

Yale HEALTH

Student
Handbook
2023-2024

Welcome - or welcome back - to Yale. We're glad you're here, and we look forward to providing you with high quality, accessible medical care geared to your needs as a Yale student.

Yale Health is a not-for-profit healthcare organization that operates a medical facility on the Yale campus (at 55 Lock Street) and provides care to the entire Yale community both through that facility and through additional clinicians and services known as the "Yale Health network" - a term you will see as you read this handbook. Our clinicians - physicians, nurse practitioners, nurse midwives, physician assistants, and others - are board certified and committed to a team approach to health care.

General information

203-432-0246

Out of area care and medical advice

877-947-CARE (2273)

E-mail

member.services@yale.edu

Website

yalehealth.yale.edu

MyChart

<https://mychart.ynhhs.org>

At Yale Health you will find

- Comprehensive medical care available from 8 am-10 pm, 7 days a week, and nurse triage 24 hours a day, 7 days a week.
- Experienced clinicians in a wide variety of specialties.
- An emphasis on wellness care, with numerous education programs tailored to student needs.
- A wide range of mental health and counseling services.
- On-site pharmacy, blood draw, and diagnostic imaging services.
- A fully licensed, 15-bed, inpatient care facility.

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COVERAGE ESSENTIALS FOR STUDENTS

The first thing you should know about Yale Health is that, if you are an eligible enrolled student attending Yale at least half time and working towards a Yale degree, you receive many Yale Health services, including primary care, at no charge. You do not have to sign up or pay extra for access to Yale Health Basic Student Health Services, which is also known as Yale Health Basic. Your status as an eligible Yale University undergraduate, graduate, or professional student automatically makes you eligible for Yale Health Basic Student Health Services. The next thing you should know is that if you are eligible for Yale Health Basic Student Health Services the University requires you to obtain adequate insurance coverage for hospitalization and specialty care. Here, you have two options.

You are automatically enrolled and will be billed for Yale Health's Hospitalization/Specialty Coverage.

OR

If you have other coverage, either by being a dependent on someone else's plan (parents' or spouse's or civil union partner's) or by purchasing other coverage on your own, you can waive Yale Health Hospitalization/Specialty Coverage.

If you choose to use anything other than Yale Health Hospitalization/Specialty Coverage, you must give formal notice that you are waiving Yale Health Hospitalization/Specialty Coverage. You must give this notice each academic year.

Waiving Yale Health Hospitalization/Specialty Coverage

If you choose to waive you must submit an online waiver at yhpstudentwaiver.yale.edu. If you are waiving Yale Health Hospitalization/Specialty Coverage, you must provide proof of alternate coverage. Waivers for the full year or the fall term must be submitted annually by September 15, and waivers for the spring term only must be submitted by January 31.

If you do not submit this waiver by the deadline, you will be billed through your SFAS (Student Financial and Administrative Services) account for Yale Health Hospitalization/Specialty Coverage. Your SFAS account must be cleared in order for you to register for classes or graduate. If you waive Yale Health coverage, you may change your mind and revoke your waiver before the September 15 (or January 31 for spring term only) deadline by submitting a revoke waiver form to the Member Services Department. Your Yale Health coverage will begin retroactive to the beginning of the term. If you miss these deadlines, you must wait until the next term in which you are eligible.

Loss of Alternate Coverage

If you lose your non-Yale Health hospitalization insurance coverage, you must either revoke your waiver and enroll in Yale Health Hospitalization/Specialty Coverage, or select another health insurance carrier. If you choose to enroll in Yale Health Hospitalization/Specialty Coverage, you must do so within 30 days of the loss of other coverage. Yale Health's coverage begins the day following the other plan's termination date. Fees are not prorated, and you must pay for the full-term cost of the Yale Health plan.

Choosing Hospitalization Coverage

The three factors to consider when choosing your health insurance are cost, coverage, and convenience. Yale Health offers high-quality, low-cost, easy-to-use hospitalization, specialty, and prescription coverage, called Yale Health Hospitalization/Specialty Coverage. Details about specifics of services and coverage are in the Terms of Coverage section of this handbook. **Note:** If you waive Yale Health Hospitalization/Specialty Coverage, you should seek specialty services from providers outside of the Yale Health Center who accept your insurance.

Advantages of Yale Health Hospitalization/Specialty Coverage include:

COST	COVERAGE	CONVENIENCE
<ul style="list-style-type: none">• No deductibles• No copays for office visits at the Yale Health Center (with the exception of the Allergy Department)• No copay for acute care at the Yale Health Center• Reasonably priced, easy-to-use dependent coverage	<ul style="list-style-type: none">• No limitations on coverage for preexisting conditions• Worldwide coverage for emergency and urgent care• A wide range of experienced clinicians, all board-certified• Students covered for a full 12 months, not just the academic year	<ul style="list-style-type: none">• No claim forms to fill out for services obtained within the Yale Health network• Coordinated care when specialty and/or hospitalization services are required• On-site diagnostic imaging services

Some Yale students do decide on other plans if they expect to be away from campus for an extended time and want coverage for routine care, such as yearly physicals, or maintenance care (e.g., diabetes monitoring). Yale Health Hospitalization/Specialty Coverage covers only emergency and urgent care, not primary care or specialty care, away from campus.

Each year, as you consider whether to purchase your hospitalization, specialty, and prescription coverage through Yale Health or through another insurer, you should ask these questions:

- What is the other plan's provider network? Will the other insurer pay for services received at the Yale Health Center?
- What is the real cost of coverage, not just the cost of the fees? Are there deductibles? Are there maximums? Limits on reimbursements? Are there copays for office visits?
- What isn't covered?
- Does the plan require prior authorization for services you might need at the Yale Health Center? Does it require pre-certification for hospital admissions?
- Would you be required to go home for certain kinds of care, even if the care is available at the Yale Health Center? Would the other plan pay for that care only if you came home?

No insurance plan covers every medical contingency, so you should also be sure to compare the terms of coverage for Yale Health Hospitalization/Specialty Coverage with the contracts of other plans you are considering, particularly if you have specific medical concerns.

You may also wish to consider purchasing both Yale Health Hospitalization/Specialty Coverage and a plan that will cover you for routine and maintenance care while you are away from campus (again, Yale Health Hospitalization/Specialty Coverage will cover emergency and urgent care anywhere). If you do so, Yale Health can help you coordinate benefits.

TERMS OF COVERAGE

The following pages contain the terms of coverage for the Yale Health coverage options available to students and enrolled dependents. They describe eligibility and enrollment conditions, explain what kinds of coverage are available, list exclusions and limitations, explain when and under what conditions Yale Health coverage terminates, and outline miscellaneous provisions. Please read this section carefully to be fully aware of your rights and responsibilities as a Yale Health member.

Eligibility and Enrollment

The following section outlines the eligibility requirements for Yale Health Basic Student Health Services and enrollment in Yale Health Hospitalization/Specialty Coverage. If after reading this section you have any questions regarding your eligibility status, the enrollment deadlines, or the coverage dates, please contact Member Services (203-432-0246).

Insuring the Student

Eligible students and their dependents have a wide range of healthcare options while at Yale, these students receive primary care services at the Yale Health Center and are required to provide proof of existing and sufficient healthcare coverage. Dependents are not required to have coverage.

Yale Health Basic Student Health Services

If you are an **eligible degree-candidate student enrolled half-time or more**, the University provides you with primary care services at the Yale Health Center through Yale Health Basic Student Health Services. These services are automatically provided; you don't need to enroll or submit any forms. For new students and newly eligible students, basic services are available to you on the date required to be on campus for orientation and continue through July 31, providing you remain eligible. For returning students, access to *Basic Student Health Services* begins August 1 and ends July 31, providing you remain eligible. For full details, see the section *Yale Health Basic Student Health Services*.

Yale Health Hospitalization/Specialty Coverage

Most students meet the University requirement for hospitalization coverage by subscribing to Yale Health Hospitalization/Specialty Coverage, which provides coverage for all approved hospitalizations, specialty care services and prescription medications.

If you are an **eligible degree-candidate student enrolled half-time or more**, you are automatically enrolled in and billed for this coverage. Full-year coverage dates are identical to those for Yale Health Basic Student Health Services. However, Yale Health Hospitalization/Specialty Coverage may also be purchased for either the fall term only or spring term only. For new students and newly eligible students, coverage for fall term only begins on the date required to be on campus for orientation and continues through January 31, while coverage for spring term only begins on the date required to be on campus for orientation and continues through July 31. For returning students, coverage for fall term only begins August 1 and ends January 31, while coverage for spring term only begins February 1 and continues through July 31.

Students who do not want this coverage must provide proof of alternate insurance and submit a properly executed waiver online annually. To decline Yale Health Hospitalization/Specialty Coverage for the full year or fall term only, you must submit the waiver at www.yhpstudentwaiver.yale.edu by September 15; to decline coverage for spring term only, you must submit the waiver at www.yhpstudentwaiver.yale.edu by January 31. If waivers are not submitted by the deadlines, the fee for Yale Health Hospitalization/Specialty Coverage will be billed to your SFAS account.

For full details, see the section *Yale Health Hospitalization/Specialty Coverage*.

Note to students who waive: If students who are subject to the University requirement to obtain hospitalization insurance lose their non-Yale Health hospitalization insurance coverage, they must either revoke their waiver and enroll in Yale Health Hospitalization/Specialty Coverage or select another hospitalization insurance carrier. Students who choose to enroll in Yale Health Hospitalization/Specialty Coverage must do so within 30 days of the loss of other coverage. Yale Health coverage begins the day following the other plan's termination date. Fees are not prorated, and students must pay for the full-term cost of Yale Health Hospitalization/Specialty Coverage.

Yale Health Affiliate Coverage

Students who do not meet the eligibility requirements for Yale Health are not required by the University to obtain hospitalization coverage. They are eligible, however, to enroll in Yale Health Affiliate Coverage and receive primary and specialty care if they are:

- degree-candidate students who are no longer enrolled half-time or more or who are paying less than half of the term's tuition
- undergraduates in a junior-year-abroad program
- students registered as special students in a degree-candidate program
- students registered in absentia who are studying at another institution
- students on a leave of absence
- students enrolled in the MBA for Executives Program or the Broad Center MMS Program through the School of Management (SOM)
- students enrolled in the Physician Assistant (PA) Online Program through the School of Medicine
- students enrolled in the Executive MPH Program through the School of Public Health
- students enrolled in the Nursing Online Program through the School of Nursing

Yale Health Affiliate Coverage combines Yale Health Basic Student Health Services with the coverage offered by Yale Health Hospitalization/Specialty Coverage. Enrollment in this coverage is not automatic. The deadline for enrollment is September 15 for the full year or fall term, and January 31 for the spring term. Students are responsible for completing and submitting the appropriate enrollment forms and full payment to Member Services by the above deadlines. For MBA for Executives Program participants, Affiliate Coverage applications are available directly from the MBA for Executives Program, and special

enrollment deadlines apply (July 15th for full-year or fall-term coverage; January 15th for spring term only); for Broad Center MMS Program participants, Affiliate Coverage applications are available directly from the Broad Center MMS Program, and special enrollment deadlines apply (July 15th for full-year or fall-term coverage; January 15th for spring term only); for Physician Assistant Online Program participants, Affiliate Coverage applications are available directly from the Physician Assistant Online Program, and special enrollment deadlines apply (July 15th for full-year or fall-term coverage; January 15th for spring term only); for Executive MPH Program participants, Affiliate Coverage applications are available directly from the Executive MPH Program, and special enrollment deadlines apply (July 15th for full-year or fall-term coverage; January 15th for spring term only); for Nursing Online Program participants, Affiliate Coverage applications are available directly from the Nursing Online Program, and special enrollment deadlines apply (July 15th for full-year or fall-term coverage; January 15th for spring term only). Affiliate Coverage dates are identical to those for Yale Health Hospitalization/Specialty Coverage.

If you become ineligible for Yale Health coverage within the term, you are no longer required to have hospitalization insurance, however, if you meet the eligibility requirements for Yale Health Affiliate Coverage you may enroll in Yale Health Affiliate Coverage within 30 days of the date you become ineligible or wait until the next term in which you are eligible for this coverage. Fees paid for Yale Health Hospitalization/Specialty Coverage will be applied to the fees for Yale Health Affiliate Coverage.

Insuring Your Dependents

Dependents of any student enrolled in Yale Health Hospitalization/Specialty Coverage or Yale Health Affiliate Coverage may be enrolled as dependents in the same plan as the student, based on the eligibility requirements listed below. Dependents enrolled in Yale Health Hospitalization/Specialty Coverage or Yale Health Affiliate Coverage also receive their coverage under the same conditions and restrictions as the student.

