Yale-New Haven Hospital

Resident Physician

Health Care Benefits

2012

What's Inside

Keep this booklet handy throughout the year to use as a quick reference guide whenever you or a family member needs medical care.

Introduction

The Yale New Haven Health System (YNHHS), which includes Yale-New Haven Hospital, Bridgeport Hospital, Greenwich Hospital, Northeast Medical Group and Yale New Haven Health Services Corporation, offers medical, prescription drug, dental and vision care coverage to eligible employees and eligible members of their families. This booklet provides information you'll need to consider when making your annual health care enrollment decisions for 2012.

YNHHS continues to comply with the requirements stipulated by the Federal Government related to health care reform legislation which passed in 2010. The 2012 plan changes listed on page 1 will require that YNHHS's "grandfathered" status be discontinued. Please refer to page 27 to read the required legal disclosure statements relevant to plan changes for 2012.

YNHHS is committed to providing all employees with comprehensive health care coverage for you and your family. By offering the same plans to all YNHHS employees, we're able to take advantage of our combined resources to provide you with quality medical coverage at an affordable cost. Our health plan partners include Anthem Blue Cross and Blue Shield for medical, CVS Caremark for prescription drug, Delta Dental for dental and VSP for vision care coverage. In 2012, YNHHS is also partnering with ActiveHealth Management to provide confidential coaching and support for members identified with 35 chronic health conditions.

Good health is a precious resource and it begins with YOU. We encourage you to take steps to practice healthy lifestyle habits and obtain the preventive screenings that are appropriate for you and are covered under the health care plans described in this booklet. When you need care, whether for an acute or chronic health condition, know your benefits and use them wisely – it's a win-win for you and for YNHHS.

What is NEW for 2012

MEDICAL PLAN CHANGES

- Preventive care services covered at 100%, no copay. This includes 100% coverage for well baby/well child care and annual adult exams. See page 6 for details.
- Annual deductible added to Advantage Plus Plan ($300 Individual/$900 Family). Deductible does **not** apply to preventive care and office visit copays but will apply to most other services. See page 4 and charts on pages 6–9 for more information.
- Urgent Care facility copays increased from $40 to $50, but will be waived at YNHHS free–standing urgent care facilities.
- Emergency Department copay increased from $80 to $100.

PRESCRIPTION DRUG COVERAGE CHANGES

- For Tier 1 Generic drugs, you'll pay a copay of $6 (no longer 10% coinsurance) at retail for a 30-day supply; for a 90-day supply under CVS Caremark Maintenance Choice Program, the copay is $15.
- For Tiers 2 – Preferred Brand and 3-Non-Preferred Brand drugs, copay minimums and maximums have increased. The maximum copay for Tier 4-Specialty drugs has also increased by $10, from $85 to $95.
- Step Therapy program expanded to include 12 classes of drugs, requiring use of generic drugs first before you can receive coverage for brand name drugs.
- Specialty Preferred Drug Program (Tier 4): For three classes of Specialty drugs – Human Growth Hormones, Rheumatoid Arthritis and Multiple Sclerosis – you will be required to use the preferred drug prior to utilization of a non-preferred drug.
- Diabetes testing supplies (e.g., test strips) moved from Tier 2 to Tier 1– generic copay level – to reduce the cost of these supplies.
- See pages 12–13 for details.

DENTAL PLAN

- No changes in benefits, but 2012 is an active enrollment year to elect either the Delta Dental Plus, Delta Dental Basic plan or no coverage for the next two years. Choose your election carefully.

Eligibility and Coverage

WHO IS ELIGIBLE?

All regular, full-time or part-time house staff members of Yale-New Haven Hospital are eligible.

In addition, you may enroll eligible members of your family for medical, prescription drug coverage, vision care and dental coverage. You may elect the following types of coverage:

- Employee (yourself only)
- Employee + Spouse; Civil Union Partner
- Employee + 1 Child (yourself and one child member)
- Family (yourself and two or more family members).

Check with your Benefits Department for more information on the eligibility rules.

