

## VYTRA HEALTH PLANS



Vytra Health Plans offers New York City employees and retirees an opportunity to access quality healthcare in Queens, Nassau and Suffolk counties. More than 13,000 private practice physicians and provider locations are available in the tri-county service area. Through a strict credentialing process and an ongoing quality assurance program, Vytra Health Plans ensures that members receive the best medical care available.

At the heart of Vytra’s healthcare plan is your Primary Care Physician (PCP). This is a family practitioner or internist or in the case of children, a pediatrician, whom you select from our extensive medical directory.

| At a Glance                                       |   |
|---|---|
| <b>Plan Type:</b>                                 | HMO   |
| <b>Geographic Service Area</b>                    | Vytra’s service area includes Queens, Nassau and Suffolk counties.  |
| <b>Does this plan use a network of providers?</b> | Yes. Visit <a href="http://Emblemhealth.com/city">Emblemhealth.com/city</a> or call 1-866-409-0999 for a list of participating providers. |
| <b>Do I need a referral to see a specialist?</b>  | Yes, written approval is required to see a specialist.  |
| <b>Contact Information</b>                        | 1-866-409-0999. Representatives will be available Monday through Friday, 8:00 a.m. to 8:00 p.m. to answer your questions.                 |
| <b>Web Site</b>                                   | <a href="http://Emblemhealth.com/city">Emblemhealth.com/city</a>  |

| Plan Features   | Cost   |
|---|--|
| <b>What is the overall deductible for this plan?</b>                                | <ul style="list-style-type: none"> <li>• <b>\$0</b></li> </ul>   |
| <b>What are the costs when you visit a health care provider’s office or clinic?</b> | <ul style="list-style-type: none"> <li>• Primary care visit to treat an injury or illness: \$5 co-pay/visit<br/>Not covered for non-participating provider</li> <li>• Specialist visit: \$5 co-pay/visit<br/>Referral required<br/>Not covered for non-participating provider</li> <li>• Other practitioner office visit: \$5 co-pay<br/>Referral required<br/>Not covered for non-participating provider</li> <li>• Preventive care/screening/immunization: No charge<br/>Not covered for non-participating provider</li> </ul> |
| <b>What are the costs if you have a test?</b>                                       | Diagnostic test (x-ray, blood work): No charge<br>Not covered for non-participating provider<br>Imaging (CT/PET scans, MRIs): No charge<br>Prior approval required<br>Not covered for non-participating provider   |
| <b>What are the costs if you have outpatient surgery?</b>                           | Facility fee (e.g., ambulatory surgery center): No charge<br>Prior approval required<br>Not covered for non-participating provider<br>Physician/surgeon fees: No charge<br>Prior approval required<br>Not covered for non-participating provider   |
| <b>What are the costs if you need immediate medical attention?</b>                  | Emergency room services: \$25 co-pay/visit<br>\$25 co-pay/visit non-participating provider<br>Waived if admitted<br>Out-of-network is covered if emergent<br>Emergency medical transportation: No charge<br>No charge non-participating provider<br>Urgent care: \$5 co-pay/visit<br>Not covered for non-participating provider  |
| <b>What are the costs if you have a hospital stay?</b>                              | Facility fee (e.g., hospital room): No charge<br>Prior approval required<br>Not covered for non-participating provider   |

|  |   |
|--|---|
|  | Physician/surgeon fee: No charge<br>Not covered for non-participating provider  |
| <b>What are the costs if you are pregnant?</b> | Prenatal and postnatal care: No charge<br>Not covered for non-participating provider<br>Delivery and all inpatient services: No charge<br>Prior approval required<br>Not covered for non-participating provider |

**WHAT ARE THE COSTS IF YOU HAVE MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS?**

| Service   | Cost   |
|---|--|
| <b>Mental/Behavioral health<br/>Outpatient services</b> | <ul style="list-style-type: none"> <li>• \$5 co-pay/visit</li> <li>• Not covered for non-participating provider</li> </ul>                             |
| <b>Mental/Behavioral health<br/>Inpatient services</b>  | <ul style="list-style-type: none"> <li>• No charge</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> </ul> |
| <b>Substance abuse<br/>Outpatient services</b>          | <ul style="list-style-type: none"> <li>• \$5 co-pay/visit</li> <li>• Not covered for non-participating provider</li> </ul>                             |
| <b>Substance abuse<br/>Inpatient services</b>           | <ul style="list-style-type: none"> <li>• No charge</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> </ul> |

**WHAT ARE THE COSTS IF YOU NEED HELP RECOVERING OR HAVE OTHER SPECIAL HEALTH NEEDS?**

| Service                                  | Cost  |
|--|---|
| <b>Home health care</b>                  | <ul style="list-style-type: none"> <li>• \$5 co-pay/visit</li> <li>• Coverage limited to 40 visits/year</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> </ul>     |
| <b>Skilled nursing care</b>              | <ul style="list-style-type: none"> <li>• No charge</li> <li>• Coverage limited to 45 visits/year</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> </ul>            |
| <b>Rehabilitation service Inpatient</b>  | <ul style="list-style-type: none"> <li>• No charge</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> <li>• 60 days per calendar year combined therapies</li> </ul>  |
| <b>Rehabilitation service Outpatient</b> | <ul style="list-style-type: none"> <li>• \$5 co-pay</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> <li>• 60 days per calendar year combined therapies</li> </ul> |
| <b>Habilitation service Inpatient</b>    | <ul style="list-style-type: none"> <li>• No charge</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> <li>• 60 days per calendar year combined therapies</li> </ul>  |
| <b>Habilitation service Outpatient</b>   | <ul style="list-style-type: none"> <li>• \$5 co-pay</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> <li>• 60 days per calendar year combined therapies</li> </ul> |
| <b>Durable medical equipment (DME)</b>   | <ul style="list-style-type: none"> <li>• No charge</li> <li>• Prior approval required</li> <li>• Not covered for non-participating provider</li> </ul>  |
| <b>Hospice service</b>                   | <ul style="list-style-type: none"> <li>• No charge</li> <li>• Covered limited to 210 days</li> <li>• Not covered for non-participating provider</li> </ul>  |

**OPTIONAL RIDER**

**WHAT IS THE COST IF YOU NEED DRUGS TO TREAT YOUR ILLNESS OR CONDITION?**

|                                   |                           | <b>Retail</b>  | <b>Mail Order</b>            |
|-----------------------------------|---------------------------|--|------------------------------|
| <b>Generic drugs*</b>             |                           | \$7 co-pay/30 day supply   | \$10.50 co-pay/90 day supply |
| <b>Preferred brand drugs*</b>     |                           | \$14 co-pay/30 day supply  | \$21 co-pay/90 day supply    |
| <b>Non-preferred brand drugs*</b> |                           | Not covered  | Not covered                  |
| <b>Specialty drugs*</b>           | Generic drugs             | \$7 co-pay/30 day supply   | \$10.50 co-pay/90 day supply |
|                                   | Preferred brand drugs     | \$14 co-pay/30 day supply  | \$21 co-pay/90 day supply    |
|                                   | Non-preferred brand drugs | Not covered  | Not covered                  |
|                                   |                           | There is an annual \$50 per person deductible.<br>There's no annual limit. |                              |

\*Must be dispensed by a Participating Pharmacy.

\*\*Must be dispensed by a Specialty Pharmacy. Written referral required.

Please refer to the Summary of Benefits and Coverage (SBC) for additional information and to see what this plan covers and any cost-sharing responsibilities.