Enrollment for dependents is not automatic and must be renewed annually.

Eligible dependents are:

- a student's lawfully married spouse
- a student's civil union partner
- any child under 26 years old who is the biologic or legally adopted child of the student or enrolled spouse/civil union partner, or a child for whom the student or enrolled spouse/civil union partner can provide proof of court-appointed guardianship or custody

Enrolling eligible dependents

You may enroll eligible dependents each year for full-year or fall-term coverage by completing and submitting an enrollment form and paying the appropriate fee to Yale Health Member Services prior to September 15. Coverage becomes effective at the same time as the student's coverage. The enrollment deadline for coverage for spring term only is January 31, and coverage becomes effective at the same time as the student's coverage. **If you fail to enroll your dependents by the enrollment deadlines you must wait until the next term in which they are eligible for coverage.**

A student who marries or is joined in a civil union during the term may enroll their **spouse/civil union partner** by submitting an enrollment form to Member Services within 30 days of the marriage/civil union and paying the full term fee. Fees will not be prorated. Coverage begins the first day of the month following the marriage/civil union.

A **newborn child** may be enrolled in Yale Health and covered from the moment of birth, provided that the newborn meets the dependent eligibility criteria and is enrolled within 30 days of birth. Upon notification by the student of the child’s birth, Yale Health Member Services will send an enrollment change application to the enrolled parent(s) of the newborn child. If after 30 days the newborn child is not added to the coverage, Yale Health will bill the student for all services rendered to the newborn from the date of birth. If you do not enroll your newborn child within 30 days of the date of birth you must wait until the next term in which the child is eligible for coverage.

If a pediatrician outside the Yale Health network is chosen, neither professional nor hospital charges for the baby will be covered.

An **adopted child** must be enrolled within 30 days of the date on which the child is placed in the student’s household. Coverage begins on the first day of placement if the enrollment form is received within 30 days of the date of placement. Legal documentation is required before coverage can become effective. Contact Member Services to ensure that you supply the correct documentation. If you do not add the child within 30 days of placement or adoption you must wait until the next term in which the child is eligible for coverage.

A child for whom you or your enrolled spouse/civil union partner are the **legal custodian or guardian** must be enrolled within 30 days of the date of court-appointed custody or guardianship. Legal documentation is required before coverage can become effective. Contact Member Services to ensure that you supply the correct documentation. If you do not add the child within 30 days you must wait until the next term in which the child is eligible for coverage.

Please note that **if your dependents lose other coverage**, you must enroll them within 30 days of the loss of other coverage and provide proof of the loss of coverage or wait until the following term in which they are eligible for coverage. Fees will not be prorated. Coverage begins the day after the other coverage ends.

Dates of Coverage

Student type	Full year	Fall term only	Spring term only
New students and newly eligible students	Date required to be on campus for orientation through July 31	Date required to be on campus for orientation through January 31	Date required to be on campus through July 31
Returning students	August 1 through July 31	August 1 through January 31	February 1 through July 31
Students who revoke their waiver because of loss of alternate coverage	The day after the other plan’s termination date through July 31	The day after the other plan’s termination date through January 31	The day after the other plan’s termination date through July 31

YALE HEALTH BASIC STUDENT HEALTH SERVICES

Primary care services are provided at the Yale Health Center for students who meet the eligibility criteria outlined in the section *Eligibility and Enrollment*. Primary care services are not covered if they are rendered by clinicians outside of the Yale Health Center. Primary care services at the Yale Health Center are coordinated by clinicians in the primary care departments, which are:

- Student Health
- Athletic Medicine (varsity athletes)
- Pediatrics
- Gynecology
- Acute Care
- Mental Health and Counseling

Additional services are also offered at no charge to eligible students within the Yale Health network and with a referral from a Yale Health clinician:

- Laboratory services (on-site and at any Quest Diagnostic laboratory in New England)
- Nutritional counseling at the Yale Health Center
- Inpatient care (for up to 30 days) at the Yale Health Inpatient Care Department
- Outpatient counseling services outside of the Yale Health Center (with any provider within the Yale Health network)
- Tobacco counseling geared towards helping students quit tobacco through the Tobacco Free Yale Assistance Program for Students

Yale Health Basic Student Health Services also include:

- Flu shots
- COVID vaccinations
- Post exposure immunizations
- Emergency contraception

Yale Health Basic Student Health Services include access to medical and surgical abortions performed by participating providers.

Unpaid or non-covered services may be billed to your SFAS account. Specialty care services, even if rendered in a primary care department, are covered under Yale Health Hospitalization/Specialty Coverage

or, if the student has waived the coverage, are the student's responsibility.

The Primary Care Clinician

The Primary Care Clinician (PCC) coordinates medical care, as appropriate either by providing treatment or by directing the student to other network providers for other services and supplies. The PCC orders lab tests and x-rays, prescribes medicines or therapies, and arranges hospitalization.

Students are encouraged to choose a physician, nurse practitioner or physician associate as their PCC. Women and persons who have or have had female organs should also choose a gynecologist or certified nurse midwife for routine gynecological care. A clinician in the Pediatrics Department should be chosen for enrolled dependent children. If students do not choose, clinicians will be designated for the student and their covered dependents.

Students can review a list of Yale Health's PCCs at www.yalehealth.yale.edu.

Changing Your PCC

Students may change their PCC at any time by contacting Member Services at member.services@yale.edu or 203-432-0246.

YALE HEALTH HOSPITALIZATION/SPECIALTY COVERAGE

Students who are eligible for Yale Health Basic Student Health Services are automatically enrolled in Yale Health Hospitalization/Specialty Coverage. Yale Health dependent coverage includes Yale Health Basic and all of the coverage outlined in the section *Yale Health Hospitalization/Specialty Coverage*.

Yale Health Hospitalization/Specialty Coverage includes free generic oral contraceptives, and related devices at the Yale Health Center Pharmacy, and free preventive immunizations at the Yale Health Center. It covers approved outpatient specialty care at the Yale Health Center at 100% in the following departments: Allergy, Dermatology, Diagnostic Imaging, Specialty Services, Obstetrics and Gynecology, Ophthalmology, and Physical Therapy, excluding approved visits to the Yale Health allergist which is covered at 100% after a \$25 copay. Approved outpatient specialty care received outside of Yale Health Center is covered at 100% after a \$20 copay. Yale Health Hospitalization/Specialty Coverage also covers approved inpatient care at Yale Health-approved inpatient facilities and all approved emergency care received at any location. Copays for approved hospital care outside of the Yale Health Center are as follows:

- \$50 copay for emergency room visits
- \$100 copay for outpatient surgeries
- \$200 copay per admission for hospital stays

In multiple copay situations, the higher copay prevails. The maximum combined out-of-pocket expense for hospital admission and surgical procedure copayments is \$1,000 per person, per plan year (August 1 – July 31). 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. The out-of-pocket limit is \$9,100 for individuals and \$18,200 for families.

There are no copays for visits to the Acute Care Department, procedures performed at the Yale Health Center, nor stays in the Yale Health Center Inpatient Care unit.

Preventive Care

Preventive services are not subject to cost-sharing (copayments, deductibles or coinsurance) when performed by a participating provider and provided the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), see link <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/> for a listing of these items/services.

a) Well-Baby and Well-Child Care. All well-baby and well-child care which consists of routine physical examinations including vision and hearing screenings, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. Also covered are the preventive care and screenings listed with an “A” or “B” rating from USPSTF (see link; <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>), including blood lead screening. Immunizations and boosters as required by ACIP are all covered (see link <https://www.cdc.gov/vaccines/schedules/hcp/index.html>). This benefit is provided to members from birth through the age of 19.

b) Annual Physical Examinations. All adult physical examinations and preventive care and screenings are covered as listed with an “A” or “B” rating from USPSTF (see link <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>). This includes but is not limited to, blood pressure screenings, cholesterol screening, colorectal cancer screening and diabetes screening.

You are eligible for a physical examination once every calendar year. In addition all adult immunizations as recommended by ACIP are covered under this plan (see link <http://www.cdc.gov/vaccines/schedules/hcp/index.html>).

c) Gynecologic Examinations. All gynecologic examinations which consist of a routine examination, cervical cancer screening, including laboratory and diagnostic services in connection with cervical cancer screening are covered under this plan. In addition all items or services with an “A” or “B” rating from USPSTF are covered (see link <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>).

The plan also covers preventive care and screenings as provided in the comprehensive guidelines supported by HRSA. (see link <http://www.hrsa.gov/womensguidelines/>).

You are eligible for a gynecologic examination once every calendar year.

d) Mammograms. All mammograms for the screening of breast cancer are covered as follows:

- One (1) baseline screening mammogram for women and persons with breasts age 35-39
- One (1) baseline screening mammogram annually for women and persons with breasts age 40 and over.

If an individual of any age has a history of breast cancer or a first degree relative with a history of breast cancer, or other indications, mammograms will be covered with a referral from the participating provider.

e) Family Planning and Reproductive Health Services. The plan covers family planning services which consist of FDA-approved contraceptive methods prescribed by a participating provider, counseling on use of contraceptives and related topics, and sterilization procedures for individuals. Also covered are vasectomies when performed by participating providers.

Exclusion:

The plan does not cover services related to the reversal of elective sterilizations.

f. Bone Mineral Density Measurements or Testing. The plan covers bone mineral density measurements or tests, and prescription drugs and devices as approved by the FDA or generic equivalents as approved substitutes. Coverage of prescription drugs is subject to the prescription drug coverage section of this plan.

Outpatient coverage

Outpatient care means health care received without being admitted to a hospital or other facility. The specialty services offered at the Yale Health Center are outpatient services and most are covered at 100% for enrolled students and their enrolled dependents. This does not include services offered on a fee-for-service basis. For additional exceptions to this policy, see the section *Exclusions and Limitations*.

Outpatient Coverage Outside Yale Health Center

Outpatient care received outside of the Yale Health network of healthcare clinicians and facilities is not covered under Yale Health Hospitalization/Specialty Coverage except for an emergency or urgent condition (see the section *Emergency Care Coverage* for a full explanation) or for care that has been arranged in advance by a Yale Health clinician and approved in advance by the Referrals Department. If in the course of medical evaluation and treatment, a member requires outpatient services not provided at the Yale Health Center, the member's primary care clinician may make a referral to an approved specialist in the Yale Health network outside the Yale Health Center. Prior authorization for coverage of these services must be obtained from the Yale Health Referrals Department. A referral from your primary care clinician is necessary but does not constitute authorization for coverage. Authorization for coverage must be obtained from the Referrals Department. Approved claims are covered at 100%.

Please note that Yale Health will not pay for the services of a non-Yale Health network clinician unless those services, including all testing and treatment ordered by the non-Yale Health network clinician, are authorized in advance by the Yale Health Referrals Department. This is true even if the member was referred for the services by a Yale Health network clinician, except in the case of emergencies (see the section *Emergency Care Coverage*).

Outpatient psychotherapy services for dependent children

Yale Health Hospitalization/Specialty Coverage covers outpatient psychotherapy services for an enrolled student's (or enrolled spouse's/civil union partner's) enrolled children under the care of one of the following providers licensed in CT: a licensed clinical psychologist, psychiatrist, licensed clinical social worker, or certified alcohol counselor. Outpatient services require prior authorization by a Yale Health provider. Periodic re-authorization for coverage of ongoing care is required. Charges for separate sessions with parents are not covered. For students and their enrolled spouse/civil union partner, psychotherapy is available only at the Yale Health Center under Yale Health Basic Student Health Services or Yale Health Affiliate Coverage; there is no reimbursement for outside services.

Applied Behavioral Analysis (ABA) Therapy coverage for children with a verified diagnosis of autism spectrum disorder.

Covered services include applied behavioral analysis (ABA) treatment for members with a verified diagnosis of autism spectrum disorder. An approved referral is required. Treatment will be authorized and managed by Magellan Health Services who will contract with agencies that provide ABA in this area. Authorization will be subject to medical necessity criteria and ongoing review to make sure that the therapy remains necessary, and that progress is being made toward identified goals. Members who are interested can contact Magellan for more information. A referral is not needed, but before ABA is authorized, Magellan will need to verify the diagnosis with a primary care clinician (PCC) and/or appropriate consultants who have conducted a diagnostic assessment. These assessments are usually covered under the medical benefit and require an approved referral from the PCC.