WHEN COVERAGE TAKES EFFECT

House staff are eligible for coverage on the first day of work.

Annual Elections

Each fall, during an annual enrollment period, you may change your FLEXplan benefit choices for the next year. That is, elections you make during the annual enrollment period will take effect as of January 1, of the following year.

When a qualified "change-in-status" event occurs during the year, however, you may be able to elect changes to your coverage within 31 days after such an event (see page 25).

Your Medical Plan

The Yale-New Haven Health Advantage Plus Plan is known as a "preferred provider organization" (PPO) type of plan. That is, certain doctors, hospitals, and other providers have agreed to provide services under the plan at negotiated rates. In addition, you generally won't have to file a claim when you go to a PPO provider.

Under a PPO plan, you're also free to go to a non-PPO doctor or other provider of your choice, although the benefits you receive will generally be less and, in most cases, you'll be required to file a claim to receive benefits.

How the Medical Plan Works

USING YALE-NEW HAVEN HEALTH SYSTEM'S FACILITIES

Under the Yale-New Haven Health Advantage Plus Plan, you'll receive the highest level of benefits when you or a covered family member obtains medical care from a Yale-New Haven Health System facility.

Anthem Blue Cross and Blue Shield Is the Claims Administrator

The claims administrator for the Yale-New Haven Health Advantage Plus Plan is Anthem Blue Cross and Blue Shield (or "Anthem" for short). Anthem's "Century Preferred" network of providers will be available to plan participants. Anthem will be responsible for processing all claims and interpreting plan provisions. Anthem may be reached at **1-888-266-2896**, or you may obtain information about its services by visiting its web site at **www.anthem.com**.

USING ANTHEM'S "CENTURY PREFERRED" PPO PROVIDERS

Under the Yale-New Haven Health Advantage Plus Plan you'll receive a high level of benefits when you or a covered family member obtains medical care from an Anthem "Century Preferred" PPO provider – doctors, hospitals, and other health care facilities who have agreed to provide services at negotiated fees.

You also have the option of obtaining care from non-PPO providers. You may choose to go in-network or out-of-network each time you need medical care. You don't have to choose a primary care physician or get a referral before seeking care from another doctor. And you may go back and forth as many times as you like during the year.

Keep in mind that this plan gives you the option of obtaining care from non-PPO providers. You may choose to go in-network or out-of-network each time you need medical care. You don't have to choose a primary care physician or get a referral before seeking care from another doctor. And you may go back and forth as many times as you like during the year.

When you obtain services from an Anthem PPO provider, you'll generally pay less than you would if you received the services from a non-PPO provider. Moreover, you'll also be assured that amounts charged by the provider will not exceed the "Maximum Allowable Amount." This expense is the most the plan will consider paying for a covered out-of-network expense. In addition, all PPO providers must satisfy strict credentialing requirements. Therefore, you'll receive quality care at lower costs. Regardless of whether you obtain care from PPO or non-PPO providers, plan benefits are subject, as applicable, to:

- the deductible,
- copays, or coinsurance, and
- the out-of-pocket maximum

THE ANNUAL DEDUCTIBLE

The annual deductible is the amount you must pay out-of-pocket for certain types of care before the plan pays benefits.

Deductible

The deductible applies to many services that you receive at a YNHHS facility or from an Anthem PPO provider, as well as all services from an out-of-network provider. The deductible does NOT apply to preventive care services and doctor visits in network.

The deductible must be met by each covered person each calendar year (maximum three per family). When the deductible expenses incurred by all covered members of a family reach the annual family maximum deductible during the year, the deductible will be met for all members of that family for the rest of that year.

>>	ADVANTAGE PLUS PLAN		
	YNHHS FACILITY *	ANTHEM PPO PROVIDER **	OUT-OF-NETWORK PROVIDER
INDIVIDUAL DEDUCTIBLE	$300		$700
FAMILY MAXIMUM DEDUCTIBLE	$900		$2,100

* YNHHS Facility – Services provided and billed by Yale-New Haven Hospital, Bridgeport Hospital, Greenwich Hospital and their affiliates

** Anthem PPO Provider – Refer to the Anthem "Century Preferred" PPO Network to identify in-network PPO providers (e.g., doctors) or facilities (e.g., hospitals).

