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, go to www.yalehealth.yale.edu or contact Member Services at 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf** or call **1-203-432-0246** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. $50 annual deductible for pediatric dental care (deductible does not apply to preventive & diagnostic). 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?	$9,100/individual; $18,200/family; $1,000 per person for hospital admission and surgical procedure copayments combined.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums (or plan fees for purposes of this plan), balance-billing 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. See https://yalehealth.yale.edu/directory/departments/student-health, https://yalehealth.yale.edu/directory/departments/mental-health-counseling, or call 1-877-947-2273 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. Visit https://yalehealth.yale.edu/coverage/student-coverage to learn more about network providers.
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 a referral 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	No charge	Not covered	---None---
	Specialist visit	At Yale Health Center: $0, except Allergy Dept: $25 copay/per visit. Outside of Yale Health Center: $20 copay/per visit	$20 copay/per visit	Preauthorization required for out-of-network care. If preauthorization is not obtained, service is not covered. Allergy Department office visits: $25 copay/per visit.
	Preventive care/ screening/immunization	No charge	Not covered	Physical exam and well-woman exam limited to one visit/calendar year. Immunizations covered based on Centers for Disease Control and Prevention (CDC) recommendations. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for. Travel immunizations and travel consultations are not covered. Select immunizations are available on a fee-for-service basis at Yale Health Center.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Preauthorization required for out-of-network care if non-emergency. Blood work is covered at in-network labs in New England only. If preauthorization is not obtained, service is not covered.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	---None---

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.**	Preferred drugs (Tier 1)	Retail: $10 copay/per prescription	Greater of 20% of the price of the drug or the applicable Tier 1 copay (plan reimburses the difference)	Copay covers up to a 30-day supply. Three copays are charged for up to 90-day supply. For out-of-network provider, the greater of 20% of the price of the drug or the applicable tier copay per prescription is charged (Yale Health reimburses the difference).
	Alternative drugs (Tier 2)	Retail: $30 copay/per prescription	Greater of 20% of the price of the drug or the applicable Tier 2 copay (plan reimburses the difference)	
	Non-preferred brand drugs & Specialty drugs (Tier 3)	Retail: $45 copay/per prescription	Greater of 20% of the price of the drug or the applicable Tier 3 copay (plan reimburses the difference)	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/per day	Not covered	---None---
	Physician/surgeon fees	No charge	Not covered	---None---
If you need immediate medical attention	Emergency room care	$50 copay/per visit	$50 copay/visit	Must meet definition of emergencyas defined by Yale Health Plan.
	Emergency medical transportation	No charge	No charge	Must meet definition of emergency as defined by Yale Health Plan.
	Urgent care	No charge	Out-of-network facilities in Connecticut: Not coveredOut-of-network facilities outside of Connecticut: $50 copay/visit	Must meet definition of urgent as defined by Yale Health Plan.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/per admission	$200 copay/per admission	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
	Physician/surgeon fees	No charge	No charge	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	No charge	Not covered	---None---
	Inpatient services	$200 copay/per admission	Not covered	---None---
If you are pregnant	Office visits	No charge	Not covered	---None---
	Childbirth/delivery professional services	No charge	Not covered	---None---
	Childbirth/delivery facility fee	$200 copay/per admission	$200 copay/per admission	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
	Home health care	No charge	Not covered	Limited to 100 days per year

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 help recovering or have other special health needs	Rehabilitation services	Outpatient – No charge except for Cardiac Rehabilitation: 20% coinsurance Inpatient - $200 copay/per admission	Not covered	Includes PT, OT, Speech. Speech therapy must be medically necessary, limited to 40 visits/calendar year. Lifetime maximum of 90 days of inpatient care at an approved rehabilitation hospital/ward. Cardiac rehabilitation is limited to 36 visits per year.
	Habilitation services	Outpatient – No charge; Inpatient - $200 copay/per admission	Not covered	Includes PT, OT, Speech. Speech therapy must be medically necessary, limited to 40 visits/calendar year. Lifetime maximum of 90 days of inpatient care at an approved rehabilitation hospital/ward.
	Skilled nursing care	No charge	Not covered	---None---
	Durable medical equipment	10% coinsurance	Not covered	The rental or purchase of durable medical equipment (braces, crutches, etc.) is covered at 90% when it is medically necessary for the treatment of an illness or injury and ordered in advance by a Yale Health network provider and approved in advance by the Yale Health Claims Department.
	Hospice services	No charge	Not covered	Limited to a maximum of 180 days.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	For children age 19 and under: one exam per 12 months, provided through EyeMed Vision Care, see appendix in student handbook for full details. Eye exams up to $28 reimbursement for out of network.

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)	
	Children's glasses	Frames – No charge, $100 allowance, 20% off balance over $100; Lenses - $25 copay/per pair once every 12 months	Frames – No charge	For children age 19 and under: one pair glasses per 12 months, provided through EyeMed Vision Care. Includes contacts, see appendix in student handbook for full details. Frames up to $50 reimbursement for out of network.
	Children's dental check-up	No charge (Preventive & Diagnostic care)	Not covered	For children age 19 and under: remaining basic, crowns, prosthodontics, and medically necessary orthodontics are covered at 50% coinsurance after $50 calendar year deductible. See appendix in student handbook for full details.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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.)

- Chiropractic care (20 visits per plan year)
- Hearing aids (1 purchase every 24 months)
- 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. The contact information for those agencies is: ct.gov/dss/. 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 on how 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/nondiscrimination-notice.

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 provide the Minimum Value Standards? Not Applicable

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-203-432-0246.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-203-432-0246.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-203-432-0246.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-203-432-0246.

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 copayment	**$0**
Hospital (facility) copayment	**$200**
Other coinsurance	**0%**

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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Peg would pay is	**$400**

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 copayment	**$0**
Hospital (facility) copayment	**$200**
Other coinsurance	**10%**

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	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$580**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) copayment	**$50**
Other coinsurance	**10%**

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	$50
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$60**

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