Inpatient Coverage

Yale Health will provide coverage for medically necessary inpatient care at a Yale Health-approved inpatient facility — licensed acute care hospital, approved skilled nursing facility, approved psychiatric hospital, approved substance abuse treatment center, approved rehabilitation center — under the authorized care of a Yale Health network physician under the terms outlined below. If, in the judgment of Yale Health, the illness or injury or its continuing care could have been treated in the Inpatient Care Department at the Yale Health Center, payment for inpatient hospital charges for students will be denied. Except for emergency admissions, any inpatient charges incurred for a hospital admission supervised by a non-Yale Health physician will be denied. For emergency care, see the section *Emergency Care Coverage*. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

Acute care medical/surgical admissions

Medically necessary inpatient care at a Yale Health-approved short-term general hospital under the care of a Yale Health network physician is covered (see the limitations for inpatient rehabilitation, psychiatric, or substance abuse care). Coverage includes the cost of a semi-private room, meals, general nursing care, and most non-professional fees billed by the hospital. In addition, professional fees of Yale Health network clinicians will be covered in full. Coverage does not include charges for convenience or personal comfort items, such as a television or telephone. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

Pregnancy Related Expenses

Services and supplies provided by a Yale Health network obstetrical clinician for pregnancy and childbirth are authorized at the same level as any illness or injury. This includes prenatal visits, delivery, and postnatal visits. Inpatient care of the pregnant individual and newborn child provided at Yale-New Haven Hospital are also authorized expenses.

Important Notes

Authorized expenses also include services and supplies provided for circumcision.

If a clinician outside the Yale Health network is chosen to care for the newborn, the associated charges, including hospital charges, will not be covered.

Charges for both pregnant individual and newborn, including admission, labor, delivery, recovery and newborn care, will be covered only at Yale-New Haven Hospital and providing that the pregnant individual and the newborn are enrolled in the plan.

Please note in regard to labor and delivery coverage: starting from four weeks before your due date, or earlier if you are advised not to travel by the Yale Health network obstetrical clinician, charges associated with hospital admission will be covered only at Yale-New Haven Hospital. High risk pregnancy itself is not considered emergent and will not be an exception. The onset of labor that happens to occur while the individual is away from New Haven will not be an exception. Exceptions will be made only when the admission to another facility is for a potentially life-threatening condition.

Rehabilitation Admissions

Rehabilitation admissions are covered for a lifetime maximum of 90 days of inpatient care at a Yale Health-approved, non-psychiatric rehabilitation hospital or rehabilitation ward of a general hospital. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#). Covered expenses include charges for services and supplies that are medically necessary, provided at a pre-approved facility, and authorized by a Yale Health physician. These services include physical therapy, and occupational therapy, speech therapy for acute conditions, illnesses and injuries, provided that the therapy is expected to restore or significantly improve physical function lost or impaired by an illness, injury or procedure and provided that the therapy cannot be effectively provided in a less costly setting. The member must be able and willing to participate in the level of therapy provided in an inpatient rehabilitation setting.

Outpatient Rehabilitation

Covered expenses include charges for services and supplies that are medically necessary and are provided within the Yale Health Center or in a pre-approved facility. These services include physical therapy, occupational therapy, speech therapy, cognitive therapy, and cardiac or pulmonary rehabilitation services. Care must be ordered by a Yale Health physician, requires prior authorization, and must meet other medical necessity requirements including the likelihood that therapy will result in meaningful improvement or restoration of physical or mental function lost or impaired by an illness, injury, or procedure. Cardiac Rehabilitation is limited to 36 visits per year and covered after a 20% coinsurance. Other specific services may be restricted or limited as outlined in the *Schedule of Benefits*.

Psychiatric or Substance Abuse Admissions

Medically necessary direct care of the acute phase of a mental condition or substance abuse problem at a Yale Health-approved psychiatric hospital, psychiatric ward of a general hospital, or institution that specializes in the treatment of substance abuse is covered. Coverage includes the cost of a semi-private room, meals, general nursing care, most non-professional fees billed by the hospital, and professional fees for services provided by non-Yale Health psychiatric clinicians. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

Allergy Services

Visits to the Yale Health allergist at the Yale Health Center are covered at 100% after a \$25 copay.

Dental Services

Dental services for follow-up care to a traumatic accidental injury to sound natural teeth are covered at 100% up to a maximum of \$5,000/plan year.

Electrolysis/Hair Removal

The plan offers partial and limited reimbursement for facial hair removal provided there is persistent, unwanted facial hair with the equivalent of 3 or greater for facial areas on the Ferrman-Gallway scale and a diagnosis that establishes the medical necessity of hair removal, such as facial hirsutism, gender incongruence or painful skin conditions. With prior authorization, services by a certified electrologist

licensed in the state of Connecticut are reimbursed at a rate of up to \$125 per one-hour session with a lifetime maximum benefit of \$10,000.

Permanent hair removal that is required for approved surgical procedures is reimbursable without limits when approved in advance.

Durable Medical Equipment

The rental or purchase of durable medical equipment (braces, crutches, CPAP, 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 clinician and approved in advance by the Yale Health Referrals Department.

Yale Health considers standard mechanical peak flow meters and spacers for metered-dose inhalers medically necessary durable medical equipment (DME) for members with asthma, bronchitis, emphysema, or other obstructive pulmonary conditions.

Emergency Care Coverage

Care for an emergency medical condition is covered at facilities worldwide. If you have an emergency medical condition, go to the nearest medical facility for treatment. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

An “Emergency Medical Condition” is defined as a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention could realistically be expected to result in:

- placing the health of the individual (or, with respect to a pregnant individual, the health of the individual or the unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant individual who is having contractions--
 - a) that there is inadequate time to affect a safe transfer to another hospital before delivery, or
 - b) that transfer may pose a threat to the health or safety of the individual or the unborn child.

When emergency care is necessary, please follow the guidelines below:

- Seek the nearest medical facility, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call Acute Care (203-432-0123) provided a delay would not be detrimental to your health.
- Within New Haven County, three emergency departments are in network and approved emergency facilities unless the member is transported by ambulance to another facility.
 - Yale New Haven Hospital, Main Campus, 20 York St., New Haven
 - Saint Raphael Campus, 1450 Chapel St., New Haven
 - YNHH Shoreline Medical Center, 111 Goose Lane, Guilford

- After assessing and stabilizing your condition, the facility should contact Acute Care (203-432-0123) to obtain your medical history and to assist the emergency physician in your treatment.
- If you obtain care for a non-emergency condition (one that does not meet the criteria above), the plan will not cover the expenses.
- Notification within 48 hours is required. Call Yale Health, the number is listed on your ID card.

The plan covers services provided in an emergency department to evaluate and treat an emergency medical condition.

Please contact the Yale Health Referrals Department (203-432-7397) after receiving treatment of an emergency medical condition.

Important Note

You should carry your Yale Health membership card with you at all times to ensure that someone will be able to contact Yale Health in the event of an incapacitating emergency. Your membership card may be downloaded from our website (<https://yalehealth.yale.edu/directory/departments/member-services>)

Emergency care and pre-authorized follow-up care for emergency conditions is covered regardless of location. An emergency condition is defined as a major acute medical problem or major acute trauma that requires immediate medical attention or a condition that could lead to serious harm or death if care is not received or is delayed. Coverage includes emergency facility fees, laboratory expenses, radiological expenses, emergency physicians' fees, ambulance transportation, and pre-authorized short-term follow-up care. If you need emergency care, go to the nearest emergency facility for treatment. Treatment for emergency conditions is covered at all emergency facilities worldwide. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

Please contact the Yale Health Referrals Department within 48 hours (or 2 business days) of receiving emergency outpatient treatment or being admitted to an emergency facility. If possible, call Acute Care (203-432-0123) before receiving emergency treatment. The Referrals Department will (1) notify Yale Health clinical staff of your condition so that they can coordinate your care as appropriate or make any further arrangements for your care and (2) pre-authorize any necessary follow-up care. **Follow-up care that is not pre-authorized may be denied.** If Yale Health deems it appropriate, Yale Health may arrange for and cover the expenses of transporting you to a Yale Health-approved facility to receive follow-up care. If the severity of your medical condition prevents you or your representative from contacting the Yale Health Referrals Department within 48 hours, you will still be covered for the emergency; but you should contact Referrals as soon as possible to ensure that Yale Health clinical staff are aware of your condition and to request that the Referrals Department pre-authorize follow-up care. You are strongly encouraged to carry your Yale Health membership card with you at all times to ensure that someone will be able to contact Yale Health in the event of an incapacitating emergency.

Urgent care is covered at 100% when it is received at the Acute Care Department at the Yale Health Center. An urgent condition is defined as the sudden and unexpected onset of an acute medical problem or trauma that requires immediate medical attention. Care for non-acute phases of chronic conditions, maintenance care, and routine care are not considered urgent. If you are away from Connecticut, you are considered out of area and you may receive urgent care at any medical facility and receive the same

coverage as for emergency care, including pre-authorized short-term follow-up care. No distinction is made in coverage between urgent care and emergency care received out of area. When you are in Connecticut urgent care is only covered when it is received at the Yale Health Center (the Acute Care Department is open 8 am – 10pm 7 days a week, and nurse triage is available 24 hours a day/7 days a week). For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#). You should contact the Yale Health Referrals Department within 48 hours (or 2 business days) of any care received out of area for an urgent condition to ensure that Yale Health clinical staff are aware of your condition and to request the Referrals Department to pre-authorize follow-up care. Follow-up care that is not pre-authorized may be denied.

If, in the judgment of Yale Health, the illness or injury does not meet the plan definition of an emergency or urgent condition, coverage will be denied. This includes all elective admissions or treatments. Coverage will also be denied for conditions that could have been but were not treated at the Yale Health Center while the student or enrolled dependent was in area.

Infertility Services

Yale Health defines infertility as a person's inability to reproduce either as a single individual or with a partner without medical intervention; or a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing. Our goal is to provide programs and services to meet our students' needs for fertility treatment for every path to parenthood.

Treatment provided for assisted conception or infertility services by a Yale Health or Yale Health network clinician is covered at 100% when referred by a Yale Health clinician and approved in advance by the Referrals Department. Students are urged to contact the Yale Health Referrals Department with any questions regarding authorization to avoid responsibility for the cost of services.

Available services include:

- Diagnosis of and consultation for individuals with male and female anatomy experiencing infertility.
- Assisted conception: service provided to a fertile individual with female anatomy who wishes to conceive using donor sperm.
- Basic infertility services (excluding IVF): including but not limited to:
 - Treatment to stimulate/induce ovulation and intrauterine insemination for infertile members with female anatomy; and
 - Infertility-related surgery and other procedures.
- Advanced reproductive technologies (ART), including IVF: In vitro fertilization (IVF) for students who do not or cannot conceive with basic infertility services.

- Components of In Vitro Fertilization

Please note that diagnosis of infertility, assisted conception, and basic infertility services are considered together. Separate lifetime limits apply to advanced reproductive technologies. See the Schedule of Benefits for details.

Definitions: Certain definitions apply to the coverage of all infertility and assisted conception services, including:

- Male anatomy infertility: failure to conceive with a fertile partner with female anatomy after one year of unprotected coitus. Infertility must be diagnosed by a network infertility specialist and documented in the medical record.
- Female anatomy infertility: failure to conceive with a fertile partner with male anatomy after one year of unprotected coitus. Infertility must be diagnosed by a network infertility specialist and documented in the medical record.
- Premature menopause: Individuals with ovarian failure who are less than 40 years of age are considered to have premature ovarian failure. Advanced reproductive technology (in vitro fertilization) services are considered medically necessary for individuals with premature ovarian failure who are less than 40 years of age.
- Adequate ovarian reserve: adequate ovarian function to result in a reasonable likelihood of successful induction and retrieval of viable oocytes. Ovarian reserve may be determined by measurement of serum FSH. To determine adequate ovarian reserve for individuals who are less than age 40, the day 3 FSH must be less than 19 mIU/mL in their most recent lab test. For individuals aged 40 and older, their unmedicated day 3 FSH must be less than 19 mIU/mL in all prior tests.

Diagnosis of and consultation for individuals with male and female anatomy experiencing infertility

Eligibility: all students of reproductive age. Prior authorization by Yale Health is required for all infertility services.

Coverage includes consultation, diagnostic imaging, and sperm analysis.

Exclusions (in addition to the exclusions and limitations above):

- Home ovulation prediction kits.
- Infertility services for individuals with natural menopause are not covered as such services are not considered treatment of disease.

Assisted conception

Eligibility: fertile members with female anatomy. Limits apply per covered member with female anatomy. Prior authorization by Yale Health is required for all infertility services.

Coverage includes services related to intrauterine insemination using donor sperm.

Basic infertility services

Eligibility: infertile members with female anatomy. Limits apply per covered member with female anatomy. Prior authorization by Yale Health is required for all infertility services.

Coverage includes but is not limited to:

- Treatment to stimulate/induce ovulation.
- Intrauterine insemination for infertile members with female anatomy.

