

HOW TO REACH US

To find out more about EmblemHealth plans and to enroll, please call us at 800-447-9169 (TTY: 711). From Oct. 1 to March 31, you can call us seven days a week from 8 a.m. to 8 p.m. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 8 p.m.

To get a complete list of services we cover, call us and ask for the "Evidence of Coverage (EOC)." You can also view the EOC online at **emblemhealth.com/medicare**. If you want to know more about the benefits, services, and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, seven days a week. If you use a TTY, please call **1-877-486-2048**.
If you want to compare our plan with other Medicare Advantage plans we offer, you can visit us at **emblemhealth.com/medicare**.

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BENEFIT	EMBLEMHEALTH VIP RX SAVER (HMO)
MONTHLY PREMIUM (The amount you pay for your insurance every month.)	You pay $0 You must continue to pay your Medicare Part B premium.
DEDUCTIBLE (The amount you pay before the plan starts to pay.)	This plan does not have a deductible for covered medical services.
MAXIMUM OUT-OF-POCKET RESPONSIBILITY (The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, and your share of the costs (copays, coinsurance), your health plan pays 100% of the costs of covered benefits. This does not include your prescription drug costs.)	$7,550 yearly for services you receive from in-network health care professionals and facilities. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Our plan has a coverage limit every year for certain in-network benefits. Please call us for the services that apply.
INPATIENT HOSPITAL COVERAGE (may require approval)	Our plan covers an unlimited number of days for an inpatient hospital admission. You pay $350 per day for days one through five You pay $0 per day for days six through 90 You pay $0 per day for days 91 and beyond
OUTPATIENT HOSPITAL COVERAGE (may require approval)	
• Hospital observation:	You pay $275
• Outpatient hospital:	You pay $350
• Ambulatory surgery center:	You pay $225
DOCTOR VISITS (In-office/virtual)	
• Primary care provider:	You pay $5 You pay $0 for annual physical exam
• Specialists:	You pay $40

BENEFIT	EMBLEMHEALTH VIP RX SAVER (HMO)
PREVENTIVE CARE (Services that keep you healthy) • Our plan covers many preventive services, including:	You pay $0 – Bone mass measurement – Breast cancer screening (mammogram) – Cardiovascular screening – Cervical and vaginal cancer screening – Colorectal cancer screening (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) – Depression screening – Diabetes screening – Prostate cancer screening (PSA) – Vaccines, including flu shots, hepatitis B shots, pneumococcal shots, and COVID-19 vaccines – “Welcome to Medicare” preventive visit (one-time) – Yearly “Wellness” visit And all additional preventive services approved by Medicare during the contract year will be covered.
EMERGENCY CARE	You pay $95 If you are admitted to the hospital within one day, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Coverage” section of this booklet for other costs.
URGENTLY NEEDED SERVICES	You pay $50
DIAGNOSTIC SERVICES/LABS/IMAGING (Lower costs when provided in a doctor’s office or free-standing facility. May require approval)	
• Diagnostic radiology services (such as MRIs, CT scans):	You pay 20% of the cost
• Lab services:	You pay $0 or $15
• Diagnostic tests and procedures:	You pay $0 or $45
• Outpatient x-rays:	You pay $40
• Therapeutic radiology services (such as radiation treatment for cancer):	You pay 20% of the cost

BENEFIT	EMBLEMHEALTH VIP RX SAVER (HMO)
HEARING SERVICES	
• Exam to diagnose and treat hearing and balance issues:	You pay $40
• Routine hearing exam (for up to one every year):	You pay $10
• Hearing aid fitting/evaluation (for up to one every year):	You pay $10
• Hearing aids (limited to two, one for each ear):	Our plan pays up to $600 every three years for hearing aids.
DENTAL SERVICES No Annual Dollar Limit	
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):	You pay $0
Preventive Dental Services:	
• Cleaning (for up to one every six months):	You pay $0
• Standard dental x-ray(s) (for up to one every six months):	You pay $0
• Fluoride treatment (for up to one every six months):	You pay $0
• Oral exam (for up to one every six months):	You pay $0
COMPREHENSIVE DENTAL SERVICES: (may require approval)	
• Restorative services:	You pay $0 - $125 based on procedure
• Endodontics:	You pay $0 - $20 based on procedure
• Periodontics:	You pay $0 - $150 based on procedure
• Extractions:	You pay $0 - $50 based on procedure
• Prosthodontics, other oral/ maxillofacial, surgery, other services:	You pay $0 - $150 based on procedure

