


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

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits . COVID-19 testing is covered at no charge both in-network and out-of-network.
Are there other deductibles for specific services?	Yes, \$100 individual/\$300 family for speech therapy. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$3,000/individual; \$6,000/family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. Call 1-203-432-0246 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$0 copay	Not covered	—————none—————
	<u>Specialist</u> visit	\$0	\$0, if preauthorized; otherwise not covered	Preauthorization required for out-of-network care. If preauthorization is not obtained, service is not covered. A \$50 late cancellation/no-show fee may apply at Yale Health Center if appointment is missed or cancelled less than 24 hours before scheduled appointment.
	<u>Preventive care/screening/immunization</u>	\$0	Not covered	Annual physical exam and well-woman exam limited to one visit/calendar year. Travel immunizations not covered.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$0 for x-ray and sonogram at Yale Health Center, \$20 copay <i>outside of Yale Health Center</i> . \$0 for blood work.	\$20 copay for x-ray and sonogram. \$0 for blood work. All services must be preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
	Imaging (CT/PET scans, MRIs)	\$0 at Yale Health Center, \$100 copay <i>outside of Yale Health Center</i>	\$100 copay. All services must be preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered. A \$50 late cancellation/no-show fee may apply at Yale Health Center if appointment is missed or cancelled less than 24 hours before scheduled appointment.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.yalehealth.yale.edu or call 1-203-432-0246</p>	Tier 1 prescription drugs	<p>Retail:</p> <ul style="list-style-type: none"> • \$10 copay (up to 30 -day prescription) • \$20 copay (31-60 –day prescription) • \$20 copay (61-90–day prescription) <p>Mail:</p> <ul style="list-style-type: none"> • \$20 copay/prescription (up to 90-day prescription) 	Greater of 30% of the price of the drug or the applicable Tier 1 copay (plan reimburses the difference)	If generic is available and brand is dispensed, member pays applicable copay plus cost difference.
	Tier 2 prescription drugs	<p>Retail:</p> <ul style="list-style-type: none"> • \$45 copay (up to 30 -day prescription) • \$90 copay (31-60 –day prescription) • \$90 copay (61-90–day prescription) <p>Mail:</p> <ul style="list-style-type: none"> • \$90 copay/prescription (up to 90-day prescription) 	Greater of 30% of the price of the drug or the applicable Tier 2 copay (plan reimburses the difference)	If generic is available and brand is dispensed, member pays applicable copay plus cost difference.

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	Tier 3 prescription drugs	Retail: <ul style="list-style-type: none"> • 40% coinsurance (up to 30-day prescription) \$60 minimum; \$120 maximum • 40% coinsurance (31–60-day prescription) \$120 minimum; \$240 maximum • 40% coinsurance (61- 90-day prescription) \$120 minimum; \$240 maximum Mail: <ul style="list-style-type: none"> • 40% coinsurance/ prescription (up to 90-day prescription) \$120 minimum; \$240 maximum 	Greater of 30% of the price of the drug or the applicable Tier 3 copay (plan reimburses the difference)	If generic is available and brand is dispensed, member pays applicable copay plus cost difference.
	Tier 4 Specialty drugs	Retail: <ul style="list-style-type: none"> • 40% coinsurance (up to 30-day prescription) \$120 maximum Mail: <ul style="list-style-type: none"> • 40% coinsurance (up to 30-day prescription) \$120 maximum 	Greater of 30% of the price of the drug or the applicable specialty copay (plan reimburses the difference)	<p>If generic is available and brand is dispensed, member pays applicable copay plus cost difference.</p> <p>A limit of a 30 day supply applies for specialty drug prescriptions.</p>
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300 copay/visit	Not covered	_____none_____
	Physician/surgeon fees	\$0	Not covered	_____none_____
If you need immediate medical attention	Emergency room care	\$150 copay/visit	\$150 copay/visit	Must meet definition of emergency. Copay waived if admitted.
	Emergency medical transportation	\$0	\$0	Must meet definition of emergency.
	Urgent care (In-person care is available from 8am to 10pm Mon to Sun;	\$0 (8am to 6pm M-F) \$20 copay for after-hours visits, from 6pm to 10pm, at	Facilities outside of Connecticut: \$50 copay/visit	Must meet definition of urgent. Facilities in Connecticut other than those listed under “Network Providers” are not covered.

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	24/7 phone support by calling Yale Health Acute Care).	Yale Health Center including visits on weekends, holidays or recess days \$50 copay for in-person after hours care (between 10 pm and 8 am) at any of our network hospital/ED providers in CT: Yale-New Haven Hospital three locations: + Main Campus, 20 York St., New Haven + Saint Raphael Campus, 1450 Chapel St., New Haven + YNHH Shoreline Medical Center, 111 Goose Lane, Guilford		
If you have a hospital stay	Facility fee (e.g., hospital room)	\$400 copay/admission	\$400 copay/admission if preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
	Physician/surgeon fees	\$0	\$0 if preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	Not covered	_____none_____
	Inpatient services	\$400 copay/admission	Not covered	_____none_____
If you are pregnant	Office visits	\$0	Not covered	_____none_____
	Childbirth/delivery professional services	\$0	Not covered	_____none_____
	Childbirth/delivery facility services	\$400 copay/admission	Not covered	_____none_____

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If you need help recovering or have other special health needs	Home health care	\$0	Not covered	Limited to 120 visits/calendar year
	Rehabilitation services	Inpatient: \$400 copay/admission Outpatient: \$0, except for <ul style="list-style-type: none"> • Speech therapy: 20% coinsurance • Cardiac rehabilitation: \$10 copay/visit 	Not covered	Speech therapy that is not part of inpatient rehabilitation or home health care is covered after \$100 individual/\$300 family deductible up to a maximum of \$4,000 per injury. Cardiac rehabilitation limited to 36 visits/calendar year.
	Habilitation services	Inpatient: \$400 copay/admission Outpatient: \$0, except for <ul style="list-style-type: none"> • Speech therapy: 20% coinsurance 	Not covered	Includes physical, occupational, and speech therapy; must be medically necessary. Speech therapy that is not part of inpatient habilitation or home health care is subject to deductible and coinsurance.
	Skilled nursing care	\$0	Not covered	Limited to 120 visits/calendar year; covered only as part of home health care benefit. Otherwise, not covered.
	Durable medical equipment	10% coinsurance	Not covered	Subject to the plan's out-of-pocket limit
	Hospice services	\$0	Not covered	Limited to 60 days.
If your child needs dental or eye care	Children's eye exam	\$0	Not covered	Limited to 1 exam per 12-month period.
	Children's glasses	Not covered	Not covered	_____none_____
	Children's dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

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

<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult + Children) • Long-term care 	<ul style="list-style-type: none"> • Most coverage provided outside the United States • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> • Acupuncture (in lieu of anesthesia) 	<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Infertility treatment
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- Bariatric surgery

- Hearing aids

- Routine eye care (Adult)

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$0
■ Inpatient copay	\$400
■ Rx copay	\$10-20

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$420
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$480

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$0
■ Inpatient copay	\$400
■ Rx copay	\$10-45

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,225
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,245

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$0
■ Emergency Department copay	\$150
■ Other coinsurance (DME)	10%

This EXAMPLE event includes services like:

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

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$160
Coinsurance	\$25
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$185