- Infertility-related surgery and other procedures.

Exclusions (in addition to the exclusions and limitations above):

- Services for individuals with natural menopause age 40 and older
- Cost of acquisition, processing, testing, or storage of donor sperm or egg
- Any drugs or products eligible for coverage under the Pharmacy benefit
- Reversal of sterilization procedures

IVF / Advanced Reproductive Technologies

Eligibility: infertile members with female anatomy for whom a successful pregnancy cannot be attained through less costly treatment(s) covered by this plan, including the services covered under Basic Infertility. In most cases, this is interpreted as a failure to conceive after three cycles of intrauterine insemination. Coverage is subject to the lifetime limits of IVF/ART. Limits apply per covered student. Prior authorization by Yale Health is required for all infertility services.

Coverage: includes but is not limited to induction of ovulation, harvesting of oocytes, in vitro fertilization, and transfer of embryo(s) into an eligible covered member. In-vitro fertilization is covered for male/male couples. Any one of these services will constitute one cycle of treatment regardless of whether this results in the transfer of a viable embryo.

Exclusions and limitations (in addition to the exclusions and limitations above):

- Any drugs or products eligible for coverage under the Pharmacy benefit.
- Coverage for IVF using a member's own eggs depends upon having an adequate ovarian function to result in a reasonable likelihood of successful induction and retrieval of viable oocytes.
- IVF in fertile individuals for any purpose other than those stated above, including for the purpose of preimplantation genetic diagnosis (PGD) or screening (PGS) is not covered. If a parent is a known carrier of a clinically significant and detectable autosomal dominant genetic disease that manifests in childhood, or both parents carry the same autosomal recessive gene mutation which would result in a clinically significant disease that manifests in childhood, preimplantation genetic testing for the gene mutation (PGT-M) to select unaffected embryos for transfer would be covered (may be subject to limitations); the IVF costs are covered in this situation (may be subject to limitations).
- Services for couples in which one of the partners has had previous sterilization procedure(s).
- Charges associated with the care of a gestational surrogate unless the surrogate is an eligible member. (See University Benefit)
- Services that are not reasonably likely to result in success.
- Investigational treatments, regimens, medications, or procedures.
- Experimental fertility procedures for which published medical evidence is not sufficient for the American Society for Reproductive Medicine, or a comparable organization to regard the procedure as an established medical practice.
- Expanded carrier testing of embryos.
- PGTA testing of embryos.
- IVF for cryopreservation of oocytes or embryos for preservation of future fertility due to aging.

Special exclusions may apply to individual components of coverage.

Fertility Preservation

Induction of ovulation, oocyte harvesting, and cryopreservation of oocytes or embryos may be covered for individuals accessing infertility services, and for those individuals facing infertility due to chemotherapy, pelvic radiotherapy (or other gonadotoxic therapies), or medically necessary treatments/surgery that will impair fertility. Plan limitations, restrictions, and exclusions apply. Please see the *Schedule of Benefits*. The use of ART to obtain oocytes or embryos for cryopreservation to circumvent reproductive aging in healthy individuals is not considered medically necessary and is not covered. Services may be subject to limitations or restrictions as described in the Schedule of Benefits.

Ophthalmologic Services

Visits to the Ophthalmology Department at the Yale Health Center are covered at 100%, including annual routine eye exams. This includes the coverage of corneal pachymetry at no charge.

Organ Transplants

Covered expenses include charges incurred for hospital and medical services related to non-experimental transplants when a referral has been made by a Yale Health network clinician and authorized in advance by the Yale Health Referrals Department. This includes hospitalization charges, professional fees, the direct costs of the organ and organ procurement and is limited to expenses not covered by other insurance coverage, grants, foundations, government programs, etc. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

Organ means solid organ; stem cell; bone marrow; and tissue, including:

- Heart
- Lung
- Heart/Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell
- Multiple organs replaced during one transplant surgery

- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the plan.

Covered transplant expenses are typically incurred during the three phases of transplant care described below.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The three phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and
3. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event or with prior authorization.

Pediatric Dental Care

Pediatric dental care is covered through Delta Dental of Connecticut (<http://www.deltadentalct.com>) for students and enrolled dependents age 19 and under. Coverage includes preventive and diagnostic care (exams, cleanings, bitewing x-rays, fluoride treatment, sealants, space maintainers), remaining basic care (fillings, extractions, root canals, periodontics, oral surgery), prosthodontic care (crowns, restorations, bridgework, dentures), and medically necessary orthodontic care. Please refer to the Appendix B, Summary of Benefits & Coverage as well as Delta Dental of Connecticut's web site (<http://www.deltadentalct.com>) for cost-sharing requirements, day/visit limits or plan maximums, network information, any preauthorization or referral requirements, and to obtain an ID card. There is a \$50 annual deductible for pediatric dental care.

Pediatric Eye Care

Pediatric eye care is covered through EyeMed Vision Care (www.eyemed.com) for students and enrolled dependents age 19 and under. Coverage includes emergency, preventive and routine eye care. Please refer to

the Appendix B, Summary of Benefits & Coverage as well as EyeMed Vision Care's web site (www.eyemed.com) for cost-sharing requirements, day or visit limits, network information, any preauthorization or referral requirements, and to obtain an ID card.

Vision Examinations

Pediatric eye care coverage includes vision examinations for students and enrolled dependents age 19 and under, for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. One vision examination is covered per plan year, unless more frequent examinations are medically necessary as evidenced by appropriate documentation.

Vision examinations are covered for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. One vision examination is covered per plan year, unless more frequent examinations are medically necessary as evidenced by appropriate documentation.

Prescribed Lenses and Frames

Pediatric eye care coverage includes but is not limited to standard prescription lenses or contact lenses for students and enrolled dependents age 19 and under, one (1) time per plan year; unless it is medically necessary to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation (Please refer to the Appendix B for a full list of covered lenses which include detail on items such as fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses; polycarbonate prescription lenses with scratch resistance coating and low vision items). Standard frames adequate to hold lenses are covered for students and enrolled dependents age 19 and under, one (1) time per plan year; unless it is medically necessary to have new frames more frequently, as evidenced by appropriate documentation. Medically necessary contact lenses are covered in the event of Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism (this is not an exhaustive list). All requests for medically necessary contact lenses must be submitted by a network provider for review and approval by our Chief Medical Officer before a claim will be processed.

Podiatry Services

Medically necessary foot care due to an underlying medical condition, such as diabetes mellitus, circulatory and neurological disorders, or morbid obesity when provided by a licensed podiatrist is covered. Podiatry services must be ordered in advance by a Yale Health network clinician and approved in advance by the Yale Health Referrals Department. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

Prosthetic Devices

Prosthetic devices, when they are medically necessary to replace a body part lost due to illness or injury, either external or internal, are covered at 90%. Dentures, dental appliances and implants, are not covered. Prior authorization by a Yale Health network clinician and prior approval by the Yale Health Referrals Department are required. Charges for replacement of a prosthetic device are covered only when replacement becomes medically necessary due to a change in the body.

Speech Therapy

Speech therapy is covered up to a maximum of 40 visits per plan year when it is medically necessary to bring about or restore normal function of the speech mechanism —when impaired due to congenital anomaly, illness, or accidental trauma — if it is ordered in advance by a Yale Health network clinician and approved in advance by the Yale Health Referrals Department. Please note that public schools are required by law to provide this service for children 3 years and older. For applicable copays, reference the list at the beginning of the [Hospitalization/Specialty Coverage section](#).

Tobacco Counseling and Nicotine Replacement Therapy

Students and their dependents may discuss the best aids for nicotine replacement/quitting tobacco with their PCC, options may include prescription medications, and/or reach out to the Student Health Educator for available free technology-based resources. Some nicotine replacement therapy products are available at no cost for students and their covered dependents while others are covered under Prescription Coverage.

Gender Affirmation Services

Medically necessary services for gender-affirmation, including counseling, hormone therapy, and specific surgical procedures are covered. Eligibility guidelines, based on widely accepted professional standards, apply to eligibility for drug therapy and surgical procedures. A complete list of covered services is available in the [Clinical Policy Bulletin: Coverage for Treatments Related to Gender Affirming Care](#). Services may be subject to limitations or restrictions as described in the *Schedule of Benefits*.

The Plan covers medically necessary treatments for gender dysphoria and gender incongruence as described below. These treatments may include:

- Hormone therapy to feminize or masculinize the body.
- Treatments to delay the onset of puberty.
- Surgery to change primary sexual characteristics (genital “bottom” and “top” breast surgery).
- Surgery to create a more feminine or masculine appearing face.
- Permanent removal of facial hair (refer to electrolysis).
- Fertility preservation (refer to the infertility section).
- Mental health services for purposes of exploring gender identity, role and expression; addressing the negative impact of gender incongruence/dysphoria and stigma on mental health; enhancing social and peer support or promoting resilience.

All coverage requires prior authorization and is subject to any relevant network restrictions, co-pays, and limits as outlined in this handbook and the Schedule of Benefits.

Services are covered when a Yale Health provider has determined that the student or dependent has gender dysphoria and/or gender incongruence that is marked and sustained, understands the risks and potential benefits of treatment and is able to provide informed consent. Additional considerations for determination of eligibility may include mental health assessments, assessment of effects of social transition, as well as

treatment of co-existing medical or psychiatric diagnoses. Irreversible treatments are generally not authorized for members under the age of 18. However, when delay would cause significant distress, procedures for members under 18 may be approved with parental consent and specific recommendations from a qualified mental health provider.

Members seeking access to treatments for gender dysphoria/incongruence should meet with their primary care clinician and request a referral to Care Management. Based on the specific services requested, Care Management will inform and assist the member with the process of seeking authorization for and obtaining necessary services.

Coverage for treatments of gender dysphoria/incongruence are in addition to the other benefits provided by Yale Health. Yale Health does not consider any treatments for gender dysphoria/incongruence to be reconstructive services to correct a physical functional impairment nor to be cosmetic surgery. Coverage for reconstructive surgery or cosmetic services is limited to the services described in relevant portions of this handbook.

Prescription Coverage

Prescription drugs are covered if medically necessary and FDA approved. Prescriptions purchased at the Yale Health Center Pharmacy are subject to a 3-tier copay structure. The copays are as follows, please refer to the Yale Health Drug List for specific drug information, www.yalehealth.yale.edu/druglist:

- \$10.00 for a generic drug, up to a 30-day supply
- \$30.00 for a preferred brand name drug, up to a 30-day supply
- \$45.00 for a non-preferred drug, up to a 30-day supply

If you use an out-of-network pharmacy (one other than the Yale Health Center Pharmacy), you pay the greater of 20% of the price of the drug or the applicable copay. You are responsible for completing and submitting claim forms for reimbursement of covered expenses that were paid directly to an out-of-network pharmacy. Yale Health will reimburse students in accordance with the terms of the plan.

Some nonprescription items, such as diabetic supplies and ostomy supplies, are also covered subject to the applicable copay. Preventive medications, including over the counter, that are recommended by the USPSTF are covered at 100%. For a complete listing, see link <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>.

Yale Health covers the diagnostic testing for Lyme disease and considers outpatient antibiotic therapy medically necessary in adult and pediatric members with the diagnosis of Lyme disease only when it is based on the clinical presentation of signs and symptoms compatible with the disease.

For a complete listing of the plan's formulary go to:
<https://yalehealth.yale.edu/directory/departments/pharmacy-prescriptions>

Definition of Medical Necessity

“Medically Necessary” health care services are health care services that a clinician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or

treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate in terms of type, frequency, extent, site and duration; c) considered effective for this patient's illness, injury or disease; d) not primarily for the convenience of the patient, physician or other health care provider; and e) not more costly than an alternative service or sequence of services (including no service or a less extensive provision of a similar service) that is at least as likely to produce equivalent therapeutic or diagnostic results for that patient. For these purposes, "generally accepted standards of medical practice" means standards based on (a) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (b) recommendations of a physician-specialty society, (c) the views of physicians practicing in relevant clinical areas, and/or (d) any other relevant factors.

OTHER COVERED HEALTH CARE EXPENSES

Ambulance Services

Authorized expenses include charges made by a professional ambulance as follows:

Ground Ambulance

Authorized expenses include charges for transportation:

- To the first hospital where treatment is given in a medical emergency.
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance

Authorized expenses include charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital, when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; and the two conditions above are met.

Exclusions and Limitations

Not covered under this benefit are charges incurred to transport you:

- If an ambulance service is not required by your physical condition; or
- If the type of ambulance service provided is not required for your physical condition; or
- By any form of transportation other than a professional ambulance service.

