Yale
NewHaven
Health

Your 2022 Health Care Benefits Connection

Lawrence + Memorial Hospital
(Non-union and Public Safety Workers Union employees)

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2022 Open Enrollment

Make a change October 25 – November 5, 5 p.m. ET

Open Enrollment is your once-a-year opportunity to make changes to your benefits so they continue to be the right fit for you and your family. Outside of experiencing a qualifying life event, it's the only time you can change plans or add or remove dependents.

You only need to take action if:

- You want to change your current benefit plan choices.
- You want to change or add coverage for family members.
- You want to participate in a Flexible Spending Account during 2022.
- You want to enroll in one of the voluntary benefit programs.

If you don't take action by November 5:

- You will not have a Health Care or Dependent Care Flexible Spending Account for 2022.
- You and any dependents currently on your plan will have the same medical, dental, and vision coverage for 2022, at the 2022 monthly premiums.
- If you waived coverage for 2021, your coverage will be waived for 2022.

Connect to your 2022 benefits

HRConnect
Call Monday–Friday, 7:30 a.m.–5 p.m. ET
844-543-2147
Make a change for 2022: ynhhsbenefits.com

What You Need to Know

This year we are keeping things simple with just a few enhancements to the YNHHS Medical Plan, dental, and vision benefits, and there are no changes to the HDHP Medical Plan. Whether or not your plan is changing, we encourage you to take a moment to review your current benefit choices and coverage level to make sure they will continue to meet your needs in 2022.

What's Changing for 2022

- The **YNHHS Medical Plan**. Beginning January 1, the new YNHHS Medical Plan annual deductible for Anthem PPO providers will be reduced by 50%. *Note: There are no changes to the HDHP Medical Plan.*
    - Individual: $1,750 ($3,500 in 2021)
    - Family: $3,500 ($7,000 in 2021)

- **HSA contribution limits will increase** to $3,650 if you have individual coverage, and $7,300 if you cover others, too. If you're age 55 or older, you can save an additional $1,000 in catch-up contributions.
- **Health Care and Dependent Care FSA.** Due to a temporary pandemic relief rule, there is no limit on the Health Care and/or Dependent Care FSA balance you can roll over from 2021 into 2022. For example, if you have a $700 balance in your Health Care FSA at the end of this year, you can carry it all over into 2022 (the usual limit is $550).

What You Need to Do

- Review this book for your medical, dental, and vision plan options, and consider how your needs may be different for 2022.
- Add or remove dependents, as needed.
- Make your **Dependent Care Flexible Spending Account or Health Care Flexible Spending Account** contribution elections for 2022. Note: The temporary pandemic relief change removes limits on balance rollovers from 2021 to 2022.
- Make your Health Savings Account (HSA) contribution for 2022. Note: The HSA is only available with the HDHP Medical Plan.
- Make a change to your benefit elections for 2022, if needed. You can return to the enrollment site at any time to change your elections between October 25 and November 5 at 5 p.m. ET.
- Print a copy of your enrollment confirmation and keep it for your records.

Things to Keep In Mind

- If you have a **Health Care FSA,** you have until March 31, 2022, to submit claims for 2021.
- If you are enrolled in the **YNHHS Medical Plan, use Signature network providers**. When you do, there's no deductible and you'll pay less for services. Connect with a Patient Resource Coordinator to assist you with your Tier 1/Signature network needs. Call 844-543-2147, option 3, to get started.
- If you are enrolled in the **HDHP Medical Plan**, it's important to remember that the $2,000 individual annual deductible only applies to "employee only" coverage. If you cover anyone else under this plan, your annual deductible is $4,000.
- **Don't skimp on care.** Although you may be tempted to put off a doctor's visit, it's always better to get care sooner, rather than later. Use your telehealth benefit to get the care you need, when you need it—without leaving home.
- Plan for the unexpected by providing additional financial security for your family. Through **YNHH voluntary benefits**, you can purchase group hospital indemnity, group legal, and group critical illness insurance at prices that are typically below market rates. You can also enroll in auto, home, and pet insurance, student loan refinancing, or identity theft protection at any time of the year.
- It's a good idea to review your **403(b) and life insurance beneficiaries** every year, and make changes, as needed.
- **If you participated in the Know Your Numbers Plus program in 2021,** you'll see your annual employee premium credit on your enrollment confirmation statement. If you did not participate this year or you're a new hire, you'll be able to participate in 2022 to earn credit toward your 2023 medical premium.

If You Take No Action During Open Enrollment

- You will be unable to contribute to a Health Care or Dependent Care FSA or to the Health Savings Account (HSA) in 2022.
- You and any dependents you currently cover (if eligible) will be automatically enrolled in the same medical, dental, and vision plans you had in 2021.
- If you waived plan coverage in 2021, your coverage will remain waived in 2022.

Eligibility

WHAT YOU NEED TO KNOW

If you're eligible for benefits, you can enroll yourself, your spouse or domestic partner, and/or your dependent children in medical, prescription drug, dental, and vision coverage—plus other voluntary and financial benefits. Your benefits are effective on your first day of employment or the day you become benefits-eligible.

Who's Eligible for Coverage

You're eligible for benefits if you're a regular, full-time employee (36 or more hours per week) or a benefits-eligible part-time employee (generally 20–35 hours per week) of Lawrence + Memorial Hospital (non-union and Public Safety Workers Union). **Note:** Under the YNHHS Medical Plan, eligibility is a minimum of 24 hours per week, and domestic partners are not covered.

If you're eligible, you can also enroll:

- Your legal spouse
- Your domestic partner
- Your dependent children under age 26:
- Biological children
- Stepchildren
- Adopted children, including those placed for adoption
- Foster children
- Any children for whom you are responsible per a court order
- Your dependent children over age 26, if fully dependent on you for support due to a disability and covered by you prior to age 26

Supporting documentation required for dependents

To enroll your dependents, you'll need to provide applicable supporting documentation such as a marriage certificate, birth certificate, court order, or federal income tax return. For details, visit HRConnect.

Enrollment

What you need to know

As a new employee, you must enroll in benefits within 30 days, or you and your dependents will have no medical, prescription drug, dental, or vision coverage. You'll have to wait until the next open enrollment period to elect these benefits, unless you experience a qualifying life event.

Don't forget—you'll need supporting documentation to enroll your dependents.

When to Enroll

Enroll for the following benefits within 30 days of your first day on the job, during the annual open enrollment period, or within 31 days of experiencing a qualifying life event:

- Medical coverage
- Prescription drug coverage
- Dental coverage
- Vision coverage
- Limited-Purpose Health Care Flexible Spending Account
- Group legal plan (voluntary benefit)
- Hospital indemnity coverage (voluntary benefit)
- Group critical illness insurance (voluntary benefit)

Enroll at any time for:

- Auto and home insurance (voluntary benefit)
- Pet insurance (voluntary benefit)
- Identity protection (voluntary benefit)
- Student loan refinancing program (voluntary benefit)

Learn more about the voluntary benefits you can choose. To enroll, call 866-874-2837 or visit the voluntary benefits website (ynhhsvoluntarybenefits.com)

When Changes Are Allowed

After you enroll, you can make changes only during annual open enrollment or within 31 days of experiencing a qualifying life event:

- Marriage
- Divorce
- Childbirth/adoption
- Coverage loss or gain

You must submit documentation that supports the event.

How to Enroll

To enroll or make changes to your benefits, visit bswift (www.ynhhsbenefits.com), our secure, online enrollment website. You'll be prompted to enter your YNHHS username and password. If you run into problems, call HRConnect at **844-543-2147**.

Need more info first? You'll find details at HRConnect (ynhhs.org/hrconnect).

MEDICAL PLAN OPTIONS: WHAT YOU NEED TO KNOW

You have two medical plan options: The new YNHHS Medical Plan or a High-Deductible Health Plan (HDHP) with Health Savings Account or Healthcare Reimbursement Account. As explained in the following sections, both plans are administered by Anthem Blue Cross and Blue Shield and offer in- and out-of-network options for care. You may choose to waive medical coverage if you're covered by another plan or your spouse is a YNHHS employee.

