

Yale HEALTH

**Coverage of Benefits for
Faculty & Staff
2019**

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PREFACE

Yale Health is pleased to provide you with this Booklet. Read this *Booklet* carefully. The plan described in this Booklet is a benefit plan of Yale University.

A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the plan.

The Booklet describes the rights and obligations of you and Yale Health, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments or riders.

Effective January 1, 2016, this Booklet supersedes all previous editions, including undated mailings and revisions as well as all other Yale University policies either written or oral that refer to the Yale Health Plan. The Yale Health plan reserves the right to interpret the provisions of the Booklet and to amend any provisions thereof. The controlling document is the version found online at: www.yalehealth.yale.edu. If there is any ambiguity or inconsistency between a printed copy of the document and the online version, the terms of the online document will control and are final. You may request a printed copy of the latest edition at any time.

Yale Health is a not-for-profit health care 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 Booklet. Our clinicians - physicians, nurse practitioners, nurse midwives, physician assistants, and others - are board certified and committed to a team approach to health care. The fact that Yale Health is not-for-profit means that you, our member, come first and that we are continually looking at ways to update and improve our services.

ELIGIBILITY

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage.

Who Can Be Covered

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class," as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a faculty member with at least half-time appointment or staff working 20 hours or more per week as defined by Yale University.
- You are covered under COBRA or Yale's Retiree Plan.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows:

If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the first day of the month coinciding with or next following the date of employment.

Obtaining Coverage for Dependents

Your dependents can be covered under your plan. You may enroll the following dependents:

- Child: son, daughter, stepchild, adopted child, child placed in household for adoption, foster child or legal ward;
- Spouse: Spouse, civil union partner, or same-sex domestic partners (recognized by the University prior to April 1, 2006).

Yale Health will rely upon Human Resources to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Dependent Children

To be eligible, a dependent child must be under age 26.

Coverage for an eligible adult disabled child may be continued past the age of 26.

Important Reminder

Keep in mind that you cannot receive coverage under the plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

HOW AND WHEN TO ENROLL

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You must enroll in a manner determined by Human Resources. To complete the enrollment process, you must provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Human Resources will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Human Resources will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 30 days of your eligibility date. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, Human Resources will provide you with information on when and how you can enroll.

Your effective date of coverage is the 1st of the month following your date of hire.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Your effective date of coverage is January 1st of the following year.

Special Enrollment Periods

If one of these situations applies, you may enroll before the next annual enrollment period.

Coverage is effective on the 1st of the month following enrollment except in the case of birth/adoption when coverage begins on the date of birth or date of adoption (see *If You Adopt a Child*, p.4), provided all of the plan guidelines are followed.

You or your dependents may qualify for a Special Enrollment Period if you have experienced any of the approved qualifying life events listed below:

- Marriage, establishment of same sex civil union partner, divorce or legal separation
- Birth or adoption of a child
- Death of a spouse or child

- Change in residence or work location that affects benefits eligibility for you or your covered dependent(s)
- Your child(ren) meets (or fails to meet) the plan's eligibility rules (for example, student status changes)
- You or one of your covered dependents gain or lose other benefits coverage due to a change in employment status (for example, beginning or ending a job)

You will need to enroll yourself or a dependent for coverage within 30 days of when other creditable coverage ends. Evidence of termination of creditable coverage must be provided to the Employee Service Center. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

Your effective date of coverage is the day after the other coverage terminates.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 30 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 30 days of a court order requiring you to provide coverage.

You will need to report any new dependents at www.yale.edu/portal or by contacting the Employee Service Center at 203-432-5552.

The effective date of coverage through marriage or civil union is the 1st of the month following the marriage or civil union.

If you do not report any new dependents within 30 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 30 days of the placement.

- Proof of placement will need to be presented to the Employee Service Center prior to the dependent's enrollment.

Effective Date of Coverage

The effective date of coverage for an adopted child is on the first day of placement or adoption. If the child is in the hospital on the date of placement or adoption, coverage begins upon discharge from the hospital.

When You Receive a Court Order Concerning a Child Support Order

The plan will provide coverage for a child who is covered under a properly issued court order, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 30 days of the court order.

Coverage for the dependent will become effective on the date of the court order.

If you do not request coverage for the child within 30 days of the court order, you will need to wait until the next annual enrollment period.

Claims for benefits filed for dependents covered by a properly issued court order will be paid to the Yale Health subscriber.

HOW YOUR MEDICAL BENEFIT WORKS

It is important that you have the information and useful resources to help you get the most out of your Yale Health medical plan. This section explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, and continuation of coverage; and
- General administration of the plan.

Important Notes

Unless otherwise indicated, "you" refers to any eligible member. You can refer to the *Eligibility* section for a complete definition of 'you'.

- Your health plan pays benefits only for services and supplies described in this Booklet as authorized expenses that are medically necessary.
- This Booklet applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- A copy of this document is available on our website, www.yalehealth.yale.edu.

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.

Ongoing Reviews

Yale Health conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Booklet.

ABOUT YOUR YALE HEALTH MEDICAL BENEFIT

This Yale Health medical benefit provides coverage for a wide range of medical expenses for the treatment of illness or injury. It does not provide benefits for all medical care. The benefit also provides coverage for certain preventive and wellness benefits. With your Yale Health benefit, you must directly access the following departments and services at Yale Health Center at 55 Lock Street: Acute Care, Internal Medicine, Obstetrics & Gynecology, Ophthalmology and Pediatrics for covered services and supplies under the benefit without a referral. All other departments and services require prior authorization.

The benefit will pay for authorized expenses up to the maximum benefits shown in this Booklet. Coverage is subject to all the terms, policies and procedures outlined in this Booklet. Not all medical expenses are covered under the benefit.

Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers, Exclusions, Limitations and Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

If Yale Health determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting Yale Health to seek a review of the determination. Please refer to the *Claims Procedures* section of this Booklet.

This Yale Health coverage provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted or otherwise arranged with Yale Health, an affiliate or third party vendor to provide health care services and supplies to Yale Health plan members.

Important Note

ID card: You will receive an ID card. It is not required for services at Yale Health Center. Your ID card identifies you as a member when you receive services outside of Yale Health Center. If you have questions or need to replace your ID card contact Member Services at member.services@yale.edu or 203-432-0246.

Availability of Providers

Yale Health cannot guarantee the availability or continued participation of a particular provider.

To better understand the choices that you have with your Yale Health benefit, please carefully review the following information.

The Primary Care Clinician

Yale Health plan requires the designation of a primary care clinician (PCC). Your PCC coordinates your medical care, as appropriate either by providing treatment or by directing you to other network providers for other services and supplies. The PCC orders lab tests and x-rays, prescribes medicines or therapies, and arranges hospitalization. You are encouraged to choose a physician, nurse practitioner or physician associate as your PCC.

Women should also choose a gynecologist or certified nurse midwife for routine gynecological care. You do not need prior authorization from your Yale Health PCC in order to obtain access to obstetrical or gynecological care from a Yale Health Obstetrics & Gynecology clinician. The Yale Health Obstetrics & Gynecology clinician, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

A clinician in the Pediatrics Department should be chosen for enrolled dependent children. If you do not choose, your clinicians will be designated for you and your family.

You can review a list of Yale Health's PCCs at www.yalehealth.yale.edu. You may also request a printed copy of the PCC Directory by contacting Member Services at member.services@yale.edu or 203-432-0246.

Changing Your PCC

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

Understanding Prior Authorization

Prior Authorization

Except for emergency and urgent care as defined below, health care services outside of Yale Health Center require prior authorization by Yale Health. Prior authorization is a process that helps you and your clinician determine whether the services being recommended are authorized expenses under the benefit. It also allows Yale Health to help your clinician coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

Prior authorization may be requested in one of two ways:

1. You may ask your primary care clinician for a referral. A referral requested by your clinician does not guarantee authorization. The referral will be reviewed and you will be notified of the status.
2. If you are unable to reach your primary care clinician or your primary care clinician is unwilling to refer you for the service(s) you request, you may call Claims at 203-432-7397 during regular business hours.

You and/or the facility or provider of services for which you have requested authorization will be notified as soon as a determination has been made, generally within 72 hours. If the service you

requested is not authorized, you may be offered alternatives that will be covered. If you receive a denial of authorization verbally, you may request notification in writing.

If authorization is denied, you have the right to appeal the decision. See [Appeals Process](#) for further information.

Emergency Care

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.

An emergency medical condition is a sudden and severe condition, sickness or injury, including, but not limited to, severe pain, which would lead a prudent layperson including the parent or guardian of a minor child or the parent or guardian of a disabled individual possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

- Placing one's health in serious jeopardy;
- Serious impairment to a bodily function(s);
- Serious dysfunction to a body part(s) or organ(s); or
- In the case of a pregnant woman, serious jeopardy to the health of 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 at 203-432-0123 provided a delay would not be detrimental to your health.
- Within New Haven County, Yale-New Haven Hospital emergency department is the only approved emergency facility unless the member is transported by ambulance to another facility.
- After assessing and stabilizing your condition, the facility should contact Acute Care at 203-432-0123 to obtain your medical history and to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify Claims at 203-432-7397 as soon as reasonably possible. For behavioral health admissions notify Magellan Healthcare at 800-327-9240.
- 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 at the telephone number listed on your ID card.