BENEFIT	EMBLEMHEALTH VIP RX SAVER (HMO)
VISION SERVICES	
• Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):	You pay $40
• Routine eye exam (for up to one every year):	You pay $10
Routine eyewear:	
• Eyeglasses (frames and lenses) or contact lenses:	One pair up to $400 plan limit every year
• Eyeglasses (frames and lenses) or contact lenses after cataract surgery:	You pay $40
MENTAL HEALTH SERVICES (may require approval)	
• Inpatient visit:	You pay $1,871 per admission. Our plan covers up to 90 days per inpatient mental health admission. Our plan also covers 60 “lifetime reserve days” as long as the stay is covered under the plan. Our plan covers up to 190 days in a lifetime for inpatient mental health services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.
• Outpatient group therapy visit:	You pay $40
• Outpatient individual therapy visit: (In-office/virtual)	You pay $40
SKILLED NURSING FACILITY (SNF) (may require approval)	Our plan covers up to 100 days in a SNF. You pay $0 per day for days one through 20 per benefit period You pay $196 per day for days 21 through 100 per benefit period
PHYSICAL THERAPY (may require approval)	
• Physical therapy, and speech and language therapy visit:	You pay $40

BENEFIT	EMBLEMHEALTH VIP RX SAVER (HMO)
AMBULANCE (may require approval)	
• Ground:	You pay $340
• Air:	You pay 20% of the cost
TRANSPORTATION	Not covered

MEDICARE PART B DRUGS	
CHEMOTHERAPY DRUGS AND OTHER PART B DRUGS:	You pay 10% of the cost in home and 20% of the cost at a retail pharmacy, mail order pharmacy, doctor’s office, and outpatient facility. These drugs may require step therapy and/or prior approval.

Prescription Drugs for EmblemHealth VIP Rx Saver (HMO)

MEDICARE PART D DRUGS

Our plan groups each drug into one of six “tiers” (levels). You will need to use the formulary (list of covered drugs) to locate what tier a drug is in.

How much you pay for your prescription drugs depends on what tier your drug is in and what stage of the benefit you are in. There are four stages in your Part D prescription drug coverage.

FOUR STAGES OF DRUG COVERAGE

Deductible

The deductible is the amount you pay before your plan starts to pay. This deductible is for retail and home delivery.

There is no deductible for Tier 1 (Preferred Generic), Tier 2 (Generic), Tier 3 (Preferred Brand), and Tier 6 (Select Care Drugs).

There is a **$395** deductible for Tier 4 (Non-Preferred Drugs) and Tier 5 (Specialty) drugs.

Initial Coverage

After you’ve reached the deductible, you’ll enter the initial coverage stage.

In this stage, you and the plan share the costs of some of the covered drugs until your total drug costs, including deductible, reach **$4,660**. The total drug costs paid by both you and our Part D plan will help you reach the coverage gap.

Retail Cost-Sharing

Tier	EmblemHealth VIP Rx Saver (HMO)				
	Deductible	Initial Coverage $0-$4,660 30-Day Supply		Coverage Gap Over $4,660	Catastrophic Over $7,400
	You pay	Preferred	Standard	You pay	You pay
Tier 1: Preferred Generic	$0	$2	$7	25%	5% or $4.15
Tier 2: Generic	$0	$15	$20	25%	5% or $4.15
Tier 3: Preferred Brand*	$0	$42	$47	25%	5% or $10.35
Tier 4: Non-Preferred Drugs	$395	$95	$100	25%	5% or $4.15 for generic/ preferred multisource drugs 5% or $10.35 for all other drugs
Tier 5: Specialty	$395	25%	25%	25%	5% or $4.15 for generic/ preferred multisource drugs 5% or $10.35 for all other drugs
Tier 6: Select Care Drugs	$0	$0	$0	$0	5% or $4.15

*$35 for Insulins and $0 eligible vaccines with no deductible

Prescription Drugs for EmblemHealth VIP Rx Saver (HMO)

Preferred Mail Order Cost-Sharing

Tier	EmblemHealth VIP Rx Saver (HMO)		
	Deductible	Initial Coverage $0-$4,660	
Monthly Supply	**You pay**	**30-day supply**	**90-day supply**
Tier 1: Preferred Generic	$0	$0	$0
Tier 2: Generic	$0	$0	$0
Tier 3: Preferred Brand*	$0	$42	$126
Tier 4: Non-Preferred Drugs	$395	$95	$285
Tier 5: Specialty	$395	25%	Not available in a long-term supply
Tier 6: Select Care Drugs	$0	$0	$0

*$35 for Insulins and $0 eligible vaccines with no deductible for 30-day supply

If you live in a long-term care facility or use a non-preferred mail order pharmacy, you pay the same as at a standard retail pharmacy.