The deductible consists of your payments for expenses covered by the plan. It **doesn't** include:

- any copays you make for care obtained from a Yale New Haven Health System or Anthem PPO provider
- amounts exceeding the maximum allowable amount
- any payments you make for expenses covered under the prescription drug program (see page 12)
- expenses that aren't covered by this plan

For services the annual deductible applies to, see pages 6–9.

COPAYS

A copay is a fixed amount you pay each time you receive certain specified services from a PPO provider before benefits are paid. Copays are paid to the provider at the time you receive the service. Remember, the copay only applies to certain services obtained from a Yale-New Haven Health System or Anthem PPO provider (see pages 7–9 for more details.)

COINSURANCE

The coinsurance is the percentage of the bill that is paid after the annual deductible has been met. For example, out-of-network expenses are covered at 70% by the Plan, you are responsible for the remaining 30%. Coinsurance in this case is 70%/30%.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum provides financial protection if you or a covered family member incurs large medical bills.

Once a covered person reaches the out-of-pocket maximum for any calendar year, the plan pays 100% of reasonable and customary covered expenses that person incurs for the rest of that calendar year, subject to plan limits. In addition, once all covered members of a family reach the family out-of-pocket maximum for any year, the plan pays 100% of reasonable and customary covered expenses covered members of that family incur for the rest of that calendar year, subject to plan limits. In addition, once all covered members of a family reach the family out-of-pocket maximum for any year, the plan pays **100%** of reasonable and customary covered expenses covered members of that family incur for the rest of that calendar year, subject to plan limits.

The out-of-pocket maximum includes covered expenses you and covered members of your family incur in any calendar year, including expenses that are applied toward meeting the deductible for that year.

Medical Plan Benefits

>>	YALE-NEW HAVEN ADVANTAGE PLUS PLAN		
	SERVICES RECEIVED FROM A YALE-NEW HAVEN HEALTH SYSTEM FACILITY	SERVICES RECEIVED FROM AN ANTHEM PPO PROVIDER	SERVICES RECEIVED FROM AN OUT-OF-NET-WORK PROVIDER
INDIVIDUAL OUT-OF-POCKET MAXIMUM	n/a	n/a	$4,000
FAMILY OUT-OF-POCKET MAXIMUM	n/a	n/a	$12,000

The out-of-pocket maximum, however, **doesn't** include:

- copays for services received from a Yale-New Haven Health System or Anthem PPO provider,
- any copays related to treatment in an emergency room,
- outpatient treatment of a mental or nervous disorder, alcoholism, or substance abuse,
- any benefit reduction required under the plan (see page 10),
- any covered expense for which benefits are initially paid at 100%,
- expenses exceeding the maximum allowable amount,
- any payments you make for expenses covered under the prescription drug program (see pages 12–13),
- expenses that aren't covered by the plan.

Benefits are paid toward covered services that are considered medically necessary for treating a health condition or disease. Benefits may be subject to certain limits and restrictions. Be sure to read the pages 6–9 for a more complete description of Plan benefits.

PUT PREVENTION INTO PRACTICE

It's important for you and your family to obtain all appropriate preventive care exams and screenings on a regular basis. For 2012, under both plans, preventive care services are covered at 100% if you receive these services at a YNHHS facility or from an Anthem PPO provider. If you visit out-of-network providers to receive preventive care services, you will pay the applicable deductible and coinsurance level for the plan you select.

The chart on page 6 describes the key preventive care services that are covered at 100%. Discuss age and gender preventive screenings and immunizations that may be appropriate for you (and your family) with your physician. You can also call Anthem Member Services at 1-888-266-2896 if you have any questions as to whether or not a screening or service is covered at 100% under the preventive care benefit.

|| PREVENTIVE VS. DIAGNOSTIC CARE ||

What's the difference? Preventive care is generally precautionary and is designed to identify potential health problems early before any symptoms appear. For example, if your doctor recommends having a colonoscopy because of your age or family history, but you yourself have no symptoms, that's preventive and the procedure will be covered at 100% (YNHHS facility or in-network only). But if your doctor recommends a colonoscopy to investigate symptoms you're having, that's diagnostic care and your plan cost share will apply.