The plan will pay for services provided in an emergency department to evaluate and treat an emergency medical condition.

Please contact Claims at 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.

Urgent care

An urgent condition is a sudden illness, injury or condition that meets all of the following criteria:

- Requires prompt medical attention to avoid serious deterioration of your health;
- Cannot be adequately managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency department; and
- Requires immediate outpatient medical care that cannot wait for your clinician to become available.

Yale Health Acute Care is available 24 hours a day, including weekends and holidays for urgent care. Call your clinician or Yale Health Acute Care if you think you need urgent care. Urgent care is covered at 100% when it is received at the Yale Health Center.

Coverage for an urgent condition

The plan will pay for the services of an urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

- Use of urgent care facilities;
- Physician services;
- Nursing services; and
- Staff radiologists and pathologists services.

Care for non-acute phases of chronic conditions, maintenance care and routine care are not considered urgent. If you are outside of CT, you are considered out-of-area and you may receive urgent care at any medical facility.

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.

If it is not feasible to contact the Yale Health Claims Department before receiving care, please do so as soon as possible after urgent care is provided and within 48 hours.

Non-urgent care

If you seek care from an urgent care provider for a non-urgent condition (one that does not meet the criteria above) the plan will not cover the expenses.

Follow-up care that is not pre-authorized will be denied and you will be responsible for the entire cost of your treatment.

Follow-up care after treatment of an emergency or urgent medical condition

Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you must contact your clinician or Care Coordination for any necessary follow-up care.

When 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 member refuses transfer, coverage for follow-up care will be denied.

Important Note

Follow-up care, which includes, but is not limited to, suture removal, cast removal and radiological tests such as x-rays, should **not** be provided by an emergency room facility and will not be covered.

Other Yale Health resources, services and providers who may assist in your care

Specialists and Other Network Providers

All specialists and other health care providers require prior authorization for covered services and supplies. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

Network Hospital

Yale Health's network hospital is Yale-New Haven Hospital.

Care Management

You may have a care manager assigned to you who works with you and your clinicians to coordinate more complex care. The care manager will help you identify your health care needs, develop a plan of care with your primary care clinician and answer questions you may have regarding your care. The care manager can provide you with health information, assist in making appointments, help find community services and assist with filling out paperwork. You may contact the Care Management Department at 203-436-5791 directly or your clinician may refer you.

Accessing Providers and Benefits Outside of Yale Health Center

- If a service you need is covered under the benefit but not available at Yale Health Center your PCC will direct you to a network provider or medical facility.
- All health care services outside of Yale Health Center require prior authorization to verify coverage for these services. You are responsible for obtaining necessary prior authorization except for emergency care and urgent care as defined above. Therefore, any out-of-pocket costs to you as a result of your failure to prior authorize services will be your responsibility. Refer to the *Understanding Prior Authorization* section for more information on the prior authorization process and what to do if your request for prior authorization is denied.
- You will not have to submit medical claims for treatment received at Yale Health Center or from network health care professionals and facilities. (If you receive a statement from a network provider or facility, please contact the Claims Department at 203-432-0250.) Yale Health will directly pay the network provider or facility less any cost sharing required by you. You will be responsible for deductibles, payment percentage and copayments, if any.
- For emergencies outside of the country the Emergency Travel Assistance program is another Yale University benefit that may assist in coordinating your care with Yale Health.

Cost Sharing For Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in the *Schedule of Benefits*.

- For certain types of services and supplies, you will be responsible for any copayments shown in the *Schedule of Benefits*.
- You must satisfy any applicable deductibles.
- After you satisfy any applicable deductible, you will be responsible for any applicable payment percentage for authorized expenses that you incur.

The plan will pay for authorized expenses, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections. You will be billed for any deductible, copayment, or payment percentage amounts, or any non-covered expenses that you incur.

REQUIREMENTS FOR COVERAGE

To be covered by the plan, services and supplies and prescription drugs must meet all of the following requirements:

1. The service or supply or prescription drug must be covered by the plan. For a service or supply or prescription drug to be covered, it must:
 - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.
2. The service or supply or prescription drug must be provided while coverage is in effect. See the *Eligibility, How and When to Enroll, Termination of Coverage and Continuing Coverage Through COBRA* sections for details on when coverage begins and ends.

Important Note

Not every service, supply or prescription drug that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

WHAT THE YALE HEALTH MEDICAL PLAN COVERS

Many preventive and routine medical expenses as well as expenses incurred for a serious illness or injury are covered when provided at Yale Health Center at 55 Lock Street. Medical expenses incurred outside of Yale Health Center require prior authorization. This section describes which expenses are covered expenses. Only expenses incurred for the services and supplies shown in this section are covered expenses. Limitations and exclusions apply.

WELLNESS

Covered expenses include but are not limited to routine physical exams, immunizations, routine cancer screenings, family planning services, routine eye exams, hearing exams. Preventive and screening services are based on generally accepted standards endorsed by authorities such as the US 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*.

CLINICIAN SERVICES

Covered non-emergency expenses include and are limited to the charges made by a physician or other clinician as long as the services are provided within the Yale Health Center, or are pre-authorized and provided by an approved physician or clinician in the Yale Health network.

INPATIENT HOSPITAL EXPENSES

Covered medical expenses include services and supplies provided by Yale-New Haven Hospital or other pre-approved inpatient facility during your stay as long as the admission is supervised by a Yale Health physician. Covered services include but are not limited to room and board, nursing services, dietary services, medications, dialysis, radiation, diagnostic imaging, operating room fees, and inpatient physical therapy. There is no coverage for charges associated with admissions that are not prior authorized, except in the case of an emergency. See the *Emergency Care* section.

Maternity services are covered at Yale-New Haven Hospital. Admission to another facility for labor and delivery after a Yale Health physician has recommended no travel will not be covered.

EMERGENCY DEPARTMENT AND URGENT CARE FACILITIES

Covered medical expenses include the services and supplies provided in an Emergency Department or Urgent Care facility provided the facility is in the Yale Health network and the condition meets the definition of [emergency or urgent care](#). The only in-network urgent care facility in the State of CT is the Yale Health Acute Care department. Within New Haven County, Yale-New Haven Hospital Emergency Department is the only approved emergency facility unless the member is transported by ambulance to another facility.

ALTERNATIVES TO HOSPITAL STAYS

Outpatient Surgery and Physician Surgical Services

Authorized expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- An office-based surgical facility of a physician or dentist;
- A surgery center; or
- The outpatient department of a hospital.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital;
- The surgery is not normally performed in a physician's or dentist's office.

Important Note

Benefits for surgery services performed in a physician's or dentist's office are described under Clinician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the hospital, surgery center on the day of the procedure;
- The operating physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Exclusions and Limitations

Unless specified above, *not* covered under this benefit are charges for:

- The services of a physician or other health care provider who renders technical assistance to the operating physician.
- A stay in a hospital.
- Facility charges for office-based surgery.

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 his or her license.
- Home short-term physical, speech, or occupational therapy. 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.

Subject to applicable benefit plan terms and limitations, Yale Health considers skilled home health nursing and therapy services medically necessary when **all** of the following criteria are met:

1. The member is homebound because of illness or injury (i.e., the member leaves home only with considerable and taxing effort and absences from home are infrequent, or of short duration, or to receive medical care); *and*
2. The services provided are not primarily for the comfort or convenience of the member or custodial in nature; *and*
3. The services are ordered by a physician and are directly related to an active treatment plan of care established by the physician; *and*
4. The services are provided in lieu of a continued hospitalization, confinement in a skilled nursing facility (SNF), or receiving outpatient services outside of the home; *and*
5. The skilled nursing care and/or therapy is appropriate for the active treatment of a condition, illness, disease, or injury to avoid placing the member at risk for serious medical complications; *and*
6. The skilled nursing care and/or therapy is intermittent in nature ; *and*
7. The treatment provided is appropriate for the member's condition including the amount of time spent providing the service as well as the frequency and duration of the services.

Exclusions and Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the home health care plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Transportation.
- Services that are custodial care.

Important Reminders

The plan does *not* cover custodial care, even if care is provided by a nursing professional and family member or other caretakers cannot provide the necessary care.

Home health care needs prior authorization by Yale Health. Refer to *How the Plan Works* for details about prior authorization.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

Hospice Care

Covered expenses must be part of a hospice care program. Hospice services require prior authorization .

Facility expenses include charges made by a hospice facility for room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management. Yale Health reserves the right to determine whether such services will be provided in the Yale Health Inpatient Care facility or other authorized pre-approved facility.