Yale New Haven Health System (YNHHS) Medical Plan

YNHHS Medical Plan

WHAT YOU NEED TO KNOW

The YNHHS Medical Plan connects you to the world-class care provided by our Signature network of facilities and providers. Of course, you can also use Anthem PPO or out-of-network providers, but you'll usually pay more if you do. The medical plan is administered by Anthem Blue Cross and Blue Shield.

Connect with YNHHS Provider

The Signature network includes: YNHHS facilities/hospitals, PCP's from NEMG, Community Medical Group (CMG), Yale Medicine (YM), WestMed in CT, Trinity Health of New England hospitals and affiliated physicians. Also included are specialists from YM, NEMG, CMG and Trinity Health, and those credentialed at YNHHS.

How the Plan Works

The YNHHS Medical Plan is designed to help keep you and your family healthy. Used in tandem with your other benefits—including care and condition management and coaching services—it's here to support you when you need care.

- You'll pay nothing for preventive care—including some preventive tests and prescription medications—when you use network providers.
- If you choose to use an Anthem network provider, you'll first have to meet an annual deductible before the plan begins to share costs. After you meet your deductible, you'll pay a copay or coinsurance for services.
- Behavioral health and substance abuse benefits are included in the medical plan.
- You only need to meet one combined annual out-of-pocket maximum for medical and prescription drugs. All your copays and coinsurance for covered services are applied toward this maximum. Once the out-of-pocket maximum is met, the plan pays 100% of eligible expenses for the remainder of the calendar year for each enrolled person.
- Special rules apply when you or your covered dependents are covered by more than one plan.

You may choose to waive medical coverage if you're covered by another plan or your spouse is a YNHHS employee.

How much you pay for care depends on the provider or facility you choose:

Signature Network—YNHHS Facilities & Providers

When you use a Signature network provider and facility, you'll pay less for covered services. You pay a flat copay for care and do not have to pay a deductible before the plan begins to pay benefits.

Note: Some Signature Network providers also provide care at facilities that are not in our health system. If you receive care at these other sites, you will pay higher costs for these facilities. For example, a surgeon who practices at Signature network facilities may also perform surgery at private surgical centers. If your surgery is done at a private center, you would pay the Anthem PPO network or Out-Of-Network rate for the doctor and the facility.

- You'll generally pay a flat copay for care when you use Signature network providers and facilities, including:
- Facilities owned by Yale New Haven Health and Trinity New England
- Our Signature Clinician network of Signature primary care providers and specialists who are credentialed at a facility owned by Yale New Haven Health
- For a complete list of the Signature network providers, visit HRConnect.
- Once you meet your annual out-of-pocket maximum, the plan will pay 100% of covered expenses through that calendar year.

Anthem PPO Providers

When you choose to receive care from an Anthem Century Preferred Network provider:

- You'll need to meet your annual deductible before the plan begins to share the cost of your care.
- After you meet your deductible, you'll generally pay 20% coinsurance or a copay until you reach your annual out-of-pocket maximum.
- Once you meet your annual out-of-pocket maximum, the plan will pay 100% of covered expenses through that calendar year.

To find a provider in the Anthem Century Preferred Network, visit the Anthem website (http://anthem.com/) or call **888-266-2896**.

Out-of-Network Providers

When you use a provider or facility that is not in the Signature or Anthem Century Preferred Network:

- You'll pay the most for care.
- Anthem will pay a maximum allowable amount (MAA) for covered services.
- You will be responsible for costs up to your annual deductible, coinsurance, and any difference between the MAA and the amount billed by the provider.
- You'll need to file a claim for the care to be covered. Payments will be made directly to the provider unless you submit a bill showing you've paid it already.

No-cost vaccines for you and your dependents

You and your covered dependents can get no-cost vaccines for shingles, pneumonia, flu (ages 18 and older only), tetanus/diphtheria, and hepatitis A and B through the CVS Caremark Broader Vaccination Network.

What You Pay for Care

Below is a summary of how certain services are covered. For a more complete list and any limitations, visit HRConnect to view the summary plan description (SPD).

To see employee premium contributions for the medical plan, visit the enrollment site.

Plan Feature	Signature Facility/ Provider	Anthem PPO Provider	Out-of-Network Provider
Annual Deductible	Individual: $0 Family: $0	Individual: $1,750 Family: $3,500	Individual: $10,000 Family: $20,000
Out-of-Pocket Maximum[1]	Individual: $3,000 Family: $6,000	Individual: $8,150 Family: $16,300	Individual: $30,000 Family: $60,000
Office Visits and Physician Services			
Primary Care Visit[2,3] (in-person or electronic)	$10 copay	$30 copay	50% of MAA* after deductible
Specialist Office Visit[2] (in-person or electronic)	$25 copay	$50 copay	50% of MAA* after deductible
Routine Adult Exam[2,4]	0%, no copay	0%, no copay	50% of MAA* after deductible
Doctor or Surgeon Services[5]	0%, $0 copay	20% after deductible	50% of MAA* after deductible
Allergy Shot in Doctor's Office (no MD visit)	$10 copay	$30 copay	50% of MAA* after deductible
Nutrition Counseling and Diabetes Self-Management Training	0%, no copay	0%, $0 copay	50% of MAA* after deductible
Women and Children			
Well-Woman Visit (OB/GYN preventive exam)[6]	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Mammography[7] (including 3D and bone density test)	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Screening Breast Ultrasound (if dense breast tissue or a history)	$20 copay	$20 copay	50% of MAA* after deductible
Maternity Care[8] (initial visit)	$10 copay	$30 copay	50% of MAA* after deductible
Well-Baby/Well-Child Care[2,9]	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Specialized Infant Formula	n/a	50% coinsurance	50% of MAA* after deductible
Infertility Services[10]	100% up to lifetime max with limits for certain services	50% up to lifetime max with limits for certain services	n/a
Ancillary Services			
Lab Services	$25 copay	20% after deductible	50% of MAA* after deductible

Plan Feature	Signature Facility/ Provider	Anthem PPO Provider	Out-of-Network Provider
Diagnostic Testing[11] (facility charges only)	$25 copay	20% after deductible	50% of MAA* after deductible
High-Tech Diagnostic Imaging[12] (facility charges only)	$100 copay	20% after deductible	50% of MAA* after deductible
Colorectal Cancer Screening[13]	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Chiropractic Visits[14]	n/a	$30 copay	50% of MAA* after deductible
Cardiac Rehabilitation[14]	$10 copay	$30 copay	50% of MAA* after deductible
Physical and Occupational Therapy[14]	$10 copay	$10 copay	50% of MAA* after deductible
Speech Therapy[14]	$10 copay	$10 copay	50% of MAA* after deductible
Inpatient and Outpatient Care			
Inpatient Hospital Services[15]	$250 copay	20% after deductible	50% of MAA* after deductible
Outpatient Surgery[16]	$100	20% after deductible	50% of MAA* after deductible
Infusion and Radiation Therapy (including medications)[17]	$25 copay	20% after deductible	50% of MAA* after deductible
Pathologists, Radiologists, and Anesthesiologists[17]	0%, $0 copay	0%, $0 copay	50% of MAA* after deductible
Behavioral Health and Substance Abuse			
Inpatient Treatment (facility charges only)	$250 copay	20% after deductible	50% of MAA* after deductible
Outpatient Treatment[18]	$10 copay	$10 copay	50% of MAA* after deductible
ABA Therapy[19]	n/a	$10 copay	50% of MAA* after deductible
Urgent and Emergency Care and Telehealth			
Emergency Department	$250 copay	$250 copay	$250 copay
Urgent Care Facility and Walk-In Medical Center	$25 copay	$50 copay	$50 copay
Ambulance	n/a	0%	0%
Telehealth (OnDemand and LiveHealth Online only)	0%, $0 copay	$30 copay	Not covered
Observation (non-emergency related)	$100 copay	20% after deductible	50% of MAA* after deductible
Non-Acute Care			
Skilled Nursing Facility[20]	20% coinsurance, no deductible	20% coinsurance, no deductible	50% of MAA* after deductible

Plan Feature	Signature Facility/ Provider	Anthem PPO Provider	Out-of-Network Provider
Home Health Care[21]	20% coinsurance, no deductible	20% coinsurance, no deductible	50% of MAA* after deductible
Hospice Care[22]	n/a	20% coinsurance, no deductible	50% of MAA* after deductible
Other			
Durable Medical Equipment	n/a	20% coinsurance, no deductible	50% of MAA* after deductible
Hearing Aids[23]	n/a	50% coinsurance, no deductible	50% of MAA* after deductible
Orthotics	n/a	50% coinsurance, no deductible	50% of MAA* after deductible

* Maximum allowable amount.

