
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.yalehealth.yale.edu or call 1-203432-0246. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-203-432-0246 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits . COVID-19 testing is covered at no charge both in-network and out-of-network.
Are there other deductibles for specific services?	Yes, \$100 individual/\$300 family for speech therapy. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$6,350/individual; \$12,700/family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Call 1-203-432-0246 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays

		(balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Primary care visit to treat an injury or illness	\$0	Not covered	_____none_____

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If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	\$0	\$0 if preauthorized; otherwise not covered	Preauthorization required for out-of-network care. If preauthorization is not obtained, service is not covered. A \$25 late cancellation/no-show fee may apply at Yale Health Center if appointment is missed or cancelled less than 24 hours before scheduled appointment.
	<u>Preventive care/screening/immunization</u>	\$0	Not covered	Annual physical exam and well-woman exam limited to one visit/calendar year. Travel immunizations not covered.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	For x-rays, \$0 at Yale Health Center; \$10 copay outside of Yale Health Center For blood work, \$0 at any Quest Lab in New England	\$0 for x-ray and sonogram. \$0 for blood work. All services must be preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
	Imaging (CT/PET scans, MRIs)	\$0 at Yale Health Center \$0 outside of Yale Health Center	\$0 if preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered. A \$25 late cancellation/no-show fee may apply at Yale Health Center if appointment is missed or cancelled less than 24 hours before scheduled appointment.

What You Will Pay

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Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.yalehealth.yale.edu or call 1-203-4320246</p>	Tier 1 prescription drugs	<p>Retail:</p> <ul style="list-style-type: none"> • \$10 copay (up to 31 - day prescription) • \$20 copay (32-62 – day prescription) • \$20 copay (63-100 – day prescription) Mail: • \$20 copay/prescription (90-100 –day prescription) 	Greater of 20% of the price of the drug or the applicable Tier 1 copay (plan reimburses the difference)	If generic is available and brand is dispensed, member pays cost difference, unless prescriber indicates “dispense as written.”
	Tier 2 prescription drugs	<p>Retail:</p> <ul style="list-style-type: none"> • \$30 copay (up to 31 - day prescription) • \$60 copay (32-62 – day prescription) • \$60 copay (63-100 – day prescription) Mail: • \$60 copay/prescription (90-100 –day prescription) 	Greater of 20% of the price of the drug or the applicable Tier 2 copay (plan reimburses the difference)	If generic is available and brand is dispensed, member pays cost difference, unless prescriber indicates “dispense as written.”

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	Tier 3 prescription drugs	Retail: <ul style="list-style-type: none"> • \$50 copay (up to 31 - day prescription) • \$100 copay (32-62 – day prescription) • \$100 copay (63-100 – day prescription) Mail: <ul style="list-style-type: none"> • \$100 copay/prescription (90-100 –day prescription) 	Greater of 20% of the price of the drug or the applicable Tier 3 copay (plan reimburses the difference)	If generic is available and brand is dispensed, member pays cost difference, unless prescriber indicates “dispense as written.”
	<u>Specialty drugs</u>	Retail: <ul style="list-style-type: none"> • \$50 copay (up to 31 - day prescription) • \$100 copay (32-62 – day prescription) • \$100 copay (63-100 – day prescription) Mail: <ul style="list-style-type: none"> • \$100 copay/prescription (90-100 –day prescription) 	Greater of 20% of the price of the drug or the applicable Specialty copay (plan reimburses the difference)	If generic is available and brand is dispensed, member pays cost difference, unless prescriber indicates “dispense as written.”
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	Not covered	_____none_____
	Physician/surgeon fees	\$0	Not covered	_____none_____
	<u>Emergency room care</u>	\$70	\$70	Must meet definition of emergency. Copay waived if admitted or if Yale

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If you need immediate medical attention				Health is notified within 48 hours by calling 877-947-2273.
	Emergency medical transportation	\$0	\$0	Must meet definition of emergency.
	Urgent care (In-person care is available from 8am to 10pm Mon to Sun; 24/7 phone support by calling Yale Health Acute Care).	\$0 Coverage for in-person after hours care (between 10 pm and 8 am) at any of our network hospital/ED providers in CT: Yale-New Haven Hospital three locations: + Main Campus, 20 York St., New Haven + Saint Raphael Campus, 1450 Chapel St., New Haven + YNHH Shoreline Medical Center, 111 Goose Lane,	Facilities outside of Connecticut \$70 copay/visit	Must meet definition of urgent. Facilities in Connecticut other than those listed under “Network Providers” are not covered. Copay for facilities outside of Connecticut is waived if admitted or if Yale Health is notified withing 48 hours by calling 877-947-2273.
		Guilford		

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If you have a hospital stay	Facility fee (e.g., hospital room)	\$0	\$0 if preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
	Physician/surgeon fees	\$0	\$0 if preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	Not covered	_____none_____
	Inpatient services	\$0	Not covered	_____none_____
If you are pregnant	Office visits	\$0	Not covered	_____none_____
	Childbirth/delivery professional services	\$0	Not covered	_____none_____
	Childbirth/delivery facility services	\$0	Not covered	_____none_____
If you need help recovering or have other special health needs	Home health care	\$0	Not covered	Limited to 120 visits/calendar year Speech therapy covered after \$100 individual/\$300 family deductible up to a maximum of \$4,000 per injury or illness. Speech therapy that is not part of inpatient rehabilitation or home health care is subject to deductible and coinsurance. Cardiac rehabilitation limited to 36 visits/calendar year.
	Rehabilitation services	\$0, but for <ul style="list-style-type: none"> • Speech therapy: 20% coinsurance • Cardiac rehabilitation: \$10 copay/visit 	Not covered	

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	<u>Habilitation services</u>	\$0	Not covered	Includes physical, occupational, and speech therapy; must be medically necessary. Speech therapy that is not part of inpatient rehabilitation or home health care is subject to deductible and coinsurance. For physical therapy, a \$25 late cancellation/no-show fee may apply at Yale Health Center if appointment is missed or cancelled less than 24 hours before scheduled appointment.
	<u>Skilled nursing care</u>	\$0	Not covered	Limited to 120 visits/calendar year; covered only as part of home health care benefit.
	<u>Durable medical equipment</u>	\$0	Not covered	Otherwise, not covered. _____none_____
	<u>Hospice services</u>	\$0	Not covered	Limited to 60 days.
If your child needs dental or eye care	<u>Children's eye exam</u>	\$0 at Yale Health Center only	Not covered	Limited to 1 exam per 12-month period at Yale Health Center only.
	<u>Children's glasses</u>	Not covered	Not covered	_____none_____
	<u>Children's dental check-up</u>	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

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- Cosmetic surgery
- Most coverage provided outside the United States
- Private-duty nursing
- Dental care (Adult + Children)
- Routine foot care
- Non-emergency care when traveling outside the U.S.
- Long-term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (in lieu of anesthesia)
- Chiropractic care
- Infertility treatment
- Hair Removal
- Bariatric surgery
- Hearing aids (for children under age 12)
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at **1-203-432-5552**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: **1-203-432-0246** or visit us at **www.yalehealth.yale.edu** or contact the Department of Labor's Employee Benefit and Security Administration at **1-866-444EBSA (3272)**. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be

different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#)

amounts ([deductibles](#), [copayment s](#) and [coinsurance](#)) and [excluded service](#) [s](#) under the [plan](#). Use this information to compare the portion of

-only coverage. costs you might pay under different health [plans](#).

Please note these coverage examples are based on self

About these Coverage

Examples:

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copay \$0
- Inpatient copay \$0
- Rx copay \$10-20

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60

The total Peg would pay is	\$80
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copay \$0
- Inpatient copay \$0
- Rx copay \$10-30

This EXAMPLE event includes

services like: Primary care physician office visits (*including disease education*) Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,030
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$1,050
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The **plan's** overall **deductible** \$0
- **Specialist** copay \$0
- **Emergency Department copay** \$70
- **Other copay** \$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*) Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$70

The **plan** would be responsible for the other costs of these EXAMPLE covered services.