This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.yalehealth.yale.edu** or by calling **1-203-432-0246**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. **$50** annual **deductible** for pediatric dental care (deductible does not apply to preventive & diagnostic). There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. $6,350/individual; $12,700/family; **$1,000** per person for hospital admission and surgical procedure **copayments** combined.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Prescription drug **copayments**, emergency room **copayments**, premiums (or plan fees for purposes of this plan), balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Call **1-203-432-0246** to obtain information about medical network **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	---None---
	Specialist visit	At Yale Health Center: $0, except Allergy Dept. office visits: $25 copay Outside of Yale Health Center: $20 copay	$20 copay if preauthorized; otherwise not covered	Copay does not apply to out-of-pocket limit. Preauthorization required for out-of-network care. If preauthorization is not obtained, service is not covered. Allergy Department office visits: $25 copay
	Other practitioner office visit	No charge 50% coinsurance for Chiropractor	$20 copay if preauthorized; otherwise not covered	Copay does not apply to out-of-pocket limit. Preauthorization required for out-of-network care. If preauthorization is not obtained, service is not covered. Chiropractic services have a maximum of 20 visits per year.
	Preventive care/ screening/immunization	No charge	Not covered	Physical exam and well-woman exam limited to one visit/calendar year. Travel immunizations not covered, but available on a fee-for-service basis at Yale Health Center.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	---None---
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	---None---

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.yalehealth.yale.edu** or call **1-203-432-0246.**	Tier 1 prescription drugs	**Retail**: $10 copay	Greater of 20% of the price of the drug or the applicable Tier copay (Yale Health reimburses the difference)	Copay covers up to a 30-day supply. Three copays are charged for up to 90-day supply.
	Tier 2 prescription drugs	**Retail**: $30 copay	Greater of 20% of the price of the drug or the applicable Tier copay (Yale Health reimburses the difference)	Copay covers up to a 30-day supply. Three copays are charged for up to 90-day supply.
	Tier 3 prescription drugs	**Retail**: $45 copay	Greater of 20% of the price of the drug or the applicable Tier copay (Yale Health reimburses the difference)	Copay covers up to a 30-day supply. Three copays are charged for up to 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay	Not covered	Copay does not apply to deductible.
	Physician/surgeon fees	No charge	Not covered	---None---
If you need immediate medical attention	Emergency room services	$50 copay/visit	$50 copay/visit	Copay does not apply to out-of-pocket maximum. Must meet definition of emergency as defined by Yale Health Plan.
	Emergency medical transportation	No charge	No charge	Must meet definition of emergency as defined by Yale Health Plan.
	Urgent care	No charge	Out-of-network facilities in Connecticut: Not covered Out-of-network facilities outside of Connecticut: $50 copay/visit	Must meet definition of urgent as defined by Yale Health Plan.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per admission	$200 copay if preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
	Physician/surgeon fee	No charge	No charge if preauthorized or emergency; otherwise not covered	Preauthorization required for out-of-network care if non-emergency. If preauthorization is not obtained, service is not covered.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	---None---
	Mental/Behavioral health inpatient services	$200 copay per admission	Not covered	---None---
	Substance use disorder outpatient services	No charge	Not covered	---None---
	Substance use disorder inpatient services	$200 copay per admission	Not covered	---None---
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	---None---
	Delivery and all inpatient services	$200 copay/ admission	Not covered	---None---
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 100 days per year
	Rehabilitation services	Outpatient – No charge except for Cardiac Rehabilitation: 20% coinsurance Inpatient - $200 copay/admission	Not covered	Includes PT, OT, Speech. Speech therapy must be medically necessary, limited to 40 visits/calendar year. Lifetime maximum of 90 days of inpatient care at an approved rehabilitation hospital/ward. Cardiac rehabilitation is limited to 36 visits per year.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
	Habilitation services	Outpatient – No charge; Inpatient - $200 copay/admission	Not covered	Includes PT, OT, Speech. Speech therapy must be medically necessary, limited to 40 visits/calendar year. Lifetime maximum of 90 days of inpatient care at an approved rehabilitation hospital/ward.
	Skilled nursing care	No charge	Not covered	---None---
	Durable medical equipment	10% coinsurance	Not covered	The rental or purchase of durable medical equipment (braces, crutches, etc.) is covered at 90% when it is medically necessary for the treatment of an illness or injury and ordered in advance by a Yale Health network clinician and approved in advance by the Yale Health Claims Department.
	Hospice service	No charge	Not covered	Limited to a maximum of 180 days.
If your child needs dental or eye care	Eye exam	No charge	No charge	For children age 19 and under: one exam per 12 months, provided through EyeMed Vision Care, see appendix in student handbook for full details. Eye exams up to $28 reimbursement for out of network.
	Glasses	Frames – No charge, $100 allowance, 20% off balance over $100; Lenses - $25 copay	Frames – No charge	For children age 19 and under: one pair glasses per 12 months, provided through EyeMed Vision Care. Includes contacts, see appendix in student handbook for full details. Frames up to $50 reimbursement for out of network.
	Dental check-up	No charge (Preventive & Diagnostic care)	Not covered	For children age 19 and under: remaining basic, crowns, prosthodontics, and medically necessary orthodontics are covered at 50% coinsurance after $50 calendar year deductible. See appendix in student handbook for full details.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area
- Your status as an enrolled student has ended as a result of graduation, withdrawal, or leave of absence

For more information on your rights to continue coverage, contact the plan at **1-203-432-0246**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact **1-203-432-0246** or visit us at **www.yalehealth.yale.edu**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,140
- **Patient pays** $400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$200
Coinsurance	$0
Limits or exclusions	$200
Total	**$400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,820
- **Patient pays** $580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$400
Coinsurance	$100
Limits or exclusions	$80
Total	**$580**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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- Costs don't include **premiums** .
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗**No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓**Yes.** An important cost is the **premium** (or plan fees for purposes of this plan) you pay. Generally, the lower your **premium** or fees, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FASs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.