[1] Amounts paid toward care provided by all in-network providers accumulate toward both the YNHHS and Anthem PPO out-of-pocket maximums. However, when the YNHHS in-network out-of-pocket maximum has been reached, amounts paid for YNHHS in-network care no longer accrue toward the Anthem PPO out-of-pocket maximum. Amounts paid for Anthem PPO in-network care continue to accrue until the Anthem PPO out-of-pocket maximum is met.

[2] Tests (e.g., some lab work) that are associated with office visits may be subject to a copay or deductible and coinsurance if they are not mandated by the ACA. Check with your provider or call Anthem to determine if a specific test is covered at 100%.

[3] A list of Signature providers is posted to: http://ynhhs.org/hrconnect

[4] One exam every calendar year starting at age 22 (includes immunizations).

[5] Other than office visit; includes maternity claims.

[6] One per calendar year. All other OB/GYN office visits are covered at the specialist office visit benefit level.

[7] Screening mammography only. Does not include breast ultrasounds.

[8] Prenatal care and delivery. Well visits to the obstetric provider are billed with one global fee that includes trimester visits, delivery, and postpartum care. Any maternity-related tests that are needed, such as blood work, glucose tolerance tests, stress tests, ultrasounds, or amniocentesis, are billed separately. Inpatient hospital and doctor or surgeon services also apply.

[9] Seven exams from birth to age 1 year; seven exams from ages 1 to 5; one exam from ages 6 to 21.

[10] The plan covers in-network fertility services only through YNHHS and Anthem PPO providers. YNHHS providers: Yale Reproductive Endocrinology and Infertility (REI) Center and YNHHS Apothecary. 100% up to lifetime max of $14,000 for medical and freezing and transferring embryos, and 100% up to lifetime maximum of $2,000 for prescription drugs through the pharmacy benefit. Anthem PPO providers: 50% of covered medical services at a participating Anthem provider, plus covered prescription drugs at a participating CVS Caremark pharmacy, up to a combined lifetime maximum of $10,000.

[11] Includes x-rays, echo stress tests, ultrasounds, diagnostic mammograms, sleep studies, and EKGs. Patients will receive a bill for the reading of the diagnostic testing and imaging (covered under “Doctor or Surgeon Services”).

[12] PET, SPECT, MRI, MRA, CTA, and CAT.

[13] Diagnostic colonoscopies covered under the outpatient surgery benefit level. Includes fecal occult blood test, barium enema, flexible sigmoidoscopy, and screening colonoscopy.

[14] Chiropractic, physical therapy, occupational therapy, and speech therapy combined maximum: 50 visits per calendar year. Cardiac rehabilitation maximum: 36 visits per calendar year.

[15] Room and board, lab work, medical supplies, and other hospital ancillary services.

[16] Hospital or surgical center facility charges only.

[17] Some Tier 1 providers send lab work to a Tier 2 lab. In this case, the lab work is covered as a Tier 2 benefit.

[18] The Employee and Family Resources (EFR) program provides up to six (6) confidential counseling sessions at no cost.

[19] Applied behavioral analysis, up to age 21.

[20] Up to 120 days per calendar year after a hospital stay.

[21] Up to 120 days per calendar year.

[22] Up to 60 days per calendar year.

[23] Two hearing aids every 36 months.

Save With Signature Providers & Facilities

The following examples* show how using a Signature provider and facility can save you money. As a reminder, if you use a Signature provider but your care takes place in a facility that is not in our network, the facility expenses will be covered as Anthem or out-of-network care.

Example #1: Signature Savings

Tony saves $5,750 using a Signature provider and Signature facility for his knee surgery.

	YNHHS Signature Provider and Facility	Anthem PPO Provider & Facility
Facility Charge Allowed	$20,000	$20,000
Doctor or Surgeon Fees Allowed	$3,000	$3,000
Annual deductible (paid by Tony)	$0	$1,750
Amount Left to Pay	$23,000	$21,250
Tony's Cost after Deductible (including inpatient copay/coinsurance)	$250	20% = $4,250
Total Amount Plan Pays	$22,750	$17,000
Total Amount Tony Pays	$250	**$4,250 + $1,750 = $6,000**

Example #2: Signature Provider + Anthem Facility Costs

If Tony had the same procedure but it takes place in an Anthem facility, he will spend $5,150 more than in the first example.

	YNHHS Signature Provider	Anthem Facility
Facility Charge Allowed	N/A	$20,000
Doctor or Surgeon Fees Allowed	$3,000	N/A
Annual Deductible (paid by Tony)	$0	$1,750 (for Anthem facility)
Amount Left to Pay	$3,000	$18,250
Tony's Cost after Deductible (including inpatient coinsurance)	$0 owed for doctor or surgeon fees + 20% for facility =$3,650 ($18,250 x 20% = $3,650)	
Total Amount Plan Pays	$3,000	$14,600
Total Amount Tony Pays	**$5,400 ($1,750 deductible + $3,650 coinsurance)**	

Example #3: Anthem PPO Provider + Anthem Facility Costs

If Tony uses an Anthem provider and an Anthem facility, he will spend $600 more than in the second example.

	Anthem PPO Provider & Facility
Facility Charge Allowed	$20,000
Doctor or Surgeon Fees Allowed	$3,000
Annual deductible (paid by Tony)	$1,750
Amount Left to Pay	$21,250
Tony's Cost after Deductible (including inpatient copay/coinsurance)	20% = $4,250 ($21,250 x 20%)
Total Amount Plan Pays	$17,000
Total Amount Tony Pays	**$4,250 + $1,750 = $6,000**

*These examples are for illustrative purposes only. Your actual cost share may vary depending on the care you receive, the facility used, and specifics if you're admitted as an inpatient. These examples are not provided as a guarantee of coverage or an actual estimate of specific benefits under the plan.

When to Connect With Anthem

For a medical stay and/or service preauthorization, call 800-238-2227 (in Connecticut) or 800-248-2227 (out of state). For behavioral health or substance abuse stays, call 800-934-0331.

Before receiving any of these services, you must call Anthem for preauthorization. Otherwise, your benefits will be reduced.

- **Inpatient stays** in a hospital, skilled nursing facility, hospice facility, subacute care or acute rehabilitation facility, or behavioral health or substance abuse treatment center (call at least 24 hours before the start of your stay)
- **High-cost diagnostic imaging services** prescribed by an out-of-network provider
- **Organ/tissue transplants,** including evaluation, donor search, organ procurement/tissue harvest, or transplant

For admissions following emergency or urgent care, you, your representative, or your doctor must call Anthem within 48 hours of admission.

If you do not precertify for the services above:

- Benefits for inpatient stays will be reduced by $200.
- Benefits for doctor fees will be reduced by 25%.

You can also connect with Anthem to:

- Find a provider in the Anthem Century Preferred Network
- Resolve insurance claim and billing issues
- Ask questions about preventive and/or diagnostic care
- Get general health information

Urgent Care & Telehealth (YNHHS Medical Plan)

WHAT YOU NEED TO KNOW

Can't wait to see a doctor? Urgent care and telehealth services help you quickly connect with affordable care.

Urgent Care

When you need immediate care for an illness or injury, you can visit the nearest YNHHS walk-in facility or a PhysicianOne Urgent Care center (CT locations only). To locate an urgent care center close to you, visit HRConnect (ynhhs.org/hrconnect) and search for urgent care.