Autism

Covered services include:

- Diagnostic and evaluation services to establish a diagnosis of developmental disorder
- Prescription drugs;
- Direct or consultative services provided by a licensed psychiatrist or licensed psychologist for psychiatric co-morbidity;
- Physical therapy provided by a licensed physical therapist;
- Speech and language pathology services provided by a licensed speech and language pathologist;
- Occupational therapy provided by a licensed occupational therapist.
- Please also see *Applied Behavioral Analysis (ABA) Therapy* section in this book.

Provided such treatments are (1) medically necessary, and (2) identified and ordered by a licensed physician, licensed psychologist or licensed clinical social worker for an insured who is diagnosed with an autism spectrum disorder. Services must be provided by an in-network provider for coverage.

Chiropractic Service

The plan reimburses charges for a licensed chiropractor after a 50% coinsurance up to a maximum of 20 visits per plan year in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be covered in accordance with the terms and conditions of this plan (see Schedule of Benefits). Services require a referral from a Yale Health clinician.

Clinical Trials

The plan covers routine patient costs for your participation in an approved clinical trial. An approved clinical trial means a phase I, II, III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

A referral by a participating provider who has concluded that your participation in the approved clinical trial would be appropriate is required.

Exclusions:

The plan does not cover the costs of the investigational drugs or devices; the costs of non-health services required for you to receive the treatment; the costs of managing the research; or costs that would not be covered under this plan for non-investigational treatments provided in the clinical trial.

Dialysis

The plan covers dialysis treatment of an acute or chronic kidney ailment.

Early Intervention Services

Early Intervention Services are available for a member from birth until the child's third birthday. These services are provided by the state of Connecticut birth to three program. Yale Health's Care Management team will assist in steering members to the appropriate resources for these services. If the member would prefer to seek therapeutic resources at the Yale Health plan, this is covered under the rehabilitative services section of the handbook.

Hearing Aids

The plan covers hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. Covered services are available for a hearing aid that is purchased as a result of a referral by a physician and include the hearing aid and charges for associated fitting and testing. One purchase every 24 months is covered.

Air conduction hearing aids are covered subject to benefit limitations when medical necessity criteria is met.

Bone anchored hearing aids are covered only if either of the following are true:

- Bone anchored hearing aids or tempered bone stimulators are considered medically necessary when certain medical and audiological criteria are met. Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid
- Other medical conditions

Home Health Care

Authorized expenses include charges for home health care services when ordered by a clinician as part of a home health plan.

Authorized expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of their license. These services need to be provided during intermittent visits of four hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker with prior authorization.

- Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Therapy Services section.
- Benefits for home health care visits are payable up to the home health care maximum. Each visit by a nurse or therapist is one visit.

Home health care is limited to 100 days per year.

Hospice

Hospice care is available if your primary attending physician has certified that you have six (6) months or less to live. The plan covers inpatient hospice care in a hospital or hospice facility including drugs and medical supplies. Coverage is provided for a maximum of 180 days.

Genetic Testing

The plan covers charges for genetic counseling when deemed medically necessary and with prior authorization.

- Yale Health considers genetic testing medically necessary when all of the following conditions are met: The member displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
- The result of the test will directly impact the treatment being delivered to the member; and
- After history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain, and a condition for which genetic testing would lead to definitive diagnosis is strongly considered.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Authorized expenses include charges made by a network physician for non-surgical treatment of infections or diseases of the mouth, jaw joints, or supporting tissues, including temporomandibular disorders (TMD) and temporomandibular joint (TMJ) dysfunction.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaw, or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, jaw joint disorder, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.

Hospital services and supplies received for a stay required because of your condition.

Orthodontic treatment needed to repair, or restore:

- (a) Natural teeth damaged; or
- (b) Other body tissues of the mouth fractured or cut due to injury.

Any such teeth must have been free from decay or in good repair, and firmly attached to the jaw bone at the time of the injury.

If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, authorized expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Authorized expenses include charges made for limited services and supplies related to the treatment of teeth, gums, and jaws and their supporting structures, muscles and nerves as follows:

Accidental injuries and other trauma. The plan covers oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state.

If a child needs oral surgery as the result of accidental injury or trauma, surgery may be postponed until a certain level of growth has been achieved.

Important Note

Trauma which occurs as a result of biting or chewing is *not* considered accidental injury, even if it is unplanned or unexpected.

Pathology

- The plan covers removal of tumors and cysts requiring pathological examination.

Anatomical Defects

- The plan covers oral surgery and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.

Related Dental Services Are Limited To:

- The first placement of a permanent crown or cap to repair a broken tooth;
- The first placement of dentures or bridgework to replace lost teeth; and
- Orthodontic therapy to reposition teeth.

Outpatient Infusion Therapy Benefits

Authorized expenses include charges made on an outpatient basis for infusion therapy by:

- Yale Health;

- The outpatient department of a hospital if unable to be provided at Yale Health Center; or
- A physician in their office or an authorized care provider within your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies and equipment;
- Nursing services required to support the infusion therapy;
- Professional services;
- Total or partial parenteral nutrition (TPN or PPN);
- Blood transfusions and blood products;
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Pain Management Services

Medically necessary pain management services provided by a network provider (including evaluation and therapy) for short- or long-term pain conditions are covered when referred by a Yale Health clinician.

Reconstructive Surgery

Covered expenses include charges made by a physician, hospital, or surgery center for reconstructive and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part and is medically necessary.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery.

Important Note

Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
 - the defect results in severe facial disfigurement, or
 - the defect results in significant functional impairment and the surgery is needed to

improve function.

- Surgery to remove any breast implant that was implanted on or before July 1, 1994, without regard to the purpose of the implantation.

Reconstructive Breast Surgery

Authorized expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Sleep Studies

Covered expenses include the diagnosis and medically necessary treatment of obstructive sleep apnea performed in an in-network healthcare facility provided the member was referred by a Yale Health clinician.

Wellness

Covered expenses include but are not limited to routine physical exams, immunizations, routine cancer screenings, family planning services, routine eye exams, and hearing exams. Preventive and screening services are based on generally accepted standards endorsed by authorities such as the U.S. Preventive Services Taskforce, the Centers for Disease Control and Prevention, the Department of Health and Human Services, and other professional organizations. Services may be subject to limitations or restrictions as described in the *Schedule of Benefits*.

Wound Care

Covered expenses include, but are not limited to dressings, topical treatments, and compressions wraps in treating a wide range of chronic or non-healing wounds when referred by a Yale Health clinician. Covered diagnoses include but are not limited to the treatment for diabetes, vascular wounds, burns, delayed closure of surgical wounds, and epidermolysis bullosa. Disposable supplies for those referred by a wound care specialist are a covered benefit.

CLAIMS PROCEDURES

Claims are normally submitted directly to Yale Health by the clinician or facility who has rendered services. If a bill is sent directly to you, it is your responsibility to submit the claim to the Yale Health Claims Department promptly. If you fail to submit the claim to the Yale Health Claims Department in a timely manner you risk having the clinician or facility who rendered services initiate collection action against you. The Yale Health Claims Department will honor claims submitted within one year of the date you received services. Claims received by Yale Health may be denied if they are received after the one-year limit has expired, unless the delay is the fault of the clinician or facility who rendered service.

If your claim or request for authorization of services is denied you have a right to appeal the decision. The appeals process involves three levels. Appeals may be based on determinations that are reported to you in writing or verbally by a clinician or another employee of Yale Health. Appeals include the following categories:

- **Clinical appeals**, which revolve around the treatment (e.g., disagreements regarding medical necessity of a particular treatment plan, clinical care issues, etc.)
- **Administrative appeals**, which relate to non-authorizations based on noncompliance with plan procedure (e.g., exhaustion of benefits, ineligibility, a request for a non-covered benefit, etc.)
- **Claims appeals**, which relate to post-service claim denials.

Medical Services and Pharmacy Appeals

First Level Internal Appeals

The first level internal appeal requires a request for reconsideration in writing and mailed to Yale Health within 180 days from the date of notification of the initial determination. Your request should include:

- The name and Yale Health member number of the member requesting the review;
- Names of healthcare providers or staff involved;
- Relevant dates;
- And any supporting documents to assist in the review, e.g., clinician notes, photographs, letters from clinicians, studies, etc.

Verbal notice of a determination of your appeal is furnished to the attending or treating clinician within the shorter of one (1) business day or three (3) calendar days of our receipt of the appeal request. Written notification of the appeal decision is sent to the member, the treating clinician and/or facility within the shorter of one (1) business day or three (3) calendar days of the verbal appeal decision notification.

Standard pre-service appeals: For appeals related to services not yet rendered (standard pre-service claims) in circumstances in which an urgent appeal is not necessary, written notice is

furnished to the member, the treating clinician, and/or facility, as applicable, as soon as possible but no later than 15 calendar days after receipt of the appeal request.

- First level requests must be mailed to the Yale Health Chief Medical Officer/Attn: Appeal/ P.O. Box 208217/New Haven, CT 06520-8217.

Standard post-service appeals: For appeals relating to services already rendered (standard post-service claims), written notice will be furnished to the member, the treating clinician and/or facility, as applicable, as soon as possible but no later than 30 calendar days after receipt of the appeal request.

- First level requests must be mailed to the Yale Health Claims Department Manager/ Attn: Appeal/ P.O. Box 208217/New Haven, CT 06520-8217.

Urgent pre-service appeals: Yale Health provides for an urgent appeal process whenever the timeframe for a standard appeal is inappropriate due to the urgency of the member's condition. Requests for urgent appeals may be made verbally or in writing to the Yale Health Chief Medical Officer/Attn: Urgent Appeal/ P.O. Box 208217/New Haven, CT 06520-8217.

Second Level Internal Appeals

If you do not agree with the first level claim appeal decision, a second level internal appeal may be requested. Second level appeals must be requested in writing (or verbally if an urgent review is requested) and mailed to Yale Health within 60 days of receipt of the first level claim appeal determination. Mail your appeal and documentation to the Yale Health Patient Representative/Attn: Appeal/ P.O. Box 208237/New Haven, CT 06520-8237. Your request should include:

- Steps previously taken;
- Any additional documentation supporting the second level claim appeal;
- And the reason for further appeal.

The Yale Health Claims Review Committee will review the appeal within 30 days of receipt of the complete appeal request, including any documents that you want the committee to consider. A written determination will be mailed to the member within 1 business day from the date the appeal decision was made.

Third Level External Review

If the second level claim appeal process maintains the denial, you have the right to request a third level claim appeal through an independent external review. Third level appeals must be requested in writing (or orally if an urgent review is requested) within 4 months of the second level claim appeal determination and mailed to the Patient Representative/ Attn: Appeal/ P.O. Box 208237/New Haven, CT 06520-8237. The Patient Representative can answer questions in regard to the process of the appeal. The third level claim appeal is reserved for claims involving “medical judgment”, broadly defined as medical necessity, level of care, health care setting, etc. This does not apply to denials for coverage or

benefit exclusions.

EXCLUSIONS AND LIMITATIONS

Yale Health offers a comprehensive healthcare program, but there are limitations and exclusions. These are listed below.

General Exclusions and Limitations

1. for charges that would not have been made had coverage not existed
2. for services that are not medically necessary
3. for services provided at the Yale Health Center on a fee-for-service basis
4. for court-ordered testing, evaluations, or treatment unless deemed medically necessary by Yale Health
5. care for conditions that state or local law require to be treated in a public facility
6. services covered or mandated by the state or federal regulations that require another source to provide coverage or services, e.g., public school systems
7. for injury or occupational illness covered by Workers' Compensation
8. to the extent that they are otherwise payable as described under *Coordination of Benefits*
9. to the extent those expenses are in any way reimbursable through any program, including Medicare
10. for charges that members are not legally required to pay

Network Exclusions and Limitations

1. inpatient hospitalization expenses for an elective admission incurred when a Yale Health member is admitted to a hospital by a non-Yale Health network physician
2. services of clinicians not in the Yale Health network as well as services ordered by these clinicians, unless referred by a Yale Health network clinician and approved in advance as a covered benefit by the Yale Health Referrals Department
3. follow-up care by a non-Yale Health network clinician unless approved in advance by the Yale Health Referrals Department

Coverage Date Exclusions and Limitations

1. services received before the student's or enrolled dependent's effective date of coverage or after the termination date
2. facility and professional fees for an inpatient stay that began before the student's or enrolled dependent's effective date of coverage

Service Exclusions and Limitations

1. acupuncture
2. alternative therapies
3. aqua therapy
4. bariatric surgery
5. biofeedback
6. testing for or treatment of cognitive disorders including attention deficit disorder
7. personal comfort and convenience items
8. **cosmetic** services and plastic surgery: Any treatment, surgery, service or supply to improve or enhance the shape or appearance of the body, unless considered medically necessary to improve function or alleviate physical symptoms, is excluded. Excluded procedures include, but are not limited to: breast augmentation except as specified below, cheek or chin implants, excision of excessive skin of the thigh, leg, hip, buttock, arm or neck unless causing functional limitations or medical complications, fat grafting, laser treatments, medications and other hair removal services, mesotherapy (injection of substance into the tissue for sculpting contours or lysing fat), liposuction, tattoo removal, and vaginal rejuvenation procedures.