Coverage Gap

The coverage gap (also called the "donut hole") starts after the total yearly drug cost (along with what our plan has paid and what you have paid) reaches **$4,660**.

While in the coverage gap for Tiers 1, 2, 3, 4, and 5 in 2023, you'll pay 25% of the plan's cost for brand-name drugs and/or generic drugs. You will pay $0 for Select Care Drugs (Tier 6). The 70% discount for brand-name drugs paid by the drug manufacturer, combined with 25% you pay, count toward your true out-of-pocket (TrOOP) costs. This helps you get out of the coverage gap. **Not everyone will reach the coverage gap.**

Catastrophic Coverage

After your yearly true out-of-pocket TrOOP drug costs reach **$7,400**, your cost-sharing will be the larger amount of **$4.15** or 5% for generic or preferred multisource drugs, and **$10.35** or **5%** for all other drugs.

Get Help Paying for Your Prescription Drugs

Extra Help

Extra Help is a free Medicare program and is known as Low-Income Subsidy (LIS). It helps people with low or limited income and resources pay Medicare Part D drug plan costs.

What do you get with Extra Help?

- Payment of 75% or more of your drug costs. These include your monthly premium for prescription drugs **(the amount you pay each month)**.
- Payment of your annual deductible **(the amount you pay before your plan starts to pay)**.
- Payment of coinsurance costs **(the percentage you pay for your prescription drugs)**.
- No coverage gap.

You automatically qualify for Extra Help if:

- You have full Medicaid coverage.
- You get help from your state Medicaid program to pay your Part B premiums in a Medicare Savings Program.
- You get Supplemental Security Income (SSI) benefits.

Many other people with low or limited income also qualify for Extra Help and don't know it!

There is no cost to apply. Contact your local Social Security office or call Social Security at **800-772-1213** (TTY: **800-325-0778**). You can also apply online at **ssa.gov/benefits/medicare/prescriptionhelp/**.

Additional Benefits

BENEFIT	EMBLEMHEALTH VIP RX SAVER (HMO)
ACUPUNCTURE (may require approval)	You pay $10 for up to 20 visits for chronic low back pain every year (maximum of 12 visits in 90 days).
CHIROPRACTIC CARE (may require approval) Manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position):	You pay $10
FOOT CARE • Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • Routine foot care (for up to four visit(s) every year):	You pay $40 You pay $40 Foot care includes removal of calluses and corns, and trimming of nails.
HOME HEALTH CARE (may require approval)	You pay $0
HOSPICE	You pay $0 for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
MEDICAL EQUIPMENT/SUPPLIES Durable Medical Equipment (wheelchairs, oxygen, etc.) (may require approval) Prosthetic Devices (braces, artificial limbs, etc.) (may require approval): • Prosthetic devices: • Related medical supplies: Diabetes Supplies and Services: • Diabetes monitoring supplies: (limited to Abbott brands) • Diabetes self-management training: • Therapeutic shoes or inserts:	You pay 20% of the cost You pay 20% of the cost You pay 20% of the cost You pay $0 You pay $0 You pay $0

Additional Benefits (Continued)

BENEFIT	EMBLEMHEALTH VIP RX SAVER (HMO)
RENAL DIALYSIS	You pay 20% of the cost
WELLNESS PROGRAMS • Fitness: • Hotline: • Teladoc®:	 SilverSneakers® — You pay $0 24-Hour Nurse Hotline — You pay $0 You pay $45
OUTPATIENT SUBSTANCE ABUSE (may require approval) • Group therapy visit: • Individual therapy visit: (In-office/virtual)	 You pay $40 You pay $40
OVER-THE-COUNTER ITEMS	$25 per month (mail order only). This amount does not roll over from month to month.
WORLDWIDE EMERGENCY AND URGENT CARE COVERAGE There is a combined $50,000 annual limit for emergency care, urgent care, and ground emergent ambulance services outside of the United States. You are not covered for air ambulance services outside the United States. See page I - 6 for additional cost-sharing information for ambulance services.	You pay $95 You pay $0 if admitted in one day

Health Insurance Plan of Greater New York (HIP) is an HMO/HMO D-SNP plan with a Medicare contract and a contract with the New York State Department of Health. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company. For more information, contact the plan.

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2023 Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service representative at **877-344-7364** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **emblemhealth.com/medicare** or call **877-344-7364** (TTY: **711**) to view a copy of the EOC.
- ☐ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).

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