You'll pay a $25 copay when visiting a YNHHS facility, and you'll pay more if you use other providers.

Telehealth

Telehealth is an ideal alternative for immediate treatment of an illness or injury when you can't get to a doctor's office or urgent care center.

You and your covered family members can visit a doctor virtually, wherever you are, whenever you need care—via phone, tablet, or computer. If you need medication, the doctor can even send a prescription to your pharmacy (within Connecticut, New York, Massachusetts, and Rhode Island).

Use the telehealth services below to connect to care outside the usual office hours. **Telehealth is not an alternative to emergency care for a life-threatening condition.**

OnDemand

See one of our own Northeast Medical Group (NEMG) providers weekdays from 7 a.m. to 7 p.m. ET, excluding holidays. To get started, download the MyChart mobile app.

The NEMG providers you see OnDemand can:

- Diagnose symptoms
- Order testing
- Prescribe medication
- Send prescriptions to the pharmacy of your choice in Connecticut, New York, Massachusetts, and Rhode Island.

OnDemand does not cover pediatric services. Find more information about OnDemand at HRConnect (ynhhs.org/hrconnect).

How It Works

1. Register with MyChart online at ynhhs.org/ondemand or through the mobile app.
2. Schedule your OnDemand visit. You'll get reminder emails, phone calls, and app pushes to remind you of your upcoming visit.
3. Complete e-Checkin on the mobile app or website 15 minutes before your visit. You'll answer questions about your medical history and insurance coverage.
4. Pay for your visit with a credit card, debit card, or your HSA Bank Flexible Spending Account debit card.
5. Join a virtual waiting room, where a medical assistant will greet you and confirm your information.
6. Visit your OnDemand doctor.
7. After your appointment, find a summary of your visit in the MyChart app.

When you or your child can't wait for care

LiveHealth Online is there for you 24/7/365. Pediatric services are not covered by OnDemand.
Call 888-548-3432.

LiveHealth Online

For pediatric services, or to see a board-certified doctor after hours, on weekends and holidays, and when you're out of state, visit LiveHealth Online (livehealthonline.com/), download the mobile app, or call **888-548-3432**.

Prescription Drugs (YNHHS Medical Plan)

WHAT YOU NEED TO KNOW

You automatically have prescription drug coverage when you enroll in the YNHHS Medical Plan. You can fill covered prescriptions at participating CVS retail pharmacies, through mail order, or through YNHHS Outpatient Pharmacy Services.

Need to fill a prescription?

Find a participating pharmacy near you.
Connect with a local pharmacy: cvs.com/store-locator/landing

Filling Your Prescription

Your prescription will be covered only if it's filled at a participating pharmacy. To fill 30-day supply prescriptions, just present your prescription and CVS Caremark prescription drug card at a pharmacy in the CVS Caremark network. To fill a maintenance medication, you must use a CVS retail pharmacy, mail order, or visit a YNHHS Outpatient Pharmacy. For specialty medications, you'll need to use mail order or specialty pharmacy services, as described below.

In an emergency or if you're out of state and can't get to a participating pharmacy, you'll pay out of pocket and then file a claim for reimbursement from CVS Caremark.

Pay nothing for certain preventive drugs

The Affordable Care Act (ACA) makes many prescription medications, vaccines, and supplements—including contraceptives and statins—available to you at no cost.
No-Cost Preventive Drug List: caremark.com/portal/asset/NoCost_Preventive_List.pdf

When you're covered by the YNHHS Medical Plan, the out-of-pocket maximum is the most you'll pay out of pocket for medical care and prescription drugs.

When a generic is available and you or your doctor chooses a brand-name drug, you'll pay the brand-name coinsurance—plus the difference in cost between the two medications.

Save on Maintenance Drugs

For medications you take on an ongoing basis, you'll use the CVS Caremark Maintenance Choice program to get refills at a lower copay for a larger supply. With CVS Maintenance Choice, you get up to two 30-day fills at a retail pharmacy before you'll need to use CVS Caremark mail service (https://info.caremark.com/mailservice) or a CVS Pharmacy for 90-day fills.

What You Pay for Fills

What you'll pay depends on the type of medication and the amount prescribed. When the cost of a drug is less than the minimum copay, you'll pay the lower amount.

Tier 1: Generic

- 30-day supply: $10 copay
- 90-day supply through CVS Maintenance Choice: $20 copay

Tier 2: Brand name

- **30-day supply:** 20% coinsurance ($35 minimum, $80 maximum) if the drug is on the list of preferred brand drugs (the formulary)
- **90-day supply through CVS Maintenance Choice:** 20% coinsurance ($70 minimum, $150 maximum) if the drug is on the list of preferred brand drugs (the formulary)

Tier 3: Non-preferred brand

- **30-day supply:** 40% coinsurance ($55 minimum, $120 maximum) if the drug isn't on the list of preferred brand drugs (the formulary)
- **90-day supply through CVS Maintenance Choice:** 40% coinsurance ($110 minimum, $230 maximum) if the drug isn't on the list of preferred brand drugs (the formulary)

Tier 4: Specialty

Up to a 30-day supply only through YNHHS Outpatient Pharmacy Services.

- Generic and brand name: $20 copay

For certain high-cost specialty drugs not available through Outpatient Pharmacy Services or the Apothecary & Wellness Center, you'll use CVS Specialty Pharmacy. These medications are subject to 40% coinsurance (up to $150 generic, $200 brand name).

Preauthorization and Other Special Circumstances

Compounded Medications

Some prescriptions, including compounded drugs, require preauthorization from CVS Caremark before they can be filled. Your pharmacist will let you know if your doctor needs to make that call.

Breast Cancer Drugs

If you're taking raloxifene (brand name: Evista) or tamoxifen (brand name: Noladex) for primary prevention of breast cancer, these generics may be available at no cost to you through the preventive provisions of the Affordable Care Act. To learn if you qualify, your doctor will need to complete the Preventive Services Zero Cost Sharing Form and fax it to CVS Caremark.

Step Therapy Program

The step therapy program requires you to try one or two generic equivalents before the brand-name drug will be covered.

Drug classes included in this program include medications that treat high cholesterol, high blood pressure, gastrointestinal disorders (GERD, for instance), sleep disorders, depression, and other conditions.

Drugs and Supplies not Covered

The following drugs and medical supplies are not covered by the plan:

- Medical devices and appliances
- Experimental drugs
- Drugs whose sole purpose is to promote or stimulate hair growth
- Retin A (for those over age 28)
- Weight-loss drugs
- Immunization agents, biological sera, blood or blood plasma
- Infertility medications
- Most over-the-counter drugs, vitamins, and nutritional supplements
- Ostomy supplies

High Deductible Health Plan (HDHP)

You have two High-Deductible Health Plan (HDHP) options: the HDHP with Health Savings Account (HSA), or the HDHP with Healthcare Reimbursement Account (HRA). Both plans are administered by Anthem Blue Cross and Blue Shield. You can select the HDHP with HRA only if you have Medicare or TRICARE. With both plans, you pay the full cost of care until you meet your annual deductible. Your HSA or HRA can help you cover those costs.

How the Plans Work

Your medical plan is designed to help keep you and your family healthy. Used in tandem with your other benefits—including dental and vision coverage and services offered through the integrated employee assistance and work/life program—it's also here to support you when you need care.

You may choose to waive medical coverage if you're covered by another plan or your spouse is a YNHHS employee.

Under both HDHP plans:

- Your coverage is identical.
- You pay nothing for preventive care—including some preventive tests and prescription medications—when you use network providers.
- You pay the full cost of care until you meet your annual deductible, after which the plan begins to share costs with you.
- You pay discounted rates when you use providers and facilities in the Yale New Haven Health System and Anthem PPO network.
- You have mental health and substance abuse benefits.
- Special rules apply when you or your covered dependents are covered by more than one plan.
- There's a combined annual deductible for medical and prescription services. Until the deductible is met, your eligible medical and prescription drug costs are applied against the deductible.