The following procedures may be considered medically necessary when specific criteria are met:

Blepharoplasty, breast reduction/augmentation, dermal injections of FDA-approved fillers for HIV lipoatrophy only, electrolysis/hair removal, excision or repair of keloids if they cause pain or functional limitation, gynecomastia surgery, lipomas that cause pain or interfere with physical activity, panniculectomy, treatment of port wine stains and other hemangiomas on the face and neck, treatment of symptomatic cavernous hemangioma or scrotal hemangiomas, rhinoplasty and septoplasty to alleviate medical complications or as part of cleft palate repair, scar revision, skin tag removal when the location causes irritation and bleeding, surgery to repair, revise, excise or otherwise treat a gross congenital deformity or malformation and ventral hernia repair.

Non-functional prostheses and their surgical implantation or attachment are covered when they replace all or part of a body part lost or impaired as a result of disease, injury or congenital defect: breast implants, ear and eye prostheses and testicular prostheses.

9. services and hospitalization involving or arising from cosmetic surgery except as noted in the reconstructive surgery section of this handbook; any therapy the purpose of which is cosmetic.
10. custodial care and convalescent care and assistance for activities of daily living
11. dental diagnosis, care, or treatment — including professional fees, anesthesia and facility charges, X rays, or appliances; the extraction of teeth including erupted or impacted teeth; the correction of malposition of the teeth and jaw; or for pain, deformity, deficiency, injury, or physical condition of the teeth; unless otherwise noted in Yale Health Hospitalization/Specialty Coverage section.
12. experimental or investigational drugs, services, or procedures as determined by Yale Health
13. electrolysis or hair removal except as approved in advance by Yale Health
14. any eye surgery solely for the purpose of correcting refractive deficiencies of the eye, such as nearsightedness (myopia) and astigmatism, including but not limited to radial keratotomy; eyeglasses, contact lens exams and lenses, corrective lenses, vision therapy; routine vision care received outside the Yale Health Center; unless otherwise noted in Yale Health Hospitalization/Specialty Care Coverage section.
15. hypnosis
16. maternity charges for a surrogate parent who is not a Yale Health member
17. hospitalization or other services for obesity or weight reduction
18. orthotics (including examinations for fitting) with the exception of foot orthotics for diabetic members.
19. outpatient psychotherapy received outside the Yale Health Center for the student or enrolled spouse/civil union partner
20. sex therapy
21. surgery, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
22. reversal of voluntary sterilization
23. target symptom clinics or centers except as approved in advance by Yale Health
24. transportation provided by a vehicle that is not medically equipped to transport ill or injured persons and/or that does not meet licensing requirements by local, county, or state regulations

25. travel medications and vaccines

Hospitalization/Specialty Coverage Exclusions and Limitations

1. services not specifically listed herein as covered services under Yale Health Hospitalization/Specialty Coverage
2. benefits not payable under *General Exclusions and Limitations, Network Exclusions and Limitations, Coverage Date Exclusions and Limitations, and Service Exclusions and Limitations*
3. experimental organ transplants

Prescription Coverage Exclusions and Limitations

Limitations

1. The Yale Health Pharmacy as well as any out-of-network pharmacy may refuse to fill a prescription order or refill when, in the professional judgment of the pharmacist, the prescription should not be filled.
2. The plan will not cover expenses for any prescription drug for which the actual charge to you is less than the required copayment or deductible, or for any prescription drug for which no charge is made to you.
3. For prescription drugs recently approved by the FDA, but which have not yet been reviewed by the Yale Health Pharmacy and Therapeutics Committee, prior authorization will be required to determine coverage.
4. For prescription drugs **not** listed on the Yale Health Drug List, prior authorization will be required to determine coverage.
5. Yale Health retains the right to review all requests for reimbursement determinations subject to the Appeals Process section of the document.

Exclusions

Not every healthcare service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician, dentist, or other accepted prescriber. The plan covers only those services and supplies that are medically necessary. Charges made for the following are not medically necessary. In addition, some services are specifically limited or excluded.

These prescription drug exclusions are in addition to the exclusions listed under your medical coverage. Certain drugs are specifically excluded from the plan.

1. administration or injection of any drug is excluded.

2. any charges more than the benefit, dollar, day or supply limits stated in this document are excluded.
3. allergy sera and extracts are excluded.
4. any non-emergency
5. incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this document, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal, including mail order are excluded.
6. any drugs or medications, services and supplies that are not medically necessary, as determined by Yale Health, for the diagnosis, care or treatment of the illness or injury involved are not covered. This applies even if they are prescribed, recommended or approved by your physician, dentist, or other accepted prescriber.
7. biological sera, blood, blood plasma, blood products or substitutes, or any other blood products are excluded.
8. cosmetic drugs, medication or preparations used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids, chemical peels, dermabrasion, treatments, bleaching, creams, ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin are excluded.
9. drugs which do not, by federal or state law, require a *prescription* order (i.e., over-the-counter (OTC) drugs), even if a prescription is written are excluded unless required by USPSTF.
10. drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it are excluded.
11. food items, including infant formulas, nutritional supplements, vitamins, medical foods, and other nutritional items, even if it is the sole source of nutrition are excluded with the following exceptions:
 - specialized infant formulas medically necessary to prevent adverse outcomes from inborn errors of metabolism.
 - parenteral nutrition supplied in an inpatient setting or pre-approved home care setting when enteral nutrition is contraindicated.
 - enteral tube feedings when medically necessary because the member has either (a) permanent non-function or disease of the structures that normally permit food to reach the small bowel; or (b) disease of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the member's overall health status. Products or formulas used to treat conditions subject to these exceptions will be assessed clinically prior to their approved use.

Vitamins as required by the USPSTF are covered at 100% which include but are not limited to prenatal vitamins, folic acid, and iron supplements.

12. any treatment, device, drug, or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects are excluded.
13. immunization or immunological agents are excluded.
14. implantable drugs and associated devices are excluded.
15. prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written are excluded unless required by USPSTF.
16. prescription orders filled prior to the effective date of coverage under this document are excluded.
17. refills in excess of the amount specified by the prescription order are excluded. Before recognizing charges, Yale Health may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
18. refills dispensed more than one year from the date the latest prescription order was written, or otherwise permitted by applicable law of the jurisdiction in which the drug was dispensed are excluded.
19. replacement of lost or stolen prescriptions is excluded.
20. drugs, services and supplies provided in connection with treatment of an occupational injury or occupational illness are excluded.
21. strength and performance drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids are excluded.
22. supplies, devices or equipment of any type are excluded, except as specifically provided in other areas of the handbook.
23. test agents except diabetic test agents are excluded.
24. nonprescription contraceptive devices.
25. benefits not payable under *General Exclusions and Limitations, Network Exclusions and Limitations, Coverage Date Exclusions and Limitations, and Service Exclusions and Limitations.*

TERMINATION OF COVERAGE

Students and student dependents enrolled in any of the Yale Health plans may terminate their Yale Health coverage for a variety of reasons - a change in eligibility status, graduation, withdrawal, a leave of absence, divorce, etc. In certain circumstances, Yale Health also reserves the right to terminate a student's (and that student's enrolled dependents') coverage.

Leaving Yale

When you leave the University your Yale Health coverage will terminate, but when it terminates depends on why, and when, you leave the University. The sections below explain this process in detail.

Graduation

Coverage for graduating students who are enrolled in Yale Health at the time of University Commencement in May will continue until July 31. Students completing degrees or leaving the University at times other than University Commencement should contact Member Services (203-432-0246) to determine coverage end dates.

Leaves of absence

Students who are granted a leave of absence are eligible to purchase Yale Health Student Affiliate Coverage for the term(s) of the leave. If the leave occurs on or *before* the first day of classes, Yale Health Hospitalization/Specialty Coverage will end retroactive to the start of the coverage period for the term. If the leave occurs any time after the first day of classes, Yale Health Hospitalization/Specialty Coverage will end on the day the Registrar is notified of the leave. In either case, students may enroll in Yale Health Student Affiliate Coverage. Students must enroll in Affiliate Coverage prior to the beginning of the term unless the Registrar is notified after the first day of classes, in which case, the coverage must be purchased within thirty days of the date the Registrar was notified. Fees paid for Yale Health Hospitalization/Specialty Coverage will be applied toward the cost of Affiliate Coverage. Coverage is not automatic, and enrollment forms are available at the Member Services Department or can be downloaded from the "Withdrawals and Leaves of Absence" page on our website (yalehealth.yale.edu). Fees will not be prorated or refunded.

Student withdrawals

Students who withdraw from the University during the first 15 days of the term will be refunded the fee paid for Yale Health Hospitalization/Specialty Coverage. Under these circumstances, you will not be eligible for any Yale Health coverage, your Yale Health membership will be terminated retroactively to the beginning of the semester, and you will be billed for any services rendered or claims paid.

Students who purchase Yale Health Hospitalization/Specialty Coverage and who withdraw from the University after the first 15 days of the term will be covered by Yale Health for 30 days following the date of withdrawal or through the last day of the term, whichever comes first (the last day of fall-term coverage is January 31; the last day of spring-term coverage is July 31). Fees will not be prorated or

refunded. If you are hospitalized on the effective date of withdrawal or during the 30-day period during which coverage is extended you will be eligible for Yale Health hospital coverage until discharged from the hospital, subject to the limits of Yale Health coverage for the illness.

Termination of Dependent Coverage

Dependent coverage may terminate for a variety of reasons: the dependents obtain other coverage, a dependent turns 26, a divorce, a civil union dissolution, or some other event occurs that changes a dependent's eligibility status. Coverage terminates at the end of the month in which the dependent becomes ineligible. Fees will not be prorated.

Divorce/Civil Union Dissolution

The student is required to notify Yale Health Member Services in writing within 30 days of the date the divorce/dissolution is final. The ex-spouse/ex-partner may not remain on the student's insurance even if the settlement requires the student to provide the ex-spouse/ex-partner with insurance coverage. Yale Health membership will terminate effective as of the last day of the month in which the divorce/dissolution is final.

If Yale Health Member Services is not notified when the divorce/dissolution becomes final, the student will be billed for all services rendered and claims paid by Yale Health on the ex-spouse's/ex-partner's behalf beginning the first day of the month following the date the divorce/dissolution is final. Yale Health fees will not be prorated.

When Yale Health Can Terminate Coverage

Yale Health may terminate the membership of a student or enrolled dependent and bill the student for all services rendered and claims paid by Yale Health for the student or dependent under the following conditions :

1. The student or dependent ceases to be eligible.
2. The student fails to pay fees.
3. Adequate medical care and treatment is jeopardized by the impaired relationship between the student or dependent and a Yale Health network clinician.
4. The student or dependent persistently and repeatedly refuses to comply with a course of treatment prescribed by a Yale Health network clinician.
5. The student or dependent permits thier Yale Health membership card to be used by another person.
6. The student or dependent makes any false statement or material misrepresentation on the enrollment form submitted when applying for Yale Health coverage.

When Yale Health terminates coverage because a student or dependent has become ineligible, the student or dependent may re-enroll within 30 days or at the start of a new term if they again become eligible. Re-enrollment under other circumstances is at the discretion of Yale Health and the University.

GENERAL POLICIES AND PROCEDURES

Coordination of Benefits (COB)

Yale Health coverage is subject to coordination of benefits (COB) provisions. Coordination of benefits is the term applied to a standard process used to determine the order in which benefit plans should pay for covered services when a member is covered by more than one benefit plan. Coordination of benefits works to your advantage by using one benefit plan to cover some of the expenses not fully covered by another plan. For example, if Yale Health covers a service to an amount less than 100% of the fee for that service and you are entitled to any benefits from a source other than Yale Health, COB entitles you to receive coverage from that source in addition to the amount Yale Health covers up to 100% of the expenses. Coordination of benefits also entitles Yale Health to receive payment from other benefit plans for some services rendered by Yale Health. You are required to notify Yale Health if you have other coverage when you enroll in any of the Yale Health plans. Failure to disclose other coverage is grounds for termination of your coverage as explained in the section *Termination of Coverage*.