Home hospice covered expenses include charges by a Hospice Care Agency for home visits including part-time or intermittent nursing care by an R.N. or L.P.N. and medical social services. Such services must be ordered by a Yale Health clinician and approved in advance.

Exclusions and Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily room and board charges over the semi-private room rate.
- Bereavement counseling; funeral arrangements; pastoral counseling; and financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Inpatient hospice care and home health care requires prior authorization by Yale Health. Refer to *How the Plan Works* for details about prior authorization.

OTHER COVERED HEALTH CARE EXPENSES

Acupuncture

The plan covers charges made for acupuncture services provided by a legally qualified physician, practicing within the scope of his/her license, if the service is performed as a form of anesthesia in connection with a covered surgical procedure.

Ambulance Service

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.

Chiropractic Service

The plan reimburses charges for a licensed chiropractor. Refer to the *Schedule of Benefits* for details on any applicable deductible, payment percentage and any maximum benefit limits.

DIAGNOSTIC AND PREOPERATIVE TESTING

Diagnostic Imaging Expenses

The plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, with prior authorization, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI); and
- Positron Emission Tomography (PET) Scans.

Outpatient Diagnostic Lab Work

Covered expenses include charges for lab services, and pathology and other tests provided to diagnose an illness or injury performed at a Quest Diagnostics laboratory in CT, MA, RI, NH, VT or ME.

Quest Outpatient Pathology

Covered expenses include charges for pathology services when the specimen is obtained at Yale Health Center or in conjunction with a previously approved outpatient procedure.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, authorized expenses include charges made for tests performed at Yale Health Center or a pre-approved facility provided the charges for the surgery are covered expenses.

Diagnostic tests ordered by non-participating providers

Diagnostic services including but not limited to laboratory testing and diagnostic imaging are covered as described above when ordered by a clinician in the Yale Health network for a covered condition or service. Coverage for diagnostic services may not be authorized when:

- ordered by a non-participating clinician, or
- in relation to an excluded condition, procedure or service, or
- when not medically necessary

Prior authorization for diagnostic testing should be obtained from the Referrals Department for any test ordered by a non-participating clinician (i.e. not in the Yale Health network).

DURABLE MEDICAL AND SURGICAL EQUIPMENT (DME)

Authorized expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

The initial purchase of DME if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Yale Health reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Yale Health.

Important Reminder

Refer to *Exclusions* for information about Home and Mobility exclusions.

ELECTROLYSIS/FACIAL 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 [Ferrmian-Gallway scale](#) and a diagnosis that establishes the medical necessity of hair removal, such as facial hirsutism, gender dysphoria or painful skin conditions. With prior authorization, services by a certified electrologist, licensed in the state of CT, are reimbursed at a rate of up to sixty dollars 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.

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.

NEWBORN CARE

Care for a newborn is covered from the moment of birth, provided that the newborn meets the dependent eligibility criteria and is enrolled within 30 days of birth. If after 30 days the newborn child is not enrolled, services rendered to the newborn from the date of birth are not covered. 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.

PODIATRY

Services provided for foot care by a licensed podiatrist are covered when medically necessary due to an underlying medical condition, such as diabetes mellitus, circulatory and neurological disorders, and morbid obesity. The benefit is paid at 100%. Podiatry services must be ordered in advance by a Yale Health network clinician and prior authorization is required by Yale Health Claims Department.

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

Please note in regard to maternity 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 mother 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.

PROSTHETIC DEVICES

Authorized expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores a body part function that has been lost or damaged by illness, injury or congenital defect. Authorized expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Authorized expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy; and
- Speech generating devices.

REHABILITATION SERVICES

Inpatient rehabilitation

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. Specific services may be restricted or limited as outlined in the *Schedule of Benefits*.

RECONSTRUCTIVE OR COSMETIC SURGERY AND SUPPLIES

Covered expenses include charges made by a physician, hospital, or surgery center for reconstructive or cosmetic services 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, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.

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.

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.

SPECIALIZED CARE

Chemotherapy

Authorized expenses include charges for chemotherapy treatment. In most cases, chemotherapy is covered as outpatient care at Yale Health Center. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

Radiation Therapy Benefits

Authorized expenses include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

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 his/her 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).

Not included under this infusion therapy benefit are charges incurred for enteral nutrition.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital and Skilled Nursing Facility Benefits* sections of this *Booklet*.

Benefits payable for infusion therapy will not count toward any applicable home health care maximums.

Important Reminder

Refer to the *Schedule of Benefits* for details on any applicable deductible, payment percentage and maximum benefit limits.

DIABETIC EQUIPMENT, SUPPLIES, AND EDUCATION

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps; covered under the Prescription benefit, subject to copay;
- Continuous blood glucose monitors without special features unless required due to blindness at no charge if ordered by a Yale Health Center clinician;
- Alcohol swabs;
- Training provided at Yale Health Center;
- Podiatry services, subject to prior authorization; and
- Blood glucose monitors purchased at Yale Health Center Pharmacy.

TREATMENT OF INFERTILITY

Treatment rendered for assisted conception or infertility services by a Yale Health or Yale Health network clinician is covered at 100% up to any applicable University lifetime maximum, upon referral by a Yale Health clinician and approved in advance by the Referrals Department. See the Schedule of Benefits for applicable limits. To avoid responsibility for the cost of services in excess of these limits, members are urged to consult the Yale Health Claims Department with any questions regarding authorization.

Available services include:

- Diagnosis of and consultation for male and female infertility
- Assisted conception: service provided to a fertile woman 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 female members; and
 - infertility-related surgery and other procedures.
- Advanced reproductive technologies (ART), including IVF: In vitro fertilization (IVF) for female members who do not or cannot conceive with basic infertility services.

Please note that diagnosis of infertility, assisted conception and basic infertility services are considered together with regard to University lifetime maximums. Separate University 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 infertility:** failure to conceive with a fertile female partner after one year of unprotected coitus with a female partner under the age of 35 or six months of unprotected coitus with a fertile female partner over 35. Infertility must be diagnosed by a network infertility specialist and documented in the medical record.

- Female infertility: failure to conceive with a fertile male partner after one year of unprotected coitus for covered members under the age of 35, or six months of unprotected coitus for those 35 or older. Infertility must be diagnosed by a network infertility specialist and documented in the medical record.
- Premature menopause: ovarian failure in women 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 women who are less than age 40, the day 3 FSH must be less than 19 mIU/mL in their most recent lab test. For women age 40 and older, their unmedicated day 3 FSH must be less than 19 mIU/mL in all prior tests.

Exclusions and Limitations

Certain exclusions apply to all infertility services. These include:

- 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
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos, except as outlined below in Preservation of Fertility
- Services that are not reasonably likely to result in success
- Investigational treatments, regimens, medications or procedures

Special exclusions may apply to individual components of coverage as outlined below.

Diagnosis of and consultation for male and female infertility

Eligibility: all Yale Health members of reproductive age subject to the University lifetime limits of Basic Infertility. 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.

Assisted conception

Eligibility: fertile female members, subject to the University lifetime limits of Basic Infertility. Limits apply per covered female member. Prior authorization by Yale Health is required for all infertility services.

Coverage includes: services related to intrauterine insemination using donor sperm.

Exclusions (in addition to the exclusions and limitations above): costs for acquisition, processing, testing or storage of donor sperm.

Basic infertility services

Eligibility: infertile female members, subject to the University lifetime limits of Basic Infertility. Limits apply per covered female member. Prior authorization by Yale Health is required for all infertility services.

Coverage includes but is not limited to:

- treatment to stimulate/induce ovulation and intrauterine insemination for infertile female members; and
- infertility-related surgery and other procedures.

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

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

IVF / Advanced Reproductive Technologies

Eligibility: infertile female members 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 failure to conceive after four cycles of intrauterine insemination. Coverage is subject to the University lifetime limits of IVF/ART. Limits apply per covered female member. 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. Any one of these services will constitute one cycle of treatment regardless of whether this results in 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
- Charges for purchase of donor eggs or sperm
- Coverage for IVF using a woman's own eggs depends upon having 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 women who are less than age 40, the day 3 FSH must be less than 19 mIU/mL in their most recent lab test. For women age 40 and older, their unmedicated day 3 FSH must be less than 19 mIU/mL in all prior tests.
- Infertility services for women with natural menopause age 40 years and older are not covered as such services are not considered treatment of disease. Women 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 women with premature ovarian failure who are less than 40 years of age.
- IVF in fertile women 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 genetic disease, and IVF is indicated for infertility as described above, *PGD to select unaffected embryos for transfer would be covered.*

Fertility Preservation

Induction of ovulation, oocyte harvesting and cryopreservation of oocytes or embryos may be covered for women facing infertility due to chemotherapy, pelvic radiotherapy (or other gonadotoxic therapies), or medically necessary surgery that will impair fertility. Use of ART to obtain oocytes or embryos for cryopreservation to circumvent reproductive aging in healthy, women is not considered medically necessary and is not covered.

TRANSPLANT SERVICES

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 Claims Department. This includes hospitalization charges, professional fees, the direct costs of the organ and organ procurement, but is secondary and is limited to expenses not covered by other sources, included but not limited to, insurance coverage, grants, foundations, government programs, etc.

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.

Important Reminders

To ensure coverage, all transplant procedures need prior authorization by Yale Health. Refer to the *How the Plan Works* section for details about prior authorization.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Exclusions and Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness; and
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness.

OBESITY TREATMENT

Yale health provides consultation, diagnostic testing and counseling by authorized primary care clinicians and/or licensed dieticians for non-surgical outpatient weight management.

Authorized expenses also include one morbid obesity surgical procedure, within a two-year period, beginning with the date of the first morbid obesity surgical procedure; unless a multi-stage procedure is planned.

But only when you have a:

- Body mass index (BMI) exceeding 40; or
- BMI greater than 35 in conjunction with any of the following co-morbidities any one of which is aggravated by the obesity:
 - Coronary heart disease;
 - Type 2 diabetes mellitus;
 - Clinically significant obstructive sleep apnea; or
 - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic) despite optimal medical management.

Exclusions and Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of co-morbid conditions; except as provided in this *Booklet*.
- Nutrition consult associated with morbid obesity surgery.

Important Reminder

Refer to the *Schedule of Benefits* for information about any applicable benefit maximums that apply to morbid obesity treatment.

OUTPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

Yale Health contracts with Magellan Healthcare to administer the behavioral health benefit. Outpatient behavioral health services for medically necessary diagnosis and treatment (see [Magellan's Medical Necessity Criteria](#) or go to their website www.magellanhealth.com/member and click Care Guide>Managing Your Care>Medical Necessity Criteria) by in-network mental health professionals are covered at 100% for recognized behavioral health and substance abuse disorders, subject to the *Exclusions and Limitations* section. Covered diagnoses are those contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, unless excluded as defined in the *Exclusions and Limitations* section. Outpatient services require prior authorization by Magellan Healthcare, 800-327-9240. Periodic re-authorization for coverage of ongoing care is required. Outpatient behavioral health services are accessed through Magellan Healthcare, 800-327-9240 or TDD# 800-456-4006. For emergency care, see the section *Emergency Care*.

INPATIENT BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

Under the terms and limits described below Yale Health will provide coverage at 100% for medically necessary inpatient care (see [Magellan's Medical Necessity Criteria](#) or go to their website www.magellanhealth.com/member and click Care Guide>Managing Your Care>Medical Necessity Criteria) at a Yale Health-approved inpatient facility under the authorized care of a Yale Health network

physician. Yale Health-approved facilities include: licensed acute care hospital; approved psychiatric hospital; approved substance abuse treatment center and approved rehabilitation center.

INPATIENT MEDICAL/SURGICAL

You and your enrolled dependents are covered for medically necessary inpatient care at a Yale Health-approved facility under the care of a Yale Health network physician. For medical/surgical services, the Yale Health network hospital is Yale-New Haven Hospital. This includes newborns. 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. Coverage includes the cost of a semiprivate room, meals, general nursing care, and ancillary 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.

If, in the judgment of Yale Health, the illness or injury or its continuing care could have been treated in the Inpatient Care unit at the Yale Health Center, payment for inpatient hospital charges 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*.

Maternity coverage: starting from four weeks before your due date, or earlier if you are advised not to travel by the Yale Health network obstetrician, 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 mother 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.

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.

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, 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.

The treatment must be completed within 24 months of the accident.

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, but only if the services take place no later than 24 months after the injury.

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 result 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 preposition teeth.

GENDER TRANSITION SERVICES

Medically necessary services for gender transition, 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 Dysphoria and Gender Transition](#). Services may be subject to limitations or restrictions as described in the *Schedule of Benefits*.

MEDICAL PLAN EXCLUSIONS

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet.

Important Note:

You have medical and prescription drug coverage. The exclusions listed below apply to all coverage under your plan.

Exclusions and limitations

Yale Health Medical Plan offers a comprehensive health care program, but there are limitations and exclusions. These are listed below.

Additional exclusions apply to specific areas of coverage. Those additional exclusions are listed separately under the *What the Plan Covers* section for each of these benefits.

GENERAL EXCLUSIONS AND LIMITATIONS

1. charges that would not have been made had coverage not existed
2. services that are not medically necessary (see [Definition of Medical Necessity](#))
3. services provided at Yale Health Center on a fee-for-service basis
4. 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. injury or occupational illness covered by Workers' Compensation
8. charges to the extent that they are otherwise covered as described below under Coordination of Benefits
9. charges that members are not legally required to pay
10. any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet and/or the *Schedule of Benefits*
11. charges for a service or supply furnished by a network provider in excess of the negotiated charge, or an out-of-network provider in excess of the recognized charge

12. charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan
13. charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license
14. court ordered services, including those required as a condition of parole or release
15. educational, experimental or investigational drugs, services, treatment, or procedures as determined by Yale Health
16. non-medically necessary services as determined by Yale Health. This applies even if they are prescribed, recommended or approved by your physician or dentist.
17. treatment generally not recognized as effective or conditions generally not recognized as responsive to treatment

NETWORK EXCLUSIONS AND LIMITATIONS

1. inpatient hospitalization charges incurred for non-emergency admission when a Yale Health member is admitted to a hospital by a non-Yale Health network physician
2. non-emergency services ordered by or provided by clinicians not in the Yale Health network, unless authorized in advance by the Yale Health Claims Department
3. follow-up care by a non-Yale Health network clinician unless authorized in advance by the Yale Health Claims Department

COVERAGE DATE EXCLUSIONS AND LIMITATIONS

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

SERVICE EXCLUSIONS AND LIMITATIONS

1. **acupuncture**; except when used instead of other anesthesia
2. **allergy**: non-standard allergy services and supplies
3. **alternative/complementary** therapies, including, but not limited to those specified in this Booklet
4. treatment for **amnesiac** disorders
5. **applied behavioral analysis**, except as specifically provided in the *What the Medical Plan Covers* section (and your other plan documents).

6. **aqua therapy**, except when provided by a physical therapist in a one-to-one setting
7. **aromatherapy**
8. **artificial organs**: any device intended to perform the function of a body organ, unless FDA approved
9. **biofeedback**, except for treatment of incontinence
10. **bioenergetic therapy**
11. coverage for any services available through the **Birth to Three system**, including fees and costs associated with the Birth to Three system services, such as the parent fees
12. **career counseling**
13. personal **comfort and convenience items**
14. **contraceptives** supplies purchased over the counter including but not limited to condoms, contraceptive foams, jellies and ointments
15. **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.

16. **Counseling and Support Services:** services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor
17. **custodial care**, convalescent care, respite care and assistance for activities of daily living
18. **dental services:** Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth, except for injury to a sound natural tooth, see [Oral and Maxillofacial Treatment \(Mouth, Jaws and Teeth\) section](#). This includes but is not limited to:
 - services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
 - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
 - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
19. **disposable outpatient supplies**
20. **drugs**, medications and supplies, except for those provided by the Pharmacy Benefit
21. **educational or teacher services:**
 - Any services or supplies related to education, training or retraining services or testing, including, but not limited to special education, remedial education, job training and job hardening programs;
 - Treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
 - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
22. services performed in **educational, vocational or recreational settings**
23. any health **examinations:**

- required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement, except as required by Yale University and when the examination is done by Yale Employee Health
 - required by any law of a government, securing insurance or school admissions, or professional or other licenses;
 - required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
 - any special medical reports not directly related to treatment except when provided as part of a covered service.
24. 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 laser vision correction, radial keratotomy
25. **eyeglasses**, contact lens exams and lenses, corrective lenses, vision therapy; routine vision care received outside the Yale Health Center
26. **facility charges** for care services or supplies provided in:
- rest homes;
 - assisted living facilities;
 - similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
 - health resorts;
 - spas, sanitariums; or
 - infirmaries at schools, colleges, or camps, except for emergency or urgent care as described in the *Emergency and Urgent Care section*.
27. coverage for any **food or food item** with the following exceptions:
- Specialized infant formulas medically necessary to prevent adverse outcomes from inborn errors of metabolism during the first two years of life.
 - 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.

Yale Health does **not** cover banked breast milk, food supplements, specialized infant formulas, vitamins and/or minerals taken orally (i.e., by mouth). Such products, including specialized infant formulas, lactose-free foods, vitamins and/or minerals which may be used to replace food or supplement a deficient diet, or to provide alternative nutrition in the presence of such conditions as allergies, gastrointestinal disorders, hypoglycemia, and obesity are not covered, even if they are required to maintain weight or strength and regardless of whether these are prescribed by a physician.

Upon request, the Yale Health Pharmacy will obtain specialized nutritional formulas and provide to members at cost for children with food allergies or intolerance when recommended by a Yale Health physician or consultant, until the child is able to tolerate a solid diet.

28. **routine foot care** is generally not considered medically necessary and is covered only when provided by a Yale Health clinician in a primary care department, dermatology, surgery or Acute Care. Routine care includes but is not limited to treatment of:
- mild to moderate Bunions
 - callouses
 - corns
 - warts
 - hyperkeratosis
 - keratoderma
 - nail clipping / trimming
 - plantar keratosis
 - uncomplicated infections or injuries not requiring surgical treatment
 - mild and uncomplicated ingrown nails
 - paronychia
 - flat feet
 - mild and uncomplicated plantar fasciitis
29. **foot** related items: any supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury
30. devices and other services related to **gender-affirming surgery** for procedures other than those specifically included in the coverage. These exclusions include but are not limited to laser hair removal, hair implants, hairline revisions, and surgery to alter facial characteristics.
31. **growth/height**: Any device, service or supply (including surgical procedures and devices to stimulate growth), solely to increase or decrease height or alter the rate of growth

32. **hearing:**

- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except for treatment of profound hearing loss in children 12 years old and younger, see *Schedule of Benefits*.
- Any hearing service or supply that does not meet professionally accepted standards.
- Hearing exams given during a stay in a hospital or other facility.

33. **home and mobility:** Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness;
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device; and
- Assessment and testing services for the home or workplace environment.

34. **home births:** Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries

35. **home health aides**

36. **home uterine activity monitoring**

37. **hypnosis and hypnotherapy**

38. treatment of **impulse control disorders**

39. **infertility**: Except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and ovulation induction and intrauterine insemination services if you are not infertile.

40. **light therapy**

41. **marriage counseling**

42. services required to obtain **medical marijuana**

43. **miscellaneous** charges for services or supplies including:

- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
 - Care in charitable institutions;
 - Care for conditions related to current or previous military service;

- Care while in the custody of a governmental authority;
- Any care a public hospital or other facility is required to provide; or
- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

44. **naturopathy**

45. hospitalization or other services for **obesity** or weight reduction except as approved in advance by Yale Health

46. **orthomolecular therapy**

47. **orthotics** (including examinations for fitting) except for the following:

- If the orthotic is an integral part of a leg brace and its expense is included as part of the cost of the brace.
- Rehabilitative foot orthotics prescribed as part of post-surgical or post-traumatic casting care.
- Rehabilitative foot orthotics prescribed for treatment or rehabilitation of neurological injury.

48. treatment of **paraphilias**

49. **personal comfort** and convenience items. Any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

50. treatment of **pervasive development disorder** (including autism spectrum disorders)

51. Services, including those related to **pregnancy**, rendered before the effective date or after the termination of coverage, unless coverage is continued as outlined under the *Continuation of Coverage* section of this Booklet

52. extra fee for **private inpatient rooms**

53. services intended for **professional growth** or certification

54. **psychodrama**

55. **IQ or educational testing**

56. **primal therapy**

57. **private duty nursing** during your stay in a hospital, and outpatient private duty nursing services

58. **programs** such as LEAP, TEACCH, Denver program, Rutgers program, wilderness programs and similar programs
59. **recovered memory therapy**
60. **services** provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member
61. **services** of a resident physician or intern rendered in that capacity
62. **services** provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings
63. **services and supplies** provided in connection with treatment or care that is not covered under the plan
64. **sexual dysfunction/enhancement:** Surgery, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
65. **sex therapy**, sex counseling, marriage counseling or other counseling or advisory services
66. **sensory** or auditory integration therapy
67. **skilled nursing facility (SNF)** services
68. **speech therapy** for treatment of delays in speech development, except as specifically provided in the *What the Medical Plan Covers* section (and your other plan documents). For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.
69. **sperm collection** or preservation service
70. **spiritual** or pastoral counseling
71. reversal of voluntary **sterilization**
72. maternity charges for a **surrogate** or birth mother who is not a Yale Health member
73. **target symptom clinics** or centers except as approved in advance by Yale Health
74. **therapies** for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered, except as specifically provided in the *What the Medical Plan Covers* section (and your other plan documents). Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

75. x-rays, or appliances for the diagnosis and treatment of **TMJ** (temporomandibular joint dysfunction); extraction of teeth including erupted or impacted teeth; correction of malposition of the teeth and jaw; or for pain, deformity, deficiency, injury, or physical condition of the teeth

76. costs associated with the **translation of documents** for processing of claims

77. **transplant** coverage does not include charges for:

- Services and supplies furnished to a donor when the recipient is not a covered person;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise prior authorized by Yale Health.

78. non-emergency **transportation**

79. **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

80. **travel vaccines**

81. **unauthorized services**, including any service obtained by or on behalf of a covered person without prior authorization by Yale Health when required. This exclusion does not apply in a medical emergency or in an urgent care situation.

82. **vision-related** services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Special supplies such as subnormal vision aids;
- Vision services or supplies which do not meet professionally accepted standards;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Eye exams for contact lenses or their fitting;
- Eyeglasses, contact lenses, lenses or frames;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

83. **work related:** Any illness or injury related to employment or self-employment that is covered by Worker's Compensation insurance or is provided outside of the Yale Health network without prior authorization.

84. all treatments or therapies in the same class or of similar type as those excluded above

YOUR PHARMACY BENEFIT

Your prescription drug plan pays benefits only for prescription drug expenses described in this document as **medically necessary and approved by the FDA**. This document applies to coverage only and does not restrict your ability to receive prescription drugs that are not or might not be covered benefits under this prescription drug plan.

This plan does not cover all prescription drugs, medications and supplies. Refer to the *Limitations* section of this coverage and *Exclusions* section of this coverage.

Covered expenses are subject to cost sharing requirements as described in the *Cost Sharing* sections and in the Schedule of Benefits.

Yale Health's Pharmacy is the only network pharmacy. Your out-of-pocket costs may vary between the Yale Health Pharmacy and out-of-network benefits.

Cost sharing for network benefits

Members share in the cost of their benefits. Cost sharing amounts and provisions are described in the *Schedule of Benefits*.

Members will be responsible for the co-payment for each prescription or refill as specified in the *Schedule of Benefits*. The co-payment is payable directly to the Yale Health Pharmacy at the time the prescription is dispensed.

Cost sharing for out-of-network benefits

Members can directly access an out-of-network pharmacy to obtain covered outpatient prescription drugs, and/or when a prescription must be filled in an emergency or urgent care situation or when traveling. Members will pay the pharmacy for the full cost of the prescription(s) at the time of purchase and submit a claim form to receive reimbursement from Yale Health. Members 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 members in accordance with the terms of the plan.

WHAT THE PLAN COVERS

The plan covers charges for outpatient prescription drugs for the treatment of an illness or injury, subject to the *Limitations* section of this coverage and the *Exclusions* section of this coverage. Prescriptions must be written by a prescriber licensed to prescribe federal legend prescription drugs.

Generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

Coverage of prescription drugs may, at Yale Health's sole discretion, be subject to Yale Health requirements or limitations. Prescription drugs covered by this plan are subject to drug utilization review by Yale Health and/or your provider and/or your pharmacy.

Coverage for prescription drugs and supplies is limited to the supply limits as described below.

Outpatient prescription drugs are covered when dispensed by either the Yale Health Pharmacy or an out-of-network pharmacy according to the terms described in this Booklet and in the *Schedule of Benefits*.

OTHER COVERED EXPENSES

The following prescription drugs, medication and supplies are also covered expenses under this prescription plan.

Off-label use

FDA approved prescription drugs may be covered when off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (National Comprehensive Cancer Network, Lexicomp, or Micromedex with a minimal evidence grade of class IIb (defined as recommended, in some cases, the given test, or treatment may be useful, and is indicated in some, but not most, cases) or equivalent (based on compendia evidence grades). Coverage of off-label use of these drugs may, at Yale Health's sole discretion, be subject to Yale Health requirements or limitations.

Diabetic supplies

Diabetic supplies that appear on the Yale Health Drug List upon presentation of a written prescription by a network clinician including:

- Diabetic needles and syringes
- Test strips for glucose monitoring and or visual reading
- Diabetic test agents
- Lancets/lancing devices
- Alcohol swabs

Contraceptives

The following contraceptives and contraceptive devices:

- Oral contraceptives
- Diaphragms, 1 per 365 consecutive day period
- Injectable contraceptives
- Contraceptive patches
- Contraceptive rings

Implantable contraceptive and IUDs are covered when prescribed by a network clinician and obtained from Yale Health's Pharmacy.

Lifestyle/performance drugs as indicated on the Yale Health Drug List:

Coverage is limited to 6 tablets or other form, determined cumulatively among all forms per 30 day supply.

PRESCRIPTION BENEFIT LIMITATIONS

Yale Health's 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.

The plan will not cover expenses for any prescription drug for which the actual charge to you is less than the required co-payment or deductible, or for any prescription drug for which no charge is made to you.

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.

For prescription drugs **not** listed on the Yale Health Drug List, prior authorization will be required to determine coverage.

Yale Health retains the right to review all requests for reimbursement determinations subject to the *Appeals Process* section of the Booklet.

PRESCRIPTION BENEFIT EXCLUSIONS

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist or other accepted prescriber. The plan covers only those services and supplies that are medically necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section. 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 in excess of the benefit, dollar, day or supply limits stated in this document are excluded.
3. Allergy sera and extracts are excluded.
4. Any non-emergency prescription incurred outside of the United States if 1) 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.
5. 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 or dentist or other accepted prescriber.

6. Biological sera, blood, blood plasma, blood products or substitutes or any other blood products are excluded.
7. Contraception: Over-the-counter contraceptive supplies, including but not limited to condoms, contraceptive foams, jellies and ointments; except as otherwise required by federal regulations and/or statutes.
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, except as otherwise required by federal regulations and/or statutes.
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.
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.
16. Prescription orders filled prior to the effective date of coverage under this Booklet 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, stolen, or destroyed 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 the *What the Plan Covers* section.
23. Test agents, except diabetic test agents, are excluded.

CLAIMS AND APPEALS

CLAIMS

Claims submitted by a member for reimbursement of covered services must be accompanied by itemized bills for services rendered (charge card receipts and balance due statements are not acceptable). Bills for services must include:

- Diagnosis
- provider name, professional credentials, address, telephone number, tax ID number
- procedure codes for determination of coverage.

If you receive a statement from a provider that does not contain the above information, please contact the provider and supply them with the information on your Yale Health ID card and request that they bill Yale Health directly.

Member obligations such as premium contribution, deductibles or co-payments cannot be appealed.

Claim forms are available in the Claims Department or can be downloaded from our website, www.yalehealth.yale.edu/forms. Please submit claims to Yale Health Claims Department/ P.O. Box 208217/New Haven, CT 06520-8217 or deliver to the Business Office on the third floor of 55 Lock Street.

Timely Filing of Claims

All claims should be reported promptly. The deadline for filing a claim is one year from the date of service or from the date of adverse determination by a primary insurer. If you have not received a response to a claim within 60 days of filing, contact the Yale Health Claims Department (203-432-0250).

APPEALS

If your claim or request for authorization of services is denied you have a right to appeal the decision. Member obligations such as premium contribution, deductibles or co-payments cannot be appealed. Appeals may be based on determinations that are reported to you in writing or verbally by a clinician or other 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.
- **Behavioral health appeals** must be submitted directly to Magellan Healthcare. See *Behavioral health service appeals*.

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.

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 orally or in writing to the Yale Health Medical Director/Attn: Urgent Appeal/ P.O. Box 208217/New Haven, CT 06520-8217.

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 Medical Director/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.

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 orally 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 208217/New Haven, CT 06520-8217. 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 208217/New Haven, CT 06520-8217. 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.

Once you have exhausted the above appeals, should the initial claim determination be upheld, you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

Behavioral health service appeals

All behavioral health services are authorized by Magellan Healthcare. A first level internal appeal of an adverse determination may be initiated by contacting Magellan's Appeals Department, P.O. Box 2128, Maryland Heights, MO 63043-2128, or by FAXing an appeal to Magellan's Appeal Department at 888-656-3820, within 180 days of the date the initial non-authorization determination, explanation of benefits (EOB), or explanation of payment (EOP) was issued. For urgent appeals call Magellan Health Services, 800-210-3957. For all other appeals mail to Magellan Health Services / Appeals / P.O. Box 2128 / Maryland Heights, MO 63043. Except for urgent appeals, appeal requests must be submitted in writing. As described in this section, the patient can also have an external review with an independent external review organization.

Magellan provides an urgent appeal 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 orally or in writing. An oral request for an urgent appeal may be made by calling Magellan at 800-201-3597. A written request for an urgent appeal may be faxed to Magellan's Appeals Department at 888-656-3820. Appeal decision timelines are determined by the status/urgency of the member at the time the appeal is requested without regard to the status/urgency of the member at the time the original determination or prior appeal determination was issued.

Clinical non-authorization decisions are reviewed on each level of appeal by a physician advisor (psychiatrist). Administrative and claims adverse decisions are reviewed on appeal by Appeals Department staff; second level administrative and claims appeals are decided by a panel of operations staff. In each case, the reviewer(s) who conducts a first level appeal or second level appeal has had no

prior involvement in the case and is not the direct report of the person who made the original determination or, in the case of second level appeals, of the first level appeal reviewer.

For each level of appeal, following review of the available information and rendering of an appeal decision by the assigned appeal reviewer, notice of the appeal determination and any additional appeals is furnished to the member, the treating clinician, and, if applicable, the facility, as follows:

Urgent appeals:

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.

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.

If you do not agree with the first level claim appeal decision, a second level claim appeal may be requested in writing (or orally, if an urgent review is requested) by contacting Magellan as described above. Second level appeals must be requested in writing within 60 days of receipt of the first level claim appeal determination. A different reviewer at Magellan than the reviewer who decided the first level internal appeal will consider the second level claim appeal. Appeals based on clinical issues will be reviewed by a health care practitioner with appropriate expertise. Appeals time frames will follow the time frames outlined above. Appeals time frames will follow the time frames outlined above.

If the second level claim appeal process maintains the denial, you have the right to request a third level claim appeal through an external independent review organization. Third level appeals must be requested in writing (or orally, if an urgent review is requested) by contacting Magellan as described above within 4 months of the second level claim appeal determination. 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.

Once you have exhausted the above appeals, should the initial claim determination be upheld, you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

TERMINATION OF COVERAGE

Faculty, staff, and their dependents enrolled in Yale Health may terminate their Yale Health coverage for several reasons — a change in eligibility status, leave of absence, divorce, annual enrollment or no longer meeting the definition of a dependent. Generally coverage ends the last day of the month in which the change of eligibility occurs or as specified by your collective bargaining agreement. In certain circumstances, Yale Health also reserves the right to terminate a member's coverage.

Information in the following section, applies to Yale faculty, staff and individual associates. If you have Yale Health coverage as a member of an associate group and your affiliation or the group's affiliation changes, check with your group administrator about your options concerning the areas covered below.

WHEN YOU TERMINATE COVERAGE

Leaving Yale

When you leave the University or end your affiliation, your Yale Health coverage will terminate. The date of coverage termination is based on your termination date or the date your affiliation ends; Yale Health cancels the coverage on the last day of the month in which these events occur. The Employee Service Center at 203-432-5552 or the associate group's administrator may specify coverage be continued for an additional period. If so, coverage ends on the last day of the month specified in the termination agreement.

Taking a leave of absence

If you take a leave of absence but your employment/affiliation status with Yale is unchanged (i.e. you are on sabbatical, maternity leave, medical leave), your Yale Health coverage and the University's contribution will continue during the period of your leave. If you contribute to the cost of your Yale Health coverage, you will continue to have the deductions taken during your leave. If your leave becomes unpaid, you will need to pay for Yale Health in lieu of payroll deductions. Please call the Employee Service Center at 203-432-5552 for more information about benefits during leaves and for specific policies on lengths of leaves and premium payments.

Termination of dependent coverage

Dependent coverage may terminate for a variety of reasons: the dependents obtain other coverage; a dependent turns 26 and does not meet the eligibility requirements; you are divorced from your spouse, or have your civil union dissolved or some other event occurs that changes a dependent's eligibility status. Coverage terminates on the last day of the month in which the dependent becomes ineligible.

Termination events for dependents

Dependents must be terminated for the following reasons:

- divorce
- civil union dissolution
- dependent child(ren) turning 26 who does not meet the eligibility requirements
- failure to follow plan provisions

Dependents may be terminated for:

- legal separation
- dependents obtain other coverage

Notice of dependent ineligibility

If an enrolled dependent is no longer eligible, you are required to notify Human Resources in writing within 30 days of the date of the event rendering the dependent ineligible. The dependent may not remain on your contract even if there is a court order or settlement requiring you to provide the dependent with insurance coverage. The ineligible dependent may, however, remain on Yale Health under the COBRA extension on a separate contract for up to 36 months. Unless the dependent files an application to remain on Yale Health under COBRA within 60 days of the date of the qualifying event, Yale Health membership will be terminated effective the last day of the month in which the dependent becomes ineligible. If Yale Health is not notified when the dependent becomes ineligible (i.e. a divorce or civil union dissolution occurs), you will be billed on a fee-for-service basis for all services rendered and claims paid by Yale Health on the dependent's behalf beginning the first day following the dependent's becoming ineligible. In addition, dependents may lose eligibility for COBRA under the following circumstances:

- becoming enrolled in Medicare after COBRA membership begins
- beginning coverage under another group plan, unless that plan contains exclusions or limitations with respect to pre-existing conditions that the members or enrolled dependents may have
- failing to pay monthly premiums

Associate groups and termination of coverage

Yale Health may terminate membership if the associate group through which a member is enrolled cancels or discontinues Yale Health coverage. The associate group may terminate membership in Yale Health for any of its members at any time by giving Yale Health written notice 15 days before the first of the month in which it wishes to terminate membership. The associate group is responsible for sending the member written notice of cancellation or discontinuation of Yale Health before the termination date. Coverage will be terminated whether or not notice was given to the member and the member shall be solely responsible for charges, if any, accrued as of the date of cancellation. Continuation of Yale Health coverage through COBRA is administered solely by the group and Yale Health is not responsible for offering the continuation of this coverage.

When Yale may terminate coverage

Yale may terminate membership and bill the member for all services rendered and claims paid by Yale Health on the member's behalf under the following conditions:

- the member fails to pay premiums;
- the member ceases to be eligible;

- the safety of the patient is jeopardized by the failure to accept a recommended course of treatment;
- the member permits his/her membership ID card to be used by another person(s);
- the member makes any false statement or material misrepresentations relating to enrollment information; or
- the safety and best interests of the Yale Health clinicians and staff are jeopardized by the member's conduct

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 the 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 by using one benefit plan to cover some of the expenses not fully covered by another plan. For example, if you have other coverage that covers less than 100% of the fee for a service and you may be entitled to benefits from Yale Health, COB entitles you to receive coverage from that source to supplement the amount Yale Health covers, if services are consistent and compliant with the other plan guidelines, up to 100% of expenses.

Coordination of benefits also entitles Yale Health to receive payment from other benefit plans for some services rendered by Yale Health. **If you have other coverage when you first enroll in Yale Health, or if the coverage changes while you are enrolled, (e.g. Medicare Disability, other insurance) you are required to notify Yale Health. Failure to disclose this information may affect the terms of your coverage or denial of claims.** The following rules determine which plan provides benefits first:

1. The plan covering the person as a subscriber provides benefits first
2. Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year
3. If the parents are divorced or separated, the order below is followed
 - the plan of the parent with custody
 - the plan of the spouse of the parent with custody
 - the plan of the parent without custody
 - the plan of the spouse of the parent without custody

If there is a court decree establishing responsibility for the child's health care, the plan of the parent with that responsibility provides benefits first. If none of these rules apply, the plan that has covered the member for the longer period of time will provide benefits first.

SUBROGATION (THIRD PARTY LIABILITY)

Third Party Liability

A member or enrolled dependent may receive compensation 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 or provided by Yale Health. If a Yale Health member brings legal action or otherwise makes a claim against a third party allegedly responsible for his or her 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.
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.

Some examples of Subrogation include motor vehicle and personal injury accidents.

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 under a Yale Health plan 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 *What the Plan Covers* section.

Please note, however, that if you receive care outside of Yale Health or the Yale Health network 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 by the provider.

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 a Yale employee and are injured on the job or become ill because of your job, report this to your supervisor as soon as your condition permits. If you seek care at Yale Health, obtain a health service appointment and report form(s) from your department supervisor and provide this information to Yale Health staff at the time of your initial evaluation and any subsequent appointments. 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 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 patient.

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 Claims 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 Booklet 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 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 services 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 Booklet.
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 Booklet.
8. The headings of various sections of this Booklet are inserted for convenience and do not (expressly or implicitly) limit, define, or extend the specific terms of the designated section.
9. If Yale determines that you, your spouse, civil union partner, or dependent child is ineligible, you will be billed for all services rendered or claims paid by Yale Health on behalf of the ineligible individual, and premiums paid will not be refunded.

COBRA CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federally-mandated plan that allows terminated employees and their dependents who would otherwise lose health coverage to continue that coverage for a specified period of time. With COBRA Yale employees and their dependents can continue health coverage, subject to certain conditions and payment of contributions. Continuation rights are available following a "qualifying event" that would cause an employee or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing coverage through COBRA

When you or your covered dependents become eligible, the University will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.; and
- Submit your application within 60 days of the qualifying event, or within 60 days of notice of this COBRA continuation right, if later; and
- Agree to pay the required contributions.

Who qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods*
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
Your marriage is annulled, you divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

* Disability May Increase Maximum Continuation to 29 Months

If you or your covered dependents are disabled

If you or your covered dependents qualify for disability status under Title II or XVI of the Social Security Act during the 18-month continuation period, you or your covered dependents:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period, and qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify the Employee Service Center within 60 days of the disability determination status and before the 18-month continuation period ends.
- Must notify the employer within 30 days of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the contributions after the 18th month, through the 29th month.

If there are multiple qualifying events

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining your contributions for continuation coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the plan costs.
- For the 18 through 29 month period, contributions during an extended disability period may never exceed 150 percent of the plan costs.

When you acquire a dependent during a continuation period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- he or she meets the definition of an eligible dependent,
- the Employee Service Center is notified about your dependent within 30 days of eligibility, and
- additional contributions for continuation are paid on a timely basis.

Important Note

For more information about dependent eligibility, see the *Eligibility and How and When to Enroll* section.

When your COBRA continuation coverage ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period - the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum.)
- You or your covered dependents do not pay required contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition

coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.

- The date the University no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Conversion from a group to an individual plan

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs, or when loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated contribution costs for the coverage. For additional conversion information, contact the Employee Service Center.

COMMUNICATIONS BY MAGELLAN HEALTHCARE TO YALE HEALTH

Magellan Healthcare administers the behavioral health benefit on behalf of the Yale Health plan. Accordingly, Magellan Healthcare and Yale Health may share your medical information as necessary to facilitate administration of the Yale Health plan and the behavioral health benefit, including for care coordination, transition of care, review of appeals, and for quality assessment and improvement activities. For example, if you make a complaint to Yale Health about Magellan Healthcare or its services or providers, Magellan Behavioral Health will share information relating to your complaint with Yale Health to facilitate resolution of your complaint. Similarly, if you require assistance from Yale Health in obtaining or coordinating necessary services Magellan Healthcare may share information with Yale Health. In all cases, information may only be shared with the Chief of Behavioral Health, the Medical Director, the Manager of Claims, the Patient Representative or their designees at Yale Health.

ERISA RIGHTS

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

However, you may be required to obtain prior authorization for any days of confinement that exceed 48 hours (or 96 hours). For information on prior authorization, contact your Plan Administrator.

The following disclosure information is provided in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

The name of the plan is: Yale Health

The name and address of the sponsor of the plan is:

Yale University
221 Whitney Avenue
P.O. Box 208256
New Haven, CT 06520-8256

Employer identification number (EIN): 06-0646973

Plan number: 502

The name and address of the Plan Administrator is:

Yale University
221 Whitney Avenue
P.O. Box 208256
New Haven, CT 06520-8256

The cost of the plan is shared by the plan sponsor and the plan participants. The plan's benefit year ends December 31st. The preceding pages set forth the eligibility requirements and coverage provided for you under this plan. The Plan Administrator may change or eliminate coverage under the plan and may terminate the entire plan or any portion of it. Your individual coverage terminates when you leave active service, when you are no longer in an eligible class, or when the Plan Administrator terminates the plan, whichever occurs first. See the Plan Administrator to determine what, if any, arrangements may be made to continue your coverage beyond the date you cease to be eligible or terminate your employment.

HIPAA

HIPAA (Health Insurance Portability and Accountability Act) passed by Congress in 1996, requires adoption of security and privacy standards by medical facilities and insurance plans to protect personal health information. While the legislation is lengthy and complex, its main features include the following:

- The right to be informed of a "covered entity's" (e.g. Yale Health's) privacy practices;
- Clear limitations on and parameters for the use and release of individually identifiable health information;
- The right of patients to obtain access and make amendments to their medical records;
- Restriction on most disclosures of health information to the minimum needed for the intended purpose;
- The right for patients to obtain access to an accounting of those to whom disclosures have been made;
- Establishment of safeguards when records are disclosed for certain public responsibilities, such as public health and law enforcement.

NOPP

Outlined below is our Notice of Privacy Practices (NOPP). This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our privacy office in writing or call Member Services at 203-432-0246.

Who has to abide by these privacy practices

Yale Health provides health care to our patients in partnership with other professionals and organizations. The following individuals will abide by the privacy practices in this notice:

- Any health care professional who treats you at Yale Health.
- All members of the Yale Health work force, including employees, medical staff, trainees, students, and volunteers.

Our pledge to you

We understand that medical information about you is personal and we are committed to protecting that information. Your medical record is created as part of providing you with quality care, as well as for the purpose of meeting legal requirements. This notice applies to all the records of your care generated or maintained by Yale Health. 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 privacy practice notice that is currently in effect.

How we may use and disclose your medical information

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 (note: only limited psychiatric or HIV information may be disclosed without your authorization for billing purposes); and to support our health care operations (such as comparing patient data to improve treatment methods).

Other examples of such uses and disclosures include: contacting you for appointment reminders, or to inform you about possible treatment options and health-related benefits or services that may be of interest to you.

- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may communicate medical information about you, without your prior authorization, for the following: public health purposes; abuse or neglect reporting; health oversight audits or inspections; to fulfill a request from a medical examiner; funeral arrangements and organ donations; workers' compensation claims; emergencies; national security needs 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.

- The Inpatient Care department has procedures which protect patient privacy while allowing for information to be given to those whom the patient designates. Patients are informed of these procedures upon their admission to the Inpatient Care department.
- We may use or disclose information about you without your authorization as part of a “limited data set” which includes limited information (such as your city or a visit date, but not your name or address), but only for certain health care operations, public health and research purposes. The recipient of the information must sign a promise to restrict how the limited data set is used.
- Under certain circumstances, we may use and disclose health information about you for research purposes, subject to an approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the information they review does not leave our facility and they agree to specific privacy protections.
- We may disclose medical information about you to a friend or family member whom you designate. We may also disclose medical information to a friend or family member if a practitioner determines it is appropriate under the circumstances, unless you inform us otherwise. 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, 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 writing to: Manager of Health Information Services/Yale Health Center/Box 208237/New Haven, CT 06520-8237.

Your rights regarding your medical record

- 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. To do so, you must submit a written request to the address below. We may charge a fee for the cost of copying, mailing, or 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 to: Manager of Health Information Services/Yale Health Center/Box 208237/New Haven, CT 06520-8237.
- If you believe that information in your record is incorrect or incomplete, you have the right to request that we correct the records. Please send a written request to the address below, providing your reason for requesting the amendment. We may deny your request if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that your record is accurate; or under certain other circumstances. You may submit a written statement of disagreement with a decision by us not to amend a record to: Manager of Health Information Services/Yale Health Center/Box 208237/New Haven, CT 06520-8237.
- You have the right to know when your medical information has been released.
- You have the right to request a list of disclosures we have made of your health information. The list will not include: (1) disclosures made for treatment, payment, and health care operations, as

previously described; or (2) disclosures made in circumstances where you have given specific and separate authorization or (3) certain other disclosures in accordance with the law.

- Please note that this policy is in effect as of April 14, 2003. You must indicate the time period for which you request the list of disclosures, which can be up to six years prior to the date of your request. Disclosure lists will be kept for a rolling period of six years. Requests can be made for any time within that six year period and must be submitted in writing to: Manager of Health Information Services/Yale Health Center/Box 208237/New Haven, CT 06520-8237.

You have the right to request 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. You may notify us of how you would like us to communicate with you by writing to: Member Services Department/Yale Health Center/Box 208237/New Haven, CT 06520-8237.

You have the right to request restrictions on the use of your medical information

You may make a written request to restrict our use or disclosure of medical information about you. You may make the following request: that we not use or disclose information for treatment, payment or health care operations or to persons involved in your care except when (1) specifically authorized by you; (2) when we are required by law to disclose the information; or (3) in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision. All written requests or appeals should be submitted to: Deputy Privacy Officer/Yale Health Center/Box 208237/New Haven, CT 06520-8237.

You have the right to request a paper copy of this notice

You may receive a paper copy of this notice upon request even if you have previously agreed to receive this notice electronically.

If we change our policies

If we change our policies, the changes will apply to medical information we already hold, as well as new information generated after the change occurs. Before we make a significant change in our policies, we will post the notice of the new policies in prominent areas and on our web site at www.yalehealth.yale.edu. You can receive a copy of the current policy at any time even if you have previously agreed to receive this notice electronically. Copies of the current notice will be available at all times at the facility. The effective date is printed at the end of the notice.

To register a complaint

- 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 by writing to: Deputy Privacy Officer/Yale Health Center/Box 208237/New Haven, CT 06520-8237.
- 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.
- You will not experience penalties or retaliation for filing a complaint.

PATIENT RIGHTS AND 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 his/her health needs, concerns, illnesses, and injuries.
3. Is treated with consideration, respect, dignity, and individuality including privacy in treatment and care for his/her needs.
4. Has the right to expect that his/her personal convictions and beliefs, when expressed, will be considered when seeking and receiving services and when decisions are made by Yale Health clinicians regarding his/her care.
5. Has the right to agree with or refuse any health care service and to be informed of the medical consequences of refusing a service.
6. Is fully informed, as evidenced by his/her consent, about diagnostic or treatment procedures as appropriate.
7. Will know the identity and professional status of his/her clinical care team and be able to select his/her own primary care clinician from the panel of Yale Health primary care clinicians to the extent possible.
8. Has the right to have his/her privacy respected.
9. Is assured that his/her medical records will be kept confidential and that access to information about his/her health will be limited to those legitimately involved in his/her care, in accordance with Yale Health's Notice of Privacy Practices.
10. Is fully informed, by an authorized clinician, of his/her 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 his/her health and reasonable management of pain.
12. Is assured confidential treatment of his/her personal and medical records and may approve or refuse their release to any individual outside the facility except in the case of his/her transfer to another health care institution or as required by law or third-party payment contract.
13. Has the right to review his/her 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 his/her condition, and has the right to refuse participation in any clinical research without jeopardizing his/her 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 his/her 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, health care 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 health care providers or commercial entities that might significantly influence his/her 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 his/her 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 non-covered 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 Yale Health's Care Coordination Department at 203-432-7397 for more information.

GLOSSARY

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

allergy or intolerance - Any condition which requires alternation or limitation of certain foods or food components to avoid problems with digestion or absorption of nutrients **ancillary fees** - Hospital or other inpatient health services other than room and board and professional services. These may include x-ray, drug and laboratory services.

body mass index - This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

brand-named prescription drug - A prescription drug with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication used by Yale Health.

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

COBRA - Consolidated Omnibus Budget Reconciliation Act, an act passed by Congress in 1986. One of the provisions of this act requires employers to allow terminated employees and their dependents who would otherwise lose their coverage to continue group health coverage for a specified length of time.

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

cosmetic - Services or supplies that alter, improve or enhance appearance.

custodial care - Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;

- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

durable medical and surgical equipment (DME) - Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpools, pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

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.

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

enteral tube feeding - Nutritional support delivered directly to the gastrointestinal track by feeding tube (percutaneous or nasogastric).

ERISA - Employee Retirement Income Security Act of 1974. A federal statute (29 U.S.C. §1001 et seq.) whose purpose is to set standards for the operation and administration of private pension plans and for other benefits such as healthcare. In the areas of its coverage the statute preempts state laws.

excess coverage - Coverage under which you are entitled to benefits only after you receive payment from any other applicable contract, agreement, plan, or insurance.

food - Any substance or material used to meet ongoing daily nutritional requirements regardless of the method of intake.

generic prescription drug - A prescription drug, whether identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration as therapeutically

equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Yale Health.

HIPAA - Health Insurance Portability and Accountability Act of 1996 that requires the adoption by medical facilities of security and privacy standards to protect personal health information.

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

inborn errors of metabolism - Any genetic disorder for which newborn screening is regularly performed and for which altered nutritional support will prevent or ameliorate developmental implications of the disorder.

Inpatient Care Department - Yale Health's fully-licensed inpatient care facility, which provides evaluation and treatment for routine conditions, as well as post-operative care, short-term hospice care, and transitional care between hospitalization and home.

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

medical necessity - See [definition on page 7](#).

members - All eligible individuals who are covered by Yale Health.

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

network pharmacy - Refers to the Yale Health Pharmacy for the provision of covered services to you and your covered dependents.

non-preferred drug - A brand-named prescription drug that does not appear as a preferred drug on the Yale Health Drug List.

out of area - Outside the state of Connecticut.

out-of-network pharmacy - Any pharmacy that is not the Yale Health Pharmacy. They are not contracted with Yale Health to reduce their fees.

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

parenteral nutrition - Nutritional support delivered by intravenous catheter to meet daily metabolic and nutritional requirements.

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

prior authorization - Services that are approved in advance by the Yale Health Claims Department.

preferred brand name drug - A brand-named prescription drug that appears as such on the Yale Health Drug List.

prescription drug - A drug, biological, or compounded medication which, by State or Federal Law, may be dispensed only by prescription and which is required by Federal Law to be labeled "Caution: Federal law prohibits dispensing without prescription."

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

provider - Any recognized healthcare professional, pharmacy or facility providing services within the scope of their license.

self-injectable drug - A prescription drug that is intended to be self-administered by injection to a specific part of the body to treat certain chronic conditions.

skilled nursing facility (SNF) - A healthcare facility, either free standing or part of a hospital, that accepts patients in need of rehab and medical care that is of a lesser intensity than that received in a hospital.

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

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.

target symptom clinic - 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.

WHCRA - Women's Health and Cancer Rights Act of 1998.

Yale Health Drug List – A listing of prescription drugs established by Yale Health which includes both brand-named prescription drugs and generic prescription drugs. This list identifies the tier of the drug, if the drug may be covered and any restrictions that apply to the use of the drug. This list is subject to periodic review and modification by Yale Health. A copy of the Yale Health Drug List will be available upon your request or may be accessed on the Yale Health website at www.yalehealth.yale.edu/druglist.

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