The difference between the plans? Only the account that comes with them—the HSA or HRA.

Health Savings Account

The Health Savings Account (HSA) is a special account that you contribute to on a pretax basis through payroll deductions. Your employer contributes to it, too. You can use the money in your HSA to cover your health care expenses until you reach your annual deductible and the plan begins to share those costs with you. **The HSA is not available to you if you are currently enrolled in Medicare or TRICARE.**

When you enroll for the HDHP with HSA, you will receive a welcome packet from HSA Bank, our HSA administrator. Follow the instructions to open your account.

After you meet your deductible, you can use your HSA to cover any coinsurance.

- For 2022, you can contribute up to $3,650 in your HSA if you have individual coverage and $7,300 if you're covering others, too. And if you're 55 or older, you can contribute an additional catch-up contribution of $1,000. Keep in mind your employer's contribution, if any, when making your election. Total contributions to your account cannot exceed these IRS maximums.
- Your HSA contributions reduce your taxable income.
- Any unused funds roll over year after year, earning interest along the way.
- The money in your HSA is yours to use forever on qualified health expenses—even if you change employers or health plans, or retire.
- Once your balance reaches $1,000, you have the opportunity to invest it for potential growth.

Note: You also have the option of opening your HSA at a financial institution of your choice. However, unlike an account opened with HSA Bank, you will not be able to fund your HSA through direct payroll contributions, nor will you receive your employer's contribution.

Healthcare Reimbursement Account

The Healthcare Reimbursement Account (HRA) is a special account to which your employer contributes to help you cover the cost of your health care expenses. You can use these funds to cover your costs as you reach your annual deductible. **The HRA is available only to employees enrolled in Medicare or TRICARE.**

- As you receive services throughout the year, you pay out of pocket for expenses like coinsurance, copays, and other services, and then get reimbursed from your HRA up to the amount of your existing balance.
- Once you've met your annual deductible, you may pay coinsurance for the care you receive; the plan will cover the rest.
- You can use the HRA only while you are enrolled in this plan. You cannot take the money with you if you change plans or employers.
- You cannot contribute to your HRA.

How much you pay depends on the provider or facility you choose:

YNHHS Facilities

When you use the following YNHHS facilities, you'll pay coinsurance after you've met your annual deductible, and you'll generally pay less for covered services:

- Bridgeport Hospital
- Greenwich Hospital
- Lawrence + Memorial Hospital
- Northeast Medical Group
- Westerly Hospital
- Yale New Haven Care Continuum (Grimes Center)
- Yale New Haven Hospital

Note: The YNHHS Facilities list above is not the same list as for the YNHHS Medical Plan. The YNHHS Medical Plan has an expanded Tier 1—Signature Network.

Anthem PPO Providers

When you choose to receive care from an Anthem Century Preferred Network provider:

- You'll need to meet your annual deductible ($2,000 individual/$4,000 family) before the plan begins to share the cost of your care.
- After you meet your deductible, you'll pay 20% coinsurance for care until you reach your annual out-of-pocket maximum.
- Once you meet your annual out-of-pocket maximum, the plan will pay 100% of covered expenses through that calendar year.

To find a provider in the Anthem Century Preferred Network, visit the Anthem website (http://anthem.com/) or call **888-266-2896**.

Out-of-Network Providers

When you use a provider or facility that is not in the Anthem Century Preferred Network:

- You'll pay the most for care.
- Anthem will pay a maximum allowable amount (MAA).
- You will be responsible for costs up to your annual deductible, coinsurance, and any difference between the MAA and the amount billed by the provider.
- You'll need to file a claim for the care to be covered. Payments will be made directly to the provider unless you submit a bill showing you've paid it already.

What You Pay for Care

Below is a summary of how certain services are covered. For a more complete list and any limitations, visit HRConnect to view the summary plan description (SPD).

Plan Feature	YNHHS Facility	Anthem PPO Provider	Out-of-Network Provider
Annual Deductible*	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000	Individual: $2,000 Family: $4,000
Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000	Individual: $3,000 Family: $6,000	Individual: $4,000 Family: $8,000
Member Coinsurance After Deductible	0% after deductible	20% after deductible	40% after deductible
Preventive Care Exams	0%, deductible waived	0%, deductible waived	40% after deductible
Office Visits	0% after deductible	0% after deductible	40% after deductible
Diagnostic Services Performed in Hospital (Lab, x-ray, MRI, PET, CAT scan, nuclear cardiology)	0% after deductible	20% after deductible	40% after deductible
Diagnostic Services Performed in Office (Lab, x-ray, MRI, PET, CAT scan, nuclear cardiology)	0% after deductible	0% after deductible	40% after deductible
Rehabilitation Therapy Performed in Hospital[1] (Physical, speech, occupational, chiropractic, cardiac rehab)	0% after deductible	20% after deductible	40% after deductible

Plan Feature	YNHHS Facility	Anthem PPO Provider	Out-of-Network Provider
Outpatient Rehabilitation Therapy Performed in Office[2] (Physical, speech, occupational, chiropractic, cardiac rehab)	0% after deductible	0% after deductible	40% after deductible
Emergency Care (Emergency room; copay waived if admitted)	$100 copay after deductible	$200 copay after deductible	$200 copay after deductible
Urgent Care (Walk-in and urgent care centers)	0% after deductible	20% after deductible	40% after deductible
Ambulance Services (Hospital-owned)	n/a	20% after deductible	40% after deductible
Ambulance Services (Not hospital-owned)	n/a	0% after deductible	40% after deductible
Telehealth	OnDemand $49 after deductible	LiveHealth Online $49 after deductible	n/a
Outpatient Surgery Performed in Hospital Ambulatory Care Center	0% after deductible	20% after deductible	40% after deductible
Inpatient Surgery (Semi-private room and board)	0% after deductible	20% after deductible	40% after deductible
Outpatient Mental Health/Substance Abuse Services Performed in Office	0% after deductible	0% after deductible	40% after deductible
Inpatient Mental Health/Substance Abuse Services	0% after deductible	0% after deductible	40% after deductible
Skilled Nursing Facility[3]	0% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment[4]	n/a	20% after deductible	40% after deductible

*The $2,000 individual annual deductible only applies to "employee only" coverage. If you cover any one else under this plan, your annual deductible is $4,000.

[1] Inpatient rehabilitative services are limited to 100 days per member per year.

[2] Physical, speech, and occupational therapy visits are limited to a combined total of 60 visits per member per calendar year. For physical therapy and occupational therapy, prior authorization is required after the first visit. Chiropractic services are limited to 12 visits per member per calendar year.

[3] Skilled nursing facility services are limited to 100 days per calendar year.

[4] You must use a participating provider to be covered for durable medical equipment and prosthetic devices.

To see employee premium contributions for the medical plan, visit ynhhsbenefits.com.

When to Connect with Anthem

For a medical stay and/or service preauthorization, call **800-238-2227** (in Connecticut) or **800-248-2227** (out of state). For behavioral health or substance abuse stays, call **800-934-0331**.

Before receiving any of the following services, you must call Anthem for preauthorization. Otherwise, your benefits will be reduced.

- **Inpatient stays** in a hospital, skilled nursing facility, hospice facility, subacute care or acute rehabilitation facility, or a behavioral health or substance abuse treatment center (CALL at least 24 hours before the start of your stay)
- **High-cost diagnostic imaging services** prescribed by an out-of-network provider
- **Organ/tissue transplants,** including evaluation, donor search, organ procurement/tissue harvest, or transplant

For admissions following emergency or urgent care, you, your representative, or your doctor must call Anthem within 48 hours of admission.

If you do not precertify for the services above:

- Benefits for inpatient stays will be reduced by $200.
- Benefits for doctor fees will be reduced by 25%.

You can also connect with Anthem to:

- Find a provider in the Anthem Century Preferred Network
- Resolve insurance claim and billing issues
- Ask questions about preventive and/or diagnostic care
- Get general health information

Urgent Care & Telehealth (HDHP)

WHAT YOU NEED TO KNOW
Can't wait to see a doctor? Urgent care and telehealth services help you quickly connect with affordable care.