>>	YALE-NEW HAVEN ADVANTAGE PLUS PLAN		
PREVENTIVE CARE SERVICES	**YNHH FACILITY**	**ANTHEM PPO PROVIDER**	**OUT-OF-NETWORK PROVIDER**
WELL BABY / WELL CHILD CARE (includes immunizations) • seven exams from birth to age one year • seven exams from age one to five years • one exam every year from age 6 to 21 years	n/a ****	100%, no copay	70% of MAA ***** subject to the deductible
ROUTINE ADULT EXAMS* • one exam every year starting at age 22 (includes immunizations)	n/a	100%, no copay	70% of MAA subject to the deductible
OB/GYN Preventive Exam** (one per year)	n/a	100%, no copay	70% of MAA subject to the deductible
MAMMOGRAPHY	100%, no copay	100%, no copay	70% of MAA subject to the deductible
COLORECTAL CANCER SCREENING*** (includes fecal occult blood test, barium enema, flexible sigmoidoscopy and screening colonoscopy)	100%, no copay	100%, no copay	70% of MAA subject to the deductible
NUTRITION COUNSELING (includes diabetes self-management training)	100%, no copay	100%, no copay	70% of MAA subject to the deductible

* Includes tests done in the physician's office at the time of the exam.
** All other OB/GYN office visits are covered at the Specialist office visit benefit level.
*** Diagnostic colonoscopies covered under the outpatient surgery benefit level.
**** n/a – not applicable
***** MAA – Maximum Allowable Amount

>>	YALE-NEW HAVEN ADVANTAGE PLUS PLAN		
SERVICE	**YNHH FACILITY**	**ANTHEM PPO PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Primary Care Physician Office Visit* (other than for preventive care visits)	n/a ***	100%, subject to a $25 copay	70% of MAA **** subject to the deductible
Specialist Office Visit**	n/a	100%, subject to a $30 copay	70% of MAA subject to the deductible
Allergy Shot Administration in Doctor's Office (no MD visit)	n/a	100%, subject to a $5 copay	70% of MAA subject to the deductible
Maternity Care (in office)	n/a	100%, subject to a $30 copay for initial visit	70% of MAA subject to the deductible
Chiropractic, Physical, Occupational and Speech Therapy (maximum 50 combined visits per year)	100%, subject to a $25 copay	100%, subject to a $25 copay	70% of MAA subject to the deductible
Outpatient Behavioral Health Treatment (prior authorization needed after 20th visit)	100%, subject to a $25 copay	100%, subject to a $25 copay	70% of MAA subject to the deductible
Outpatient Substance Abuse Treatment (prior authorization needed after 20th visit)	100%, subject to a $25 copay	100%, subject to a $25 copay	70% of MAA subject to the deductible
Basic Lab Services (blood work and lab tests, such as urinalysis, strep, etc.)	100%, no copay	100%, no copay	70% of MAA subject to the deductible
X-Rays, including diagnostic mammograms (facility charges)	100%, no copay	100%, no copay	70% of MAA subject to the deductible
Emergency Department	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)

* Primary Care Physicians (PCP) include Internal Medicine, General or Family Practice and Pediatrics

** Specialists include Allergist, Cardiologist, Dermatologist, Orthopedist, Podiatrist, Ear/Nose/Throat, Gastroenterologist, Optometrist, Ophthamalogist, etc. OB/GYN visits other than annual preventive exam also covered at Specialist level.

*** n/a – not applicable

**** MAA – Maximum Allowable Amount

Special note: Northeast Medical Group (NEMG) physicians are Anthem PPO in-network providers. Their services are not covered under the "YNHHS Facility" tier.