Subrogation (Third Party Liability)

A member or enrolled dependent may be compensated for an illness or injury for which another party is liable to pay damages. In these cases that party has the primary payment responsibility and Yale Health has the legal right to be reimbursed for services covered by Yale Health. If a Yale Health member brings legal action or otherwise makes a claim against a third party allegedly responsible for their condition, that Yale Health member agrees to:

1. notify the Yale Health Billing Department as soon as possible and to keep the Billing Department informed at all times of subsequent developments;
2. reimburse Yale Health for its costs and services out of any resulting settlement to the full extent permitted by law; and
3. cooperate in protecting the interests of Yale Health under this provision and execute and deliver to Yale Health or its nominees any and all documents (e.g., accident reports) requested by Yale Health that may be necessary to effectuate and protect its rights.

Yale Health will provide medical care upon a member's request with the understanding that the member will reimburse Yale Health in full for any treatment rendered or expense incurred on their behalf without deductions of any nature, including attorney's fees, to the full extent permitted by law.

Workers' Compensation

In cases of work-related injury or illness, members may be entitled to coverage under workers' compensation, employer's liability insurance, or occupational disease law. If it is determined that you are eligible for coverage through these sources for services provided by Yale Health, Yale Health is entitled to be reimbursed for those services. Yale Health will pay only for that portion of services covered by Yale Health that is not covered by an approved workers' compensation, employer's liability insurance, or occupational disease law claim. If it is determined that you are not eligible for coverage through these

sources for services covered by Yale Health, Yale Health will cover those services according to the terms of coverage. Please note, however, that if you receive care that is not covered by Yale Health for a work-related injury or illness and your claims through workers' compensation, employer's liability insurance, or occupational disease law are denied, Yale Health will not cover those claims and you will be billed directly.

If you become eligible for coverage under workers' compensation, employer's liability insurance, or occupational disease law, Yale Health is entitled to:

1. charge the entity obligated under such law(s) for services rendered at Yale Health
2. charge the member for services covered by Yale Health to the extent that the member has been paid for the same services under such law(s) or insurance
3. reduce any sum Yale Health owes the member by the amount that the member has been paid for the services under such law(s) or insurance
4. withdraw payment from a clinician or facility equal to the amount Yale Health has paid for services rendered to the member

If you are injured on the job or become ill because of your job, report this to your employer as soon as your condition permits. You must also notify the clinician who provides your care that it is a work-related condition. For Yale employees, Yale Health will provide medical treatment upon a member's request and bill workers' compensation for these services. For non-Yale employees, Yale Health will provide medical treatment and bill the responsible insurance carrier or employer directly upon receipt of an attending physician's claim form assigning payment directly to Yale Health. Failure to provide this or any other necessary documents required to effectuate and protect the rights of Yale Health will result in direct billing to the Yale Health member.

Miscellaneous Provisions

1. Members are subject to all the rules and regulations of Yale Health. They must receive care from a Yale Health network clinician or such care must be arranged by a Yale Health clinician and approved in advance by the Yale Health Referrals Department.
2. The member and each enrolled dependent agree that any clinician, hospital, referral agency, or agent that has made a diagnosis or provided treatment for an ailment may furnish to Yale Health all information and records, to the extent permitted by law, relating to said diagnosis or treatment. Members further agree that Yale Health may send all such information and records to Yale Health or network clinicians and/or to medical or financial audit firms with whom Yale Health contracts.
3. The coverage and rights described in this student handbook are personal to the member and enrolled dependents and cannot be assigned or transferred.
4. In the event of a major disaster, epidemic, or circumstances not reasonably within the control of Yale Health, Yale Health shall provide services insofar as practical, according to its best

judgment, within the limits of its facilities and staff. In this event, Yale Health shall have no liability for delay or failure to provide or arrange for services on account of such events.

5. Members or applicants for membership shall complete and submit to Yale Health such enrollment forms, medical review questionnaires, or other forms or statements as Yale Health may reasonably request. Members or applicants warrant that the information contained therein shall be true, correct, and complete, and all rights to coverage and services hereunder are subject to that condition.
6. Yale Health may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of the policies and coverage plans described in this student handbook.
7. The Yale Health membership card issued to each member is for identification purposes only and does not in and of itself confer any rights to any of the services described in this student handbook.
8. The headings of various sections of this student handbook are inserted merely for the purpose of convenience and do not (expressly or implicitly) limit, define, or extend the specific terms of the section so designated.
9. If it is determined that a student, spouse, civil union partner, or dependent child was ineligible for membership, the student will be billed for all services rendered or claims paid by Yale Health on their behalf, and fees paid will not be refunded.

Notice of Privacy Practices (NOPP)

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described below. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

We may use and disclose medical information about you without your prior authorization for treatment, such as sending medical information about you to a specialist as part of a referral (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment, such as sending billing information to your insurance company or Medicare; and to support our healthcare operations, such as comparing patient data to improve

treatment methods or for professional education purposes (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization is required for most disclosures other than emergencies. Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts. It is always your choice to opt out of receiving fundraising communications from us.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protection. For more information on research and how to opt out of research use of your records see www.yalestudies.org or 1-877-978-8343.

If admitted as an inpatient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and may release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to clergy members, even if they do not ask for you by name.

We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

In any other situation not covered by this notice, including the use or disclosure of psychotherapy notes, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Who will follow this notice?

Yale Health, Yale New Haven Health System (YNHHS) and Yale School of Medicine (YSM) facilities provide health care to our patients in partnership with other professionals and healthcare organizations. The information privacy practices in this notice will be followed by:

- Any healthcare professional who treats you at any of our locations
- All departments and affiliated covered entities of Yale New Haven Health System, including; Bridgeport Hospital, Greenwich Hospital, Northeast Medical Group, and Yale-New Haven Hospital
- Yale School of Medicine
- The clinical care providers of Yale School of Nursing as well as their affiliates
- All employees, medical staff, affiliates, trainees, students, or volunteers of the entities listed above

While each of these facilities and affiliates operates independently, they may share your health information for coordination of care, treatment, payment, and healthcare operations purposes.

Right to Be Notified of a Breach:

We will notify you in the event that the confidentiality of your information has been breached.

Right to Access and or Amend Your Records:

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care. All requests for copies or access must be submitted in advance, in writing. If your request for inspection is granted, we will arrange for a convenient time and place for you to look at your record. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

You have the right to request a list accounting for any disclosures of your health information we have made, as required by law.

To request this list of disclosures, indicate the relevant period which must be after April 14, 2003, but in no event for more than the last six years. You must submit your request in writing to the Medical Record or Billing Department as appropriate.

Right to Request Restrictions:

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it unless all of the conditions below are met:

- You request that your information is not shared with an insurer for purposes of payment or

- other purposes unrelated to your treatment;
- You pay all charges associated with the services you received out-of-pocket in full; and
- We are not required by law to release your information to the insurer.

We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at yalehealth.yale.edu. You can receive a copy of the current notice at any time. The effective date is listed at the end. Copies of the current notice will be available each time you come to our facility for treatment. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office listed below.

If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy

Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Consent to Treatment

In order to receive care from Yale Health, your consent to treatment is required. By presenting to the Yale Health Center for care, you implicitly consent to and/or acknowledge the following: (i) you consent to treatment as a patient of Yale Health for the purpose of receiving medical care and treatment and/or diagnostic procedures as determined to be necessary or advisable in your care; (ii) you consent to admission to the Yale Health Infirmery when indicated by your medical condition; (iii) you consent to the performance of one or more tests to determine your blood alcohol breath level if you present to Yale Health intoxicated, in connection with which you may be admitted to the Yale Health Infirmery or transferred to the Yale-New Haven Hospital emergency department; (iv) you acknowledge that Yale Health may use telehealth tools in

your care including, but not limited to, video visits, e-consults with specialists, and audio and/or video monitoring in acute and inpatient departments; (v) you acknowledge that as part of your medical care and treatment, you may be tested for HIV and this testing is voluntary; you will notify your Yale Health care provider if you do not agree to HIV testing; and (vi) you acknowledge that photographic images, videotaped images or other images may be made of you for purposes of medical documentation or education as Yale Health deems appropriate, and that the use or release of such images will be in accordance with Yale Health's Notice of Privacy Practices. You acknowledge that discussion of the risks, benefits, and alternatives to each procedure, treatment, or test is available to you so that you can make informed decisions about your care.

PATIENT RIGHTS & RESPONSIBILITIES

The following policies regarding the rights and responsibilities of patients have been adopted by Yale Health.

Yale Health will ensure that each patient:

1. Is fully informed of these rights and of all rules and regulations governing patient conduct and responsibilities.
2. Has the right to receive the best care Yale Health can offer for their health needs, concerns, illnesses, and injuries.
3. Is treated with consideration, respect, dignity, and individuality including privacy in treatment and care for their needs.
4. Has the right to expect that their personal convictions and beliefs, when expressed, will be considered when seeking and receiving services and when decisions are made by Yale Health clinicians regarding their care.
5. Has the right to agree with or refuse any healthcare service and to be informed of the medical consequences of refusing a service.
6. Is fully informed, as evidenced by their consent, about diagnostic or treatment procedures as appropriate.
7. Will know the identity and professional status of their clinical care team and be able to select their own primary care clinician from the panel of Yale Health primary care clinicians to the extent possible.
8. Has the right to have their privacy respected.
9. Is assured that their medical records will be kept confidential and that access to information about their health will be limited to those legitimately involved in their care, in accordance with Yale Health's Notice of Privacy Practices.
10. Is fully informed, by an authorized clinician, of their medical condition unless medically contraindicated (as documented by a clinician in the medical record) and is afforded the opportunity to participate in the planning of medical treatment.
11. Is entitled to receive an appropriate assessment of their health and reasonable management of pain.
12. Is assured confidential treatment of their personal and medical records and may approve or refuse their release to any individual outside the facility except in the case of their transfer to another healthcare institution or as required by law or third-party payment contract.

13. Has the right to review their medical record, except when restricted by law, and to have the information explained or interpreted as necessary.
14. Is fully informed of any clinical research related to their condition, and has the right to refuse participation in any clinical research without jeopardizing their access to medical care and treatment.
15. Is fully informed of Yale Health resources for resolving disputes, grievances, and conflicts.
16. Is fully informed of services available and related charges including any charges for services not covered by their membership in Yale Health, and has the right to request an itemized bill and to have the charges explained.
17. Is entitled to have an advance directive, such as a living will, healthcare proxy, or durable power of attorney for health care, concerning health care decisions, and to have the advance directive honored to the extent permitted by law.
18. Is fully informed of the existence of business relationships between Yale Health and other healthcare providers or commercial entities that might significantly influence their treatment and care.

All rights and responsibilities specified in paragraphs numbered 1 through 18 particularly as they pertain to a patient adjudicated incompetent in accordance with state law or a patient who is found, by their clinician, to be medically incapable of understanding these rights or a patient who exhibits a communications barrier devolve to and are binding on such patient's guardian, next of kin, sponsoring agency, or representative payee (except when the facility itself is representative payee).

The aforementioned rights are for patients of Yale Health without regard to sex, race, color, religion, age, disability, national or ethnic origin, sexual orientation or gender identity or expression.

The responsibilities of patients of Yale Health include:

Providing information. Patients must provide to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health, such as documentation of advance directives or changes to such directives. Patients must report perceived risks in their care and unexpected changes in their health. They can help Yale Health understand their status by providing feedback about service needs and expectations.

Asking questions. Patients must ask questions when they do not understand their care, treatment, services, or what they are expected to do.

Following instructions. Patients must follow the plan of care developed. They should express any concerns about their ability to follow the proposed care plan or course of care, treatment, and services.

Accepting consequences. Patients must recognize the effects of lifestyle choices on their health and take reasonable steps to remain healthy.

Following rules and regulations. Patients must follow Yale Health's rules and regulations.

Showing respect and consideration. Patients must be considerate of Yale Health’s staff and property, as well as other patients and their property.

Meeting financial commitments. Patients must provide Yale Health with complete insurance information to ensure that medical bills are paid properly. Patients must be aware that they are financially responsible for payment of any deductibles, coinsurance, fee-for-service visits, and noncovered services and must promptly meet any financial obligation agreed to with Yale Health.

Women’s Health and Cancer Rights Act of 1998 (WHCRA)

The Women’s Health and Cancer Rights Act of 1998 provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Call the Yale Health Claims Department at 203-432-0250 for more information.