Urgent Care

When you need immediate care for an illness or injury, you can visit the nearest YNHHS walk-in facility or a PhysicianOne Urgent Care center. To locate an urgent care center close to you, visit HRConnect and search for "urgent care."

Once you meet your annual deductible, you'll pay nothing when visiting a YNHHS facility; you'll pay more if you use other providers.

Telehealth

Telehealth is an ideal alternative for immediate treatment of an illness or injury when you can't get to a doctor's office or urgent care center.

You and your covered family members can visit a doctor virtually, wherever you are, whenever you need care—via phone, tablet, or computer. If you need medication, the doctor can even send a prescription to your pharmacy (in Connecticut, New York, Massachusetts, and Rhode Island).

Use the telehealth services below to connect to care outside the usual office hours. **Telehealth is not an alternative to emergency care for a life-threatening condition.**

OnDemand

See one of our own Northeast Medical Group (NEMG) providers weekdays from 7 a.m. to 7 p.m. ET, excluding holidays. To get started, download the MyChart mobile app.

The NEMG providers you see OnDemand can:

- Diagnose symptoms
- Order testing
- Prescribe medication
- Send prescriptions to the pharmacy of your choice in Connecticut, New York, Massachusetts, and Rhode Island.

If you've already met your annual deductible, you'll pay a $49 copay to use OnDemand. OnDemand does not cover pediatric services. Find more information about OnDemand at HRConnect.

How It Works

1. Register with MyChart online at ynhhs.org/ondemand or through the mobile app.
2. Schedule your OnDemand visit. You'll get reminder emails, phone calls, and app pushes to remind you of your upcoming visit.
3. Complete e-Checkin on the mobile app or website 15 minutes before your visit. You'll answer questions about your medical history and insurance coverage.
4. Pay for your visit with a credit card, debit card, or your HSA Bank Flexible Spending Account debit card.
5. Join a virtual waiting room, where a medical assistant will greet you and confirm your information.
6. Visit your OnDemand doctor.
7. After your appointment, find a summary of your visit in the MyChart app.

When you or your child can't wait for care

LiveHealth Online is there for you 24/7/365. Pediatric services are not covered by OnDemand.
Call 888-548-3432.

LiveHealth Online

For pediatric services, or to see a board-certified doctor after hours, on weekends and holidays, and when you're out of state, visit LiveHealth Online (livehealthonline.com), download the mobile app or call **888-548-3432**.

If you've already met your annual deductible, you'll pay a $49 copay to use LiveHealth Online. You can pay with a credit or debit card, including your HSA debit card or your FSA debit card. Be sure to provide your Anthem ID card information, so your claim is processed as an office visit.

Prescription Drugs (HDHP)

WHAT YOU NEED TO KNOW

You automatically have prescription drug coverage through CVS Caremark when you enroll in either of the High-Deductible Health Plans. You can use your HSA or HRA to pay for your share of the cost. You can fill covered prescriptions at participating CVS retail pharmacies or through the CVS Caremark mail service.

Until the deductible is met, all covered medical and prescription costs are applied against the deductible. You will pay the actual cost of your prescription, as negotiated between CVS Caremark and the pharmacy.

Need to fill a prescription?

Find a participating pharmacy near you.
Connect with a local pharmacy: www.caremark.com/

Filling Your Prescription

Short-Term Medications

You can fill up to a **30-day supply** of a prescription at more than 5,000 participating pharmacies in the Connecticut, New York, and New Jersey area (64,000 nationwide), including major pharmacy and supermarket chains and most independent drug stores. Simply present the prescription and your CVS Caremark prescription drug card.

In an emergency or if you're out of state and can't get to a participating pharmacy, you'll pay out of pocket and then file a claim for reimbursement from CVS Caremark.

Pay nothing for certain preventive drugs

The Affordable Care Act (ACA) makes many prescription medications, vaccines, and supplements—including contraceptives and statins—available to you at no cost.

When a generic is available and you or your doctor chooses a brand-name drug instead, you'll pay the brand-name copay—plus the difference in cost between the two medications.

What You Pay for Fills

The High-Deductible Health Plans have a combined annual deductible for medical and prescription drug services. You'll pay the full cost of services until you meet your deductible; for prescription drugs, you'll pay the actual cost of your medication, as negotiated between CVS Caremark and the pharmacy.

Under these plans, the most you'll pay out of pocket for medical care and prescription drugs in any calendar year is $3,000 per individual or $6,000 per family.

How much you'll pay for your prescription depends on the type of medication and the amount prescribed. When the cost of a drug is less than the minimum copay, you'll pay the lower amount.

Tier 1: Generic

- **30-day supply:** $10 copay after deductible
- **31- to 90-day supply:** $10 copay after deductible through CVS Caremark mail service (info.caremark.com/mailservice)

Tier 2: Brand Name

- **30-day supply:** $25 copay after deductible, if the drug is on the list of preferred brand drugs (the formulary)
- **31- to 90-day supply:** $50 copay after deductible through CVS Caremark mail service (info.caremark.com/mailservice)

Tier 3: Non-Preferred Brand

- **30-day supply:** $40 copay after deductible, if the drug isn't on the list of preferred brand drugs (the formulary)
- **31- to 90-day supply:** $80 copay after deductible through CVS Caremark mail service (info.caremark.com/mailservice)

A Word About Specialty Drugs

Certain high-cost specialty drugs are subject to the Advance Control Specialty Formulary. This formulary includes specialty generics and clinically effective brand therapies, and combines other specialty programs, such as Specialty Guideline Management to ensure proper utilization. For the most current formulary listing, visit the Caremark website (caremark.com/) or call CVS Caremark customer service at **877-636-0406**.

Preauthorization and Other Special Circumstances

Compounded Medications

Some prescriptions, including compounded drugs, require preauthorization from CVS Caremark before they can be filled. Your pharmacist will let you know if your doctor needs to make that call. Compounded drugs are covered as Tier 3 medications.

Breast Cancer Drugs

If you're taking raloxifene (brand name: Evista) or tamoxifen (brand name: Nolvadex) for primary prevention of breast cancer, these generics may be available at no cost to you through the preventive provisions of the Affordable Care Act. To learn if you qualify, your doctor will need to complete the Preventive Services Zero Cost Sharing Form and fax it to CVS Caremark.

Drugs and Supplies Not Covered

The following drugs and medical supplies are not covered by the plan:

- Medical devices and appliances
- Experimental drugs
- Drugs whose sole purpose is to promote or stimulate hair growth
- Retin A (for those over age 28)
- Weight-loss drugs
- Immunization agents, biological sera, blood or blood plasma
- Infertility medications
- Most over-the-counter drugs, vitamins, and nutritional supplements
- Ostomy supplies

Health Care FSA

WHAT YOU NEED TO KNOW

A Health Care Flexible Spending Account (FSA) helps you set aside money to pay for health care expenses you'll have during the year. The pluses: You contribute pretax income, so you're paying no taxes on your contributions—plus, your contributions reduce your taxable income.

If you're enrolled in the HDHP and want pretax options for covering out-of-pocket dental and vision expenses, you can open a Limited-Purpose FSA. And even if you don't enroll in a medical plan, you can contribute to a full Health Care FSA to help you cover medical, prescription drug, dental, and/or vision out-of-pocket-expenses.

How It Works

When you elect your benefits as a new employee or during annual open enrollment, you choose your FSA contribution level for the calendar year (up to $2,750 in 2022).

Important information about your 2021 and 2022 FSA! Due to a temporary pandemic relief rule, there is no limit on the Health Care FSA balance you can roll over from 2021 into 2022. For example, if you have $700 balance at the end of this year, you can carry it all over into 2022 (the usual limit is $550).

During every open enrollment period, you'll elect the amount you want to contribute to your FSA the following year. Your election does not automatically roll over from year to year.

Your pretax paycheck contributions are deposited directly into your FSA, which is administered by HSA Bank.

You can use your FSA to pay for eligible expenses, including:

- Copays and coinsurance
- Prescription drugs and over-the-counter medications (with a doctor's prescription)
- Medical equipment, like crutches, and supplies such as bandages
- Vision care, like eyeglasses and contact lenses
- Dental expenses, such as fillings and braces

When you have eligible expenses, you can use your FSA debit card to pay for them. Or, you can submit receipts and file a claim for reimbursement.

Please keep in mind that you cannot reimburse yourself for the same expense with money from both your HRA and FSA.

Limited-Purpose FSA

If you enroll in the HDHP with HSA, you can contribute to the Limited-Purpose FSA. This account works the same way the full Health Care FSA works, with one exception: It is for dental and vision expenses only.

Managing Your Account

You set up and manage your FSA on the HSA Bank website (www.hsabank.com) or via the mobile app. Then, you can upload receipts and submit claims, pay providers, and track your account balance and transactions.

You have until March 31 of the following year to submit receipts for reimbursement.

Dental Benefits

WHAT YOU NEED TO KNOW

You can choose from two Cigna dental plans that cover all your dental needs, from routine exams and cleanings to major services like bridgework, crowns, and orthodontia. Although you may see any dentist you like, when you visit a Cigna Dental network dentist, you'll pay less and you won't have to file a claim.

Find a participating dentist

The Cigna website makes it simple to locate a participating dentist in your area.
Connect with a network dentist: hcpdirectory.cigna.com

Plan Features

Choose from two plans: **Cigna Dental Option 1** (Basic) or **Cigna Dental Option 2** (Enhanced).

Both plans feature:

- A nationwide network of Cigna dentists
- Discounted rates for using participating Cigna network dentists
- Preventive and diagnostic care at no cost to you
- Coverage for restorative services and orthodontia

The key difference: Option 2 provides a higher annual maximum benefit and higher levels of coverage for basic restorative and orthodontic services. Its higher benefit levels will cost you more per paycheck.

You can also choose to waive dental coverage.

Know Before You Go

Before you sit down for a procedure that will cost more than $200, contact Cigna to request a pretreatment review of benefits. That way, you'll know how much the plan will cover, and how much you'll need to pay.

How the Plans Compare

Here's what you'll pay after you've satisfied your calendar-year deductible, except as noted.

Plan Feature	Option 1 (Basic)	Option 2 (Enhanced)
Annual Deductible*	Individual: $50 Family: $150	Individual: $50 Family: $150
Individual Maximum Calendar-Year Benefit* (excludes orthodontia)	$1,200	$1,500

Plan Feature	Option 1 (Basic)	Option 2 (Enhanced)
Preventive & Diagnostic Care Services (no deductible) includes routine exams, cleanings, x-rays, sealants, and other services	$0	$0
Basic Restorative Care such as fillings, oral surgery, extractions, root canals, periodontics, and repairs to dentures, bridges, and crowns	20% coinsurance after deductible	10% coinsurance after deductible
Major Restorative Care such as dentures, bridges, crowns, and implants	40% coinsurance after deductible	40% coinsurance after deductible
Orthodontia	40% coinsurance after deductible Lifetime maximum benefit (per person):* $1,000	40% coinsurance after deductible Lifetime maximum benefit (per person):* $1,500

*All plan deductibles and maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

For additional details about covered services, including what the plan pays if you use an out-of-network provider or facility, exclusions, and limitations, visit HRConnect to view the summary plan description (SPD).

If You Use an Out-of-Network Dentist

- You may pay more for services because non-participating dentists have not negotiated fee discounts with Cigna.
- You may need to pay the dentist yourself and then submit a claim to be reimbursed by Cigna.
- If you need to submit a dental claim yourself, ask your dentist for a standard American Dental Association claim form.

Vision Benefits

WHAT YOU NEED TO KNOW

The vision plan from Vision Service Plan (VSP) helps cover an annual eye exam and a pair of glasses or contact lenses every calendar year for you and any family member on your plan. Although you can receive care from any vision service provider you choose, you'll always pay less when you see a participating VSP provider.

Find a Participating Doctor

You'll maximize your benefits and pay less out of pocket when you see a VSP doctor.
Connect with a network doctor: www.vsp.com

Plan Benefits

Unless indicated, amounts shown are what the plan pays.

Plan Feature	In-Network Benefit	Out-of-Network Benefit
Eye exam (every 12 months)	100% after $10 copay	Up to $50
Corrective lenses (every 12 months)	100% after $10 copay for lenses, $25 copay for frames[1] Standard progressive: $50 Premium progressive: $80–$90 Custom progressive: $120–$160	Single vision: Up to $50 Lined bifocals, trifocals: Up to $75 Trifocals: Up to $100 Progressive: Up to $75
Frames (every 12 months)	Up to $170, plus 20% discount	Up to $70
Contact lenses (every 12 months)[2]	$125, plus 15% discount on VSP doctor services	Up to $105

[1] Standard lenses, including glass or plastic single vision, bifocal, or trifocal and polycarbonate lenses for dependent children.

[2] When you select contact lenses instead of glasses.

For additional details about covered services, exclusions, and limitations, visit HRConnect to view the summary plan description (SPD).

Employee & Family Resources

WHAT YOU NEED TO KNOW

Because life doesn't come with a playbook, the Employee and Family Resources (EFR) program, administered by Beacon Health Options, is here for you 24/7, at **no cost**. EFR connects you to the confidential support, referrals, information, and other resources you need to get you through the good and not-so-good times.

Got more than you can handle?

Call toll-free, 24/7: 877-275-6226

Program Features

EFR is our employee assistance and work/life program, and it provides free, 24/7, confidential services and resources to you and members of your family.

What can you use it for?

- Get help dealing with relationship issues, anxiety and depression, substance abuse, and more.
- Have up to six free sessions with a licensed counselor.
- Get referrals to legal and financial services.
- Locate the perfect summer camp for your kids or an adult day care provider to watch an elderly parent while you're at work.
- Find resources, like videos, articles, and webinars covering a variety of topics, on the Beacon Health Options website (www.achievesolutions.net/ynhhs).

Consider reaching out to a Beacon counselor for up to six free visits before accessing your Anthem behavioral health benefits, which require a copay.

Education Support for Children

WHAT YOU NEED TO KNOW

When your child needs extra learning support or help taking that next educational leap, connect with the experts at Bright Horizons for free guidance and resources that address their unique needs.

Special Needs Help

If your child is having trouble focusing, lagging behind developmentally, or struggling with social skills, you'll find personalized help from a compassionate Bright Horizons Special Needs™ advisor. You can also watch webinars to learn what you need to successfully guide and advocate for your child's education.

College Advising

For students preparing to apply to college, there's College Coach. Offering expert guidance on the college admissions and financial aid process, college admissions consultants can help your child identify best-fit schools and review college admission essays.

To get started, visit Bright Horizons (clients.brighthorizons.com/ynhhs).

Dependent Care FSA

WHAT YOU NEED TO KNOW

Setting aside pretax dollars in a Dependent Care Flexible Spending Account (FSA) can help you save on child and adult day care expenses. The Dependent Care FSA covers eligible dependent care expenses, including child and adult day care while you work, and preschool, summer camp, and before- and after-school programs.

How It Works

When you elect your benefits as a new employee or during annual open enrollment, you choose your FSA contribution level for the calendar year (up to $5,000 if you and your spouse file joint tax returns; $2,500 if you file separately).

You'll need to elect your contribution level during open enrollment each year (as long as you have an FSA), because FSA elections don't roll over from year to year.

Your pretax paycheck contributions are deposited directly into your Dependent Care FSA, which is administered by HSA Bank.

Managing Your Dependent Care FSA

You set up and manage your FSA on the HSA Bank website (www.hsabank.com) or via the mobile app. You have the option to pay dependent care expenses directly from your FSA, with your HSA Bank debit card, or submit receipts and be reimbursed for expenses you pay out of pocket.