>>	YALE-NEW HAVEN ADVANTAGE PLUS PLAN		
SERVICE	**YNHH FACILITY**	**ANTHEM PPO PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Urgent Care Facility	100%, no copay*	$50 copay (copay waived if admitted)	n/a **
High Cost Diagnostic Imaging PET/SPECT/ MRI/MRA/CTA/CAT (facility charges)	100%, subject to the deductible	100%, subject to the deductible and a $250 copay	70% of MAA*** subject to the deductible
Outpatient Surgery (hospital or surgi-center facility charges)	100%, subject to the deductible	100%, subject to the deductible and a $700 copay	70% of MAA subject to the deductible
Doctor or Surgeon Services (other than an office visit)	n/a	100%, subject to the deductible	70% of MAA subject to the deductible
Inpatient Hospital Services (room and board, lab work, medical supplies and other hospital ancillary services)	100%, subject to the deductible	100%, subject to the deductible and a $1,000 copay per admission (up to three copays per year)	70% of MAA subject to the deductible
Inpatient Behavioral Health Treatment (facility charges)	100%, subject to the deductible	100%, subject to the deductible and a $300 copay per admission (up to three copays per year)	70% of MAA subject to the deductible
Inpatient Substance Abuse Treatment (facility charges)	100%, subject to the deductible	100%, subject to the deductible and a $300 copay per admission (up to three copays per year)	70% of MAA subject to the deductible
Ambulance	n/a	100%, subject to the deductible	100%, subject to the deductible

* YNHHS Free-Standing Urgent Care Facilities include the following:
- Fairfield Urgent Care Center – 390 Stillson Road, Fairfield, CT
- Huntington Walk-In Medical Center – 887 Bridgeport Avenue, Shelton, CT
- YNHH Urgent Care Center – 317 Foxon Road, East Haven, CT

** n/a – not applicable

*** MAA – Maximum Allowable Amount

>>	YALE-NEW HAVEN ADVANTAGE PLUS PLAN		
SERVICE	**YNHH FACILITY**	**ANTHEM PPO PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Skilled Nursing Facility (up to 120 days per calendar year after a hospital stay)	n/a *	100%, subject to the deductible	70% of MAA ** subject to the deductible
Home Health Care (up to 120 days per calendar year)	n/a	100%, subject to the deductible	70% of MAA subject to the deductible
Durable Medical Equipment	n/a	100%, subject to the deductible	70% of MAA subject to the deductible
Infusion Therapy	100%, subject to the deductible	100%, subject to the deductible	70% of MAA subject to the deductible
Hospice Care (up to 60 days per calendar year)	n/a	100%, subject to the deductible	70% of MAA subject to the deductible
Orthotics	n/a	50%, subject to the deductible	50% of MAA subject to the deductible
Infertility Services Phases II and III treatment, plus medication (up to maximum lifetime benefit of $8,000)	n/a	50%, subject to the deductible	50% of MAA subject to the deductible
Specialized Infant Formula	n/a	50%, subject to the deductible	50% of MAA subject to the deductible

* n/a – not applicable

** MAA – Maximum Allowable Amount

BENEFITS FOR MASTECTOMY SERVICES

The Yale New Haven Health Advantage Plus Plan and the Yale New Haven Health Advantage Plan provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). In line with medical expenses, the Maximum Allowable Amount is the most the plan will consider paying for mastectomy services.

Keep this notice for your records and call the plan administrator for more information.

Precertification

WHEN YOU MUST PRECERTIFY

You must notify Anthem Blue Cross and Blue Shield by calling **1-800-238-2227** (in Connecticut) or **1-800-248-2227** (out-of-state) before receiving any of these services:

- Inpatient stays in a hospital, skilled nursing facility, mental health and substance abuse treatment center, hospice, subacute care, or acute rehabilitation facility.
- Organ/tissue transplants.
- High cost diagnostic imaging services prescribed by an out-of-network provider.

