EmblemHealth®

VIP® PREMIER MEDICARE PLAN
2017 Summary of Benefits
For Medicare-Eligible Retirees Residing in Manhattan, Brooklyn, Bronx, Staten Island, Queens, Nassau, Suffolk & Westchester Counties

➢ PROFESSIONAL SERVICES	2017 Medicare Plan
PCP office visits	Covered in full
Specialist office visits	$10 copay per visit
Annual physical exam/preventive care	Covered in full
Physical, Speech & Occupational Therapy	$10 copay per visit
Cardiac/Pulmonary Rehab	$10 copay per visit
Flu & Pneumonia Vaccinations	Covered in full
Diagnostic Services including X-ray, EKG's	$10 copay per visit
Lab Tests	Covered in full
Routine Foot Care (Up to 4 visit per year)	$10 copay per visit
Chiropractic Care	$ 10 copay per visit

➢ INPATIENT HOSPITAL SERVICES	2017 Medicare Plan
Surgeon & physician fees	Included in hospital admission copay
Semi-private room and board	$50 copay per day (days 1-5)
Anesthesia	Included in hospital admission copay
Nursing care (hospital provided)	Included in hospital admission copay
X-ray & Lab tests (inpatient)	Included in hospital admission copay
Prescribed drugs	Included in hospital admission copay
Operating & recovery room fees	Included in hospital admission copay
Intensive Care Unit	Included in hospital admission copay
Therapy (physical, speech and occupational therapy)	Included in hospital admission copay

➢ OUTPATIENT FACILITY SERVICES	2017 Medicare Plan
Ambulatory surgery	$50 copay per visit
Outpatient surgery	$150 copay per visit
Emergency room fees	$75 copay per visit (waived if admitted within 1 day)
Ambulance service to the hospital (Non-emergent ambulance transportation requires authorization)	$50 copay per service
Renal dialysis	10% coinsurance
X-ray (outpatient)	$50 copay per visit
Lab tests (outpatient)	Covered in full
Diagnostic Services including MRI's, MRA's, PET, and CAT Scans	$50 copay per visit
Radiation Therapy	$50 copay per visit

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➢ MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE CARE	2017 Medicare Plan
Mental Health Care	
• Inpatient: no limit in a general hospital; 190-day lifetime limit in a psychiatric facility	$50 copay per day (days 1-5)
• Outpatient therapy	$10 copay per visit
Alcohol and Substance Abuse Care	
• Inpatient: based on medical necessity, up to Medicare limits	$50 copay per day (days 1-5)
• Inpatient Detoxification	$50 copay per day (days 1-5)
• Outpatient therapy	$10 copay per visit

➢ PRESCRIPTION DRUGS	
PREFERRED* **	**Standard**
Deductible: $0 Initial Coverage Limit (ICL): $3,700 Retail: Preferred Generic: $0 copay Generic: $10 copay per 30-day supply, $20 copay per 60-day supply, $30 per 90-day supply Preferred Brand: $40 copay per 30-day supply, $80 copay per 60-day supply, $120 copay per 90- day supply Non-Preferred Drugs: 23% coinsurance Specialty: 33% coinsurance	Deductible: $0 Initial Coverage Limit (ICL): $3,700 Retail: Preferred Generic: $5 copay per 30-day supply, $10 copay per 60-day supply, $15 per 90-day supply Generic: $15 copay per 30-day supply, $30 copay per 60-day supply, $45 per 90-day supply Preferred Brand: $47 copay per 30-day supply, $94 copay per 60-day supply, $141 copay per 90- day supply Non-Preferred Drugs: 25% coinsurance Specialty: 33% coinsurance

When prescribed by a Participating Provider and filled by a participating mail order vendor.	Mail Order: Preferred Generic: $0 copay Generic: $15 copay per 30-day supply, $30 copay per 60-day supply, $45 per 90-day supply Preferred Brand: $47 copay per 30-day supply, $94 copay per 60-day supply, $141 copay per 90- day supply Non-Preferred Drugs: $100 copay per 30-day supply, $200 copay per 60-day supply, $300 copay per 90-day supply Specialty: 33% coinsurance **Coverage Gap:** Member pays copays and coinsurance listed above until reaching catastrophic coverage. **Catastrophic Coverage:** When a member reaches $4,950 of true out-of-pocket (TrOOP) costs for the calendar year, the member will pay the greater of $3.30 copay for generic, $8.25 copay for brand, or 5% coinsurance.
➢ **PART B DRUGS**	10% coinsurance

➢ **OTHER BENEFITS**	**2017 Medicare Plan**
Skilled Nursing Facility Care Up to 100 days per benefit period	$0 copay per day (days 1-20) $50 copay per day (days 21-100)
Home Health Care (non-custodial)	Covered in full
Hospice Care Provided by Medicare-certified hospice. Covered for 180 days plus unlimited 60-day extension if Medicare guidelines are met.	Covered by Medicare
Urgent Care	$10 copay per visit

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Routine Vision Care • One eye exam per calendar year by a Participating Provider. • One pair of eyeglasses per calendar year when chosen from a select group of frames at a participating optical provider.	$15 copay per visit Covered in full
Hearing Exam and Aid • One routine hearing exam per calendar year by a Participating Provider. • Hearing Aid	$10 copay One hearing aid (up to $500) or a $500 credit toward the purchase of a hearing aid every 36 months
Comprehensive Dental **HIP Participating Dentist must be used**	Not Covered
Dental Discount**	$5 for one examination (comprehensive or periodic) every 6 months. $10 per visit for one prophylaxis (cleaning) every 6 months. Additional services, including but not limited to X-rays, fillings, crowns or dentures will be provided at a discounted rate subject to a fee schedule.
Durable Medical Equipment*	10% Coinsurance
Private Duty Nursing	Not Covered
Dialysis Transportation (For end-stage renal disease/kidney related diseases to/from dialysis centers only)	Not Covered
Transitional Health Care Services (Members will receive home health aide services and personal care services (ADL'S) performed by a home health aide for up to 30 days after their discharge from a hospital.	Not Covered
Over the Counter Medication (OTC) • Cough and Cold • PPI (Proton Pump Inhibitors) Axid, Prilosec, etc. • Analgesics (includes aspirins) • Anti-Acid (Mylanta, Bismuth)	Not Covered

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FOOTNOTES

[*]Durable Medical Equipment must be medically necessary, in accordance with Medicare guidelines and prescribed by a HIP participating medical provider, to be covered. Please note prior approval for customized Durable Medical Equipment must be obtained through the CMP program.

***This is not a plan benefit, this is a dental discount offered to all Medicare enrollees.*

****Member receives reduced cost-sharing when filling prescriptions at a Preferred Pharmacy Network.*

Maximum Out of Pocket Costs *- $6,700 annual out of pocket maximum. Once met, medical and hospital services have no cost sharing. The out of pocket maximum does not apply to supplemental benefits not covered by Medicare such as hearing aids and preventive dental care.*

Your pharmacy benefit will be made up of two plans
Your benefit consists of a primary Medicare Advantage plan and a secondary supplemental plan for the Coverage Gap Stage only. Your pharmacy will only need to submit your prescription once to the Emblem Health Premier (HMO) Medicare Plan. During the Coverage Gap Stage, if your prescription is identified as an applicable drug – typically brand-name drugs – the prescription will automatically process under the secondary supplemental coverage. This ensures the correct copayment is applied to your prescription in all stages of the benefit. All of the information needed to process your prescription is included on your member ID card. To ensure your coverage is applied correctly, present your ID card each time you fill a prescription. For more information on the Medicare Coverage Gap Discount Program refer to the benefits description above. This benefit design does not apply if you are receiving Extra Help from Medicare.

HIP Health Plan of New York (HIP) is an HMO plan with a Medicare contract. Enrollment in HIP depends on contract renewal. HIP is an EmblemHealth company. Enrolled members must use HIP participating providers for all medical and hospital services except for emergency care or urgently needed care. If you receive medical or hospital care that is not provided or authorized by HIP (other than emergency care or urgently needed care as defined in your contract) neither HIP nor Medicare will pay for that service and you will be responsible for the full payment for the care you received. This benefit package is subject to change annually at the plan's contracted renewal time with the Centers for Medicare & Medicaid Services. (CMS) (Effective 01-01-17 through 12-31-17).

The information contained in the Summary is intended to provide a general overview of the benefits available in the Medicare HMO Plan. For an actual description of your benefits including exclusions, limitations or specific conditions that may modify the benefits described in this Summary see your 2017 Medicare EOC. In the event of a discrepancy between the information contained in this Summary and the provisions of your 2017 Medicare EOC, the specific provisions of the EOC shall prevail over the overview provided in this Summary.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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This information is available for free in other languages. Please call our customer service number at 1-877-344-7364; TTY call 711 during Monday to Sunday, 8 am to 8 pm.

ATTENTION: If you speak other languages, language assistance services, free of charge, are available to you. Call 1-877-344-7364 (TTY: 711), seven days a week from 8 am to 8 pm. ATENCIÓN: Si usted habla español, tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al 1-877-344-7364 (TTY: 711)