Contacts

Enrolling & Benefits Information

HRConnect
Monday–Friday,
7:30 a.m. to 5 p.m. ET
844-543-2147
203-200-3838 (fax)
ynhhs.org/hrconnect

Medical Benefits

Anthem Blue Cross
and Blue Shield
844-963-0447
www.anthem.com/

Patient Resource Coordinators (PRC)
Help finding Tier 1 providers
844-543-2147, option 3

COBRA
bswift
866-365-2413
ynhhsbenefits.com

Telehealth
OnDemand
833-483-5363
ynhhs.org/ondemand

LiveHealth Online
888-548-3432
livehealthonline.com/

Prescription Drug Benefit

CVS Caremark
800-776-1355
www.caremark.com

Dental Benefit

Cigna
800-244-6224
my.cigna.com

Vision Benefit

Vision Service Plan (VSP)
800-877-7195
www.vsp.com

Employee & Family Support Benefits

Employee assistance and work/life program
Beacon Health Options
877-275-6226
achievesolutions.net/ynhhs

Education support for children
Bright Horizons
For children who need extra help:
clients.brighthorizons.com/ynhhs
For individual advising:
ynhhs-brighthorizons.torchlight.care

College Coach
888-527-3550
ynhh@getintocollege.com
passport.getintocollege.com
Employer Username: YNHHS
Password: Benefits4You

Voluntary Benefits

YNHHS Voluntary Benefits
866-874-2837
http://ynhhsvoluntarybenefits.com/

Financial Benefits

Dependent Care FSA
Health Care FSA
HSA Bank
844-650-8936
866-357-6232 (Spanish)
www.hsabank.com
Chat 8:30 a.m. – 5 p.m. CT
askus@hsabank.com

Disability and family/ medical leave
Equitable (Disability)
866-274-9887
equitable.com

Family/medical leave
The Hartford (FMLA)
888-301-5615
www.thehartford.com/employee-benefits/employees

Retirement 403(b)
Mutual of America
860-659-3610
www.mutualofamerica.com

Terms to Know

Claims Administrator

The insurance company or third party that reviews, approves, and pays benefits claims.

Coinsurance

Once you've met your annual deductible, coinsurance is the percentage of costs you'll pay out of pocket for services covered by your plan (until you meet your out-of-pocket maximum for the year).

Copay

The fixed amount you pay for an in-network service.

Deductible

The amount you must pay for covered health services each year before the plan begins to pay its share of costs. The deductible may not apply to some services, including preventive care, in-network doctor visits, and services billed by a YNHHS facility.

Each family member covered under the plan must meet the deductible each calendar year. The deductible does not include copays, amounts exceeding the maximum allowable amount (MAA), prescription drug expenses, or expenses not covered by the plan.

Example: The individual deductible for the High-Deductible Health Plan is $2,000. When **two covered members** of your family have each met their $2,000 deductible, the $4,000 family deductible for the year will have been met. After you meet the deductibles, the plan will pay its share of costs for all covered family members during that calendar year.

Dependent Children Over Age 26

You can continue coverage for your fully handicapped dependent child past the child's 26th birthday only if you submit proof within 31 days of the child's 26th birthday that the child is disabled. Coverage will end in the following situations: when your child is no longer handicapped, if you do not provide proof of continued disability, if you fail to have any required exam for that child, or when dependent coverage terminates for any other reason.

Diagnostic Care

Specific care and/or procedures that help a doctor investigate symptoms or test results and make a diagnosis.

Example: You typically receive preventive care during an annual checkup. If a preventive screening yields an abnormal result, you may receive diagnostic care to determine why.

Health Reimbursement Account (HRA)

An account offered in conjunction with the HDHP for employees enrolled in Medicare or TRICARE. Your employer contributes to your HRA. As you receive services throughout the year, you pay out of pocket for expenses like coinsurance, copays, and other services, and then get reimbursed from your HRA up to the amount of your existing balance. Unlike an HSA, the HRA is not portable; you can't take it with you if you leave your employer or change medical plans.

Health Savings Account (HSA)

A special account that's typically paired with a high-deductible health plan (HDHP). You and/or your employer contribute to the account, and you can use these funds to cover qualified healthcare expenses, including your annual deductible, copays, and coinsurance. Annual contributions for individuals and families are set by the IRS. The money in your HSA is yours to use into retirement, even if you change plans or employers.

High-Deductible Health Plan (HDHP)

A health plan with a higher annual deductible than most PPO plans, but it doesn't begin to share the costs for covered services until you meet the $4,000 annual deductible. To help you cover these costs, you can use funds in the Health Savings Account (HSA) or Health Reimbursement Account (HRA) that's paired with your HDHP.

In-Network Provider

The facilities, providers, and suppliers that Anthem Blue Cross and Blue Shield has contracted with to provide health care services. The L+M High-Deductible Health Plans use Anthem's National PPO Provider Network; the YNHHS Medical Plan offers two different in-network provider networks:

1. The Signature network (YNHHS Medical Plan only) includes: YNHHS facilities/hospitals, PCP's from NEMG, Community Medical Group (CMG), Yale Medicine (YM), WestMed in CT, Trinity Health of New England hospitals and affiliated physicians. Also included are specialists from YM, NEMG, CMG and Trinity Health, and those credentialed at YNHHS.
2. Anthem Preferred Provider Organization (PPO) includes providers and facilities in Anthem's Century Preferred Network.

Maximum Allowable Amount (MAA)

The maximum amount that Anthem will pay for a covered service or the billed charge—whichever is lower. Applies to out-of-network services only.

Out-of-Network Provider

Any provider or facility that has not contracted with Anthem Blue Cross and Blue Shield and is not part of Anthem's Century Preferred Network. Anthem will pay up to the MAA for these services, and all claims will be subject to applicable deductibles and coinsurance.

Out-of-Pocket Costs

Any cost or fee that you pay for medical services, prescription drugs, or medical supplies. These include your annual deductible, and copays and coinsurance.

Out-of-Pocket Maximum

The most you will pay in a calendar year for medical or prescription drug expenses. Once the out-of-pocket maximum has been met, the plan pays 100% of covered expenses for the covered person or family for the remainder of the calendar year, including copays and expenses that are applied toward the annual deductible.

The out-of-pocket maximum does not include benefit reductions due to failure to precertify, covered expenses paid at 100%, expenses exceeding the MAA, expenses not covered by the plan, or employee premium contributions.

Preferred Provider Organization (PPO)

Doctors, hospitals, and other providers who have agreed to negotiated fees with Anthem. Typically, you'll pay less than you would for services from a non-PPO provider.

Preventive Care

Screenings, annual checkups, and patient counseling to prevent illness, disease, or other health problems. Under the Affordable Care Act (ACA), all health plans must cover certain preventive health services at no cost to the patient. Some prescription drugs are also considered preventive under the ACA and are covered at 100%.

Primary Care Physician

A medical doctor who provides or coordinates health services for a patient. Primary care physicians are typically aligned with internal medicine, general or family medicine, and pediatrics practices.

Prior Authorization

A decision reached by your health plan—before services are performed or purchases are made—that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Your plan may require prior authorization for certain services, except in an emergency. Prior authorization is not a promise that your plan will cover the cost. Prior authorization for prescription drugs ensures medications are safe and being prescribed for FDA-approved uses.

Qualifying Life Event

A major life event—including a change in family size, marriage, divorce, or loss of current coverage—that allows you and/or eligible family members to enroll in or make changes to your existing health coverage. If you experience a qualifying life event, you must make the change within 31 days on ynhhsbenefits.com.

Specialist

A physician who focuses on a specific area of medicine to diagnose, manage, prevent, or treat certain symptoms and conditions.

Examples include allergist, cardiologist, dermatologist, orthopedist, podiatrist, ear/nose/throat, gastroenterologist, OB/GYN, ophthalmologist.

Voluntary Benefits

Products offered through an employer that the employer typically pays for at below-market rates. These can include life, disability, critical-illness, accident, homeowner's, auto, and pet insurance; ID theft protection; legal services; and other benefits.

Documents & Forms

All documents and forms can be accessed on HRConnect (ynhhs.org/hrconnect). You'll also find summary plan descriptions, summaries of material modifications, carrier claim forms, and more.