WHEN TO NOTIFY ANTHEM BLUE CROSS AND BLUE SHIELD

For inpatient stays, you must notify Anthem Blue Cross and Blue Shield of the scheduled admission date at least **24 hours before the start of the hospital stay**.

Pregnancy is subject to these notification time periods:

- **Non-Emergency Inpatient Hospital Stay Without Delivery of Child**: A hospital stay during pregnancy but before the admission for delivery, which isn't emergency care, requires notification before the admission.
- **Inpatient Confinement for Delivery of Child**: Anthem Blue Cross and Blue Shield must be notified only if the inpatient care for the mother or child is expected to continue more than 48 hours after a normal vaginal delivery, or more than 96 hours after a cesarean section. For inpatient care (for either mother or child) that continues past these 48/96 hour limits, Anthem Blue Cross and Blue Shield must be notified before the end of these time periods.

Expecting?

When you first become pregnant, contact ActiveHealth Maternity **1-866-938-0320** to enroll in this special prenatal care program. You'll receive educational materials and support from a nurse who specializes in prenatal care. A special incentive for participating is a personalized outfit for your new baby.

ORGAN/TISSUE TRANSPLANT NOTIFICATION

You must notify Anthem Blue Cross and Blue Shield as soon as possible before the scheduled date of any of the following services, or as soon as reasonably possible:

- evaluation,
- donor search,
- organ procurement/tissue harvest, or
- transplant.

Anthem Blue Cross and Blue Shield will then complete the utilization review. You, your doctor, and the facility will receive a letter confirming the results of the review.

EMERGENCY AND URGENT CARE NOTIFICATION

When emergency or urgent care is required and results in a hospital admission, you (or your representative or doctor) must call Anthem Blue Cross and Blue Shield **within 48 hours of admission**.

NEW!
Help with chronic conditions

Effective January 1, 2012, YNHHS has partnered with a new vendor—ActiveHealth Management—to provide confidential coaching and support for employees and covered dependents who have a variety of chronic health conditions. These include coronary artery disease, high blood pressure, diabetes, cancer, as well as gastrointestinal, orthopedic and pulmonary problems. You may receive an invitation to participate in this special program.

BENEFIT REDUCTION IF ANTHEM BLUE CROSS AND BLUE SHIELD IS NOT CALLED

If you fail to precertify your care, your benefits will be reduced as follows:

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

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Your mental health and substance abuse treatment benefits are also provided through Anthem Blue Cross and Blue Shield. You receive maximum benefits when you go in-network but you can always choose to go out-of-network and use any provider you like.

You must notify Anthem at **1-800-934-0331** before receiving any of these services:

- Inpatient stays in a mental health and substance abuse treatment center, or
- Outpatient visits beyond the 20th visit.

IF YOU ARE COVERED BY TWO PLANS

The Yale-New Haven Health medical and dental plans have coordination-of-benefits provisions that help prevent duplication and overpayment of benefits when you or covered members of your family are covered by more than one plan. Here's how it works:

- If you're the patient, our plan pays benefits first. The other plan then may pay benefits according to its coordination-of-benefits rules after you submit the claim.
- If your spouse is the patient, his or her plan will pay benefits first. Our plan will pay its normal benefits, minus any benefits paid by your spouse's plan. This means you won't receive any benefits from our plan if your spouse's plan pays benefits that are equal to or greater than the benefits our plan would otherwise pay.
- If your child is the patient and he or she is covered by our plan and your spouse's plan, the plan that will pay benefits first is determined by when your or your spouse's birthday occurs. The plan of the person whose birthday occurs earlier in the year will pay benefits first. If our plan pays benefits second, its normal benefit will be reduced by the amount paid by the other plan.

Employee Assistance and Work/Life Services

An additional resource available to you and your family *at no cost* is the YNHHS Employee and Family Resources program. Effective January 1, 2012, the new system-wide vendor will be ValueOptions. This **confidential** program can help with a wide range of behavioral health and work/life concerns, including relationship issues, anxiety/depression, alcohol and substance abuse problems, childcare/eldercare needs, legal and financial concerns, etc. **You can receive up to six sessions with a counselor. It's free and confidential**. You many want to consider using this resource BEFORE accessing your Anthem behavioral health benefits. Call ValueOptions toll-free, 24/7 at 1-877-275-6226.

