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 1-203-432-0246**. 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 referral to see a specialist?	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.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0	Not covered	——————————none——————————
	Specialist 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.
	Preventive care/screening/ immunization	$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	Diagnostic test (x-ray, blood work)	$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. Includes testing for COVID-19.
	Imaging (CT/PET scans, MRIs)	$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. 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.

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)	
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 **1-203-432-0246**	Tier 1 prescription drugs	**Retail**: • $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 checks box “dispense as written.”
	Tier 2 prescription drugs	**Retail**: • $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 checks box “dispense as written.”
	Tier 3 prescription drugs	**Retail**: • $50 copay (up to 31 -day prescription) • $100 copay (32-62 –day prescription) • $100 copay (63-100 –day prescription) **Mail**: • $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 checks box “dispense as written.”

	Specialty drugs	**Retail**: • $50 copay (up to 31 -day prescription) • $100 copay (32-62 –day prescription) • $100 copay (63-100 –day prescription) **Mail**: $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 you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	Not covered	——————none——————
	Physician/surgeon fees	$0	Not covered	——————none——————
If you need immediate medical attention	Emergency room care	$70	$70	Must meet definition of emergency. Copay waived if admitted or if Yale 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	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.

		+ YNHH Shoreline Medical Center, 111 Goose Lane, Guilford		
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
	Rehabilitation services	$0, but for • Speech therapy: 20% coinsurance • Cardiac rehabilitation: $10 copay/visit	Not covered	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.
	Habilitation services	$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.
	Skilled nursing care	$0	Not covered	Limited to 120 visits/calendar year; covered only as part of home health care benefit. Otherwise, not covered.
	Durable medical equipment	$0	Not covered	——————none——————
	Hospice services	$0	Not covered	Limited to 60 days.
If your child needs dental or eye care	Children's eye exam	$0	Not covered	Limited to 1 exam per 12-month period.
	Children's glasses	Not covered	Not covered	——————none——————
	Children's dental check-up	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.)

- Cosmetic surgery
- Dental care (Adult + Children)
- Long-term care
- Most coverage provided outside the United States
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot 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)
- Bariatric surgery
- Chiropractic care
- Hearing aids (for children under age 12)
- Infertility treatment
- 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 **1-866-444-**

EBSA (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.

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.

About these Coverage Examples:

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, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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**

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**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,030
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,050**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
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.