APPENDIX A: GENERAL GLOSSARY OF HEALTH CARE COVERAGE AND MEDICAL TERMS

acute Describes an illness or injury that has a rapid onset with symptoms that are usually severe and of relatively short duration.

allowed amount Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See balance billing.)

appeal A request for your plan to review a decision or a grievance again.

balance billing When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may *not* balance bill you for covered services.

benefit year The benefit year for students runs from August 1 to July 31. All benefits that refer to annual deductibles or yearly maximums are calculated on the basis of this time period.

child, children The student’s child/children, including any natural, adopted, or step-children, or any other child/children under 26 years old who is the biologic or legally adopted child/children of the student or enrolled spouse/civil union partner, or child/children for whom the student or enrolled spouse/civil union partner can provide proof of court-appointed guardianship or custody.

clinician A physician, optometrist, nurse practitioner, nurse midwife, physician assistant, psychotherapist, and other licensed individuals who provide direct patient care.

coinsurance Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health plan’s allowed amount for an office visit is \$100 and you’ve met your deductible, your coinsurance payment of 20% would be \$20. The health plan pays the rest of the allowed amount.

complications of pregnancy Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the pregnant individual or the fetus. Morning sickness and a non-emergency caesarean section aren’t complications of pregnancy.

coordination of benefits (COB) The method used by Yale Health and all health insurance companies to determine who pays for healthcare expenses when a person is eligible for coverage by more than one insurance carrier or health plan.

copayment A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

cost-sharing Amounts the student must pay for covered services, expressed as copayments, deductibles, and/or coinsurance.

cover, covered, or covered services The medically necessary services paid for, arranged, or authorized by Yale Health for the student and/or any enrolled dependents under the terms and conditions of this plan.

deductible The amount you owe for health care services your health plan covers before your health plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

dependents The student's spouse and children.

durable medical equipment (DME) Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

elective admission An inpatient admission that is medically necessary and scheduled in advance for a condition for which the member does not require immediate medical attention.

eligible student An enrolled student attending Yale at least half-time and working towards a Yale degree. The following students are NOT eligible:

- degree-candidate students who are no longer enrolled half-time or more or who are paying less than half of the term's tuition;
- undergraduates in a junior-year-abroad program;
- students registered as special students in a degree-candidate program;
- students registered in absentia who are studying at another institution;
- students on a leave of absence;
- students enrolled in the School of Management's MBA for Executives Program and the Broad Center MMS Program;
- students enrolled in the School of Medicine's PA Online Program;
- students enrolled in the School of Public Health's Executive MPH Program;
- students enrolled in the School of Nursing's Nursing Online Program;
- non-degree students.

emergency condition A major acute medical problem or major acute trauma that requires immediate medical attention or a condition that could lead to serious harm or death if care is not received or is delayed.

emergency room care Emergency services you get in an emergency room.

exclusions, excluded services Health care services that your health plan does not pay for or cover.

facility Yale Health-approved, State of Connecticut certified or licensed hospital; ambulatory surgical center; birthing center, dialysis center; rehabilitation facility; skilled nursing facility; hospice; home health agency or home care services agency; psychiatric hospital, psychiatric ward of a general hospital, or institution that specializes in the treatment of substance abuse that provides medically necessary inpatient care.

grievance A complaint that you communicate to your health insurer or plan.

habilitation services Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

health insurance coverage A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

home health care Health care services a person receives at home.

hospice services Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

HIPAA Health Insurance Portability and Accountability Act that requires the adoption of medical facilities of security and privacy standards to protect personal health information.

hospital outpatient care Care in a hospital that usually doesn't require an overnight stay.

hospitalization care Care a patient receives while admitted to a hospital.

in-network coinsurance The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

in-network copayment A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health plan. In-network copayments usually are less than out-of-network copayments.

inpatient services Clinical services provided after the patient is admitted to a hospital or other facility for treatment.

jaw joint disorder A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint, a myofascial pain dysfunction (MPD) of the jaw, or any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

medically necessary Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine (see [Definition of Medical Necessity](#)).

Medicare Title XVIII of the Social Security Act, as amended.

member The student or covered dependent for whom required premiums have been paid. Whenever a member is required to provide a notice pursuant to a grievance or emergency department visit or admission, “member” also means the member’s designee.

network A defined group of providers and facilities, linked by contractual arrangements, that provide a broad range of primary and acute care services.

newly eligible Students who experience a break in coverage because they are in a status that makes them ineligible, such as being registered in absentia, and do not purchase Yale Health Affiliate Coverage during that period, are considered "newly eligible" when they are once again enrolled half-time or more in a Yale degree program.

non-preferred provider or non-Yale Health network clinician A provider who doesn’t have a contract with your health plan to provide services to you. You’ll pay more to see a non-preferred provider or non-Yale Health network clinician. Check your policy to see if you can go to all providers who have contracted with your health plan, or if your health plan has a “tiered” network and you must pay extra to see some providers.

official opening of dorms A date, set by each individual school, indicating the first day that students may move into their dorm rooms.

out-of-network coinsurance The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do *not* contract with your health plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

out-of-network copayment A fixed amount (for example, \$30) you pay for covered health care services from providers who do *not* contract with your health plan. Out-of-network copayments usually are more than in-network copayments.

out-of-pocket limit The most you pay during a policy period (usually a year) before your health plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health plan doesn’t cover. Some health plans don’t count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit. The out-of-pocket limit is \$9,100 for individuals and \$18,200 for families.

outpatient services Clinical services provided to a patient who has not been admitted to a hospital or other facility for treatment.

partial hospitalization services A mental health or substance abuse program operated by a hospital that provides clinical services as an alternative or follow-up to inpatient hospital care.

plan The generic term used to describe the coverage options offered to students and their dependents by Yale Health.

plan area State of Connecticut.

plan year The 12-month period beginning on the effective date of coverage or any anniversary date thereafter, during which the coverage is in effect.

preauthorization A decision by your health plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health plan will cover the cost.

preferred provider or Yale Health network clinician A provider who has a contract with your health plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or Yale Health network clinicians or if your health plan has a "tiered" network and you must pay extra to see some providers. Your health plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health plan, but the discount may not be as great, and you may have to pay more.

premium The amount that must be paid for your health plan. You and/or your program/school usually pay it monthly, quarterly or yearly.

prescription drug coverage Health plan that helps pay for prescription drugs and medications.

prescription drugs Drugs and medications that by law require a prescription.

primary care The basic care an individual receives from a physician, physician assistant, certified nurse midwife, or nurse practitioner.

referral An authorization given to a Yale Health network clinician from another clinician in order to arrange for additional care for a member. A referral can be transmitted electronically or by the member's clinician completing a paper referral form. Except as otherwise authorized by Yale Health, a referral will not be made to a non-network clinician.

rehabilitation services Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

SFAS Student Financial and Administrative Services. SFAS accounts were formerly known as bursar accounts.

skilled nursing care Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

specialty care Secondary, specialized care an individual receives, usually by referral from a primary care clinician (e.g., orthopedics, dermatology, oncology, neurology, etc.)

spouse The person to whom the student is legally married, including a same sex spouse. Spouse includes a civil union partner.

subrogation The seeking of reimbursement for costs and services in case of illness or injury determined to be the legal responsibility of a third party.

Summary of Benefits & Coverage A document that describes the copayments, deductibles, coinsurance, out-of-pocket limits, preauthorization requirements, referral requirements, and other limits on covered services.

target symptom Treatment facilities that target individual symptoms for treatment (e.g., sleep disorder clinics, headache clinics, pain clinics, etc.).

urgent condition The sudden and unexpected onset of an acute medical problem or trauma that requires immediate medical attention.

utilization review The review to determine whether services are or were medically necessary or experimental or investigational (i.e. treatment for a rare disease or a clinical trial).

WHCRA Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal statute that provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas.

***APPENDIX B: DELTA DENTAL AND EYEMED PLAN DESIGN FOR
PEDIATRIC COVERAGE:***



Yale University Student Pediatric Plan
Group #04721
Delta Dental PPO Plus Premier™

	In-Network		Out-of-Network
	If a Delta Dental PPO™ Dentist is Used	If a Delta Dental Premier® is Used	If a Non-Participating Dentist is Used
Preventive & Diagnostic Exams & Cleanings <i>(each twice in a calendar year)</i> Bitewing X-Rays <i>(2 per calendar year)</i> Full Mouth X-Rays <i>(1 set every three years)</i> Fluoride Treatments <i>(Frequency limitations apply)</i> Sealants	100%	100%	100%
Major Fillings & Simple Extractions Crowns & Gold Restorations Oral Surgery Bridgework Full & Partial Dentures Periodontics	50%	50%	50%
Annual Maximum	Unlimited	Unlimited	Unlimited
Annual Deductible Per Person Waived for	\$50 Preventive & Diagnostic	\$50 Preventive & Diagnostic	\$50 Preventive & Diagnostic
Orthodontics (Medically Necessary)	50%	50%	50%

Dependent children are covered to age 20.

The calendar year maximums & deductibles cross-accumulate among Delta Dental PPO, Delta Dental Premier and non-participating dentists.

Over 300,000 participating dental offices nationwide participate with the national Delta Dental system, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract. Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the member. **Maximum benefit may be derived by utilizing the services of a participating dentist.**

Where the eligible patient is treated by a Delta Dental PPO™ dentist, the fee for the covered service(s) will not exceed the Delta Dental PPO maximum allowable charge(s). Where the eligible patient is treated by a Delta Dental Premier® dentist who does not participate in Delta Dental PPO or by a *Participating Specialist*, the dentist has agreed not to charge eligible patients more than the dentist's filed fee or Delta Dental's established maximum plan allowance, and Delta Dental will pay such dentists based on the least of the actual fee, the filed fee, or Delta Dental's established maximum plan allowance for the procedure(s). Claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO dentists, or *Participating Specialists* are paid based on the lesser of the dentist's actual charge or the prevailing fee. Members utilizing non-participating dentists may be billed for the difference between the dentist's charge and Delta Dental's allowable charge.

Visit your own dentist. If you do not have a dentist, visit www.deltadentalct.com for a directory of participating dentists.

During your FIRST appointment, tell your dentist that you are covered under this program. Give him/her your Group's name, its Delta Dental Group Number and your Member ID number.

If you have any questions regarding your benefits, you may contact our Customer Service Department Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m. EST, at 1-800-452-9310.

This overview contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc. which governs the benefits and operation of your program. In CT, Delta Dental of Connecticut writes dental coverage on an insured basis and Delta Dental of New Jersey administers self-funded dental benefit programs. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview.

2021



Yale University Dependents Only Plan
 EyeMed Select Plan H, Fee For Service
 Employer pays 80% or more -OR- Bundled With Group Medical or Dental
 Option 1

Version 7

Vision Care Services	Member Cost In-Network	Member Out-of-Network Reimbursement* & Group Charge Out-of-Network
Exam with Dilatation as Necessary	\$0 Copay	\$28
Retinal Imaging Benefit	Up to \$39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames:		
Any available frame at provider location	\$0 Copay; \$100 Allowance, 20% off balance over \$100	\$50
Standard Plastic or Glass Lenses		
Single Vision	\$25 Copay	\$7
Bifocal	\$25 Copay	\$21
Trifocal	\$25 Copay	\$46
Lenticular	\$25 Copay	\$46
Standard Progressive Lens	\$90 Copay	\$21
Premium Progressive Lens	80% of Charge less \$30 Allowance	\$21
Lens Options:		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate - Adults	\$40	N/A
Standard Polycarbonate - Kids under 19	\$0 Copay	\$28
Standard Anti-Reflective Coating	\$45	N/A
Polarized	20% off Retail Price	N/A
Glass	\$0 Copay	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses <i>(Contact lens allowance includes materials only)</i>		
Conventional	\$0 Copay; \$100 allowance, 15% off balance over \$100	\$80
Disposable	\$0 Copay; \$100 allowance, plus balance over \$100	\$80
Medically Necessary	\$0 Copay, Paid-in-Full	\$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Monthly Administrative Fee Per Subscriber Per Month (Composite)	\$0.50	
Yale University agrees to be financially responsible for (i) the actual Provider Contracted Reimbursement rate per service above less applicable copay and (ii) the Monthly Administrative Fee.		

All plans are based on a 48-month contract term and 48-month rate guarantee.
 Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

* Member Reimbursement, Out-of-Network will be the lesser of the listed amount, or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.
 Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
 After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
 The contact lens benefit allowance is not applicable to this service.
 Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
 Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
 Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.
 Rates are valid for groups domiciled in the State of CT.
 Fees quoted will be valid until the 1/1/2016 plan implementation date. Date quoted: 7/2/2015.
 Rates assume greater than 80% Employer contribution for employees and dependents or that the vision program is bundled with medical/dental benefit.

Plan Exclusions:

- 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Anisokonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
- 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
- 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
- 8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care;
- 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If Yale University Dependents Only Plan has chosen this benefit design, sign here:

Signature _____

Date _____

TCO

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