FILING MEDICAL CLAIMS

If you obtain care from a Yale-New Haven Health System or Anthem PPO provider, there generally are no claim forms to file. You simply pay any required copay directly to the provider and the plan will pay benefits directly to that provider.

To file a claim when expenses are incurred from a non-PPO provider, get a claim form and instructions from the Benefits Department. Remember, separate claim forms are needed for each person for whom a claim is made.

Benefits for hospital expenses are paid directly to the hospital unless you submit a bill as proof that you already paid the hospital. Other benefits to which you're entitled are paid directly to you unless you assign them to a specific provider. If you assign benefits, you'll be notified of the payments made so that you'll know if any portion of the bill isn't covered by the plan.

Prescription Drug Coverage

Your prescriptions will be covered automatically under a program administered by CVS Caremark, one of the country's largest prescription drug administrators. This program offers two cost-effective ways to fill prescriptions for covered drugs and medications: at participating retail pharmacies and, when you need maintenance drugs, use the CVS Caremark "Maintenance Choice Program."

You may fill up to a **30-day supply** of a prescription at over 5,000 participating pharmacies in the Connecticut, New York, and New Jersey area (53,000 nationwide), including most independent drug stores and at major pharmacy chains (such as CVS, Rite-Aid, Brooks and Walgreen's). To determine if a pharmacy is a part of the CVS Caremark network, visit the online pharmacy provider directory at **www.caremark.com**

When you fill a short-term prescription at a participating pharmacy, simply present the prescription and your CVS Caremark prescription drug card. You'll pay:

TIER 1

$6 copay* per prescription if it's filled with a generic drug, or

TIER 2

20% coinsurance per prescription ($30 minimum*; $55 maximum), if it's filled with a brand-name drug that's on the list of preferred brand drugs called the "formulary",

or

TIER 3

40% coinsurance per prescription ($50 minimum*; $95 maximum), if the brand-name drug isn't on the list of preferred brand drugs.

TIER 4

Specialty Drugs, see page 13.

|| IMPORTANT ||

Prescriptions filled at non-participating pharmacies will not be covered unless you need to fill a prescription in an emergency that occurs while out-of-state. In this case, you'll pay the full cost of the prescription at the time it's filled and later file a claim for reimbursement with CVS Caremark.

For long-term, maintenance medications, you are to use the CVS Caremark "**Maintenance Choice Program**." This program allows you to save money and to get up to a 90-day supply of a maintenance drug either through the CVS Caremark Mail Service Program or at any CVS pharmacy. The choice is yours. However, please note that whatever option you choose your prescription for up to the 90-day supply must be on file at that pharmacy.

When you fill a prescription under the "Maintenance Choice Program," you'll pay:

TIER 1

$15 copay* per prescription if it's filled with a generic drug, or

TIER 2

20% coinsurance per prescription ($60 minimum*; $110 maximum), if it's filled with a brand-name drug that's on the list of preferred brand drugs called the "formulary", or

TIER 3

40% coinsurance per prescription ($100 minimum*; $190 maximum), if the brand-name drug isn't on the list of preferred brand drugs.

* **Minimum Copay** – If the actual cost of a drug is less than the minimum copay, you will pay the lower amount.

MAINTENANCE DRUGS

These are medications that you take regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, arthritis, diabetes or high cholesterol. Oral contraceptives also fall into this category. Using the "Maintenance Choice Program" for these medications not only saves you money in lower copays for a larger supply but also saves our self insured plan money too. In view of the potential savings, maintenance drugs are only available through the "Maintenance Choice Program" after receiving two 30-day fills at any retail pharmacy.

The drugs covered under the prescription drug program include:

- legend drugs (drugs that require a prescription)
- compounded drugs
- insulin
- diabetic supplies (such as syringes, test strips, lancets, glucometers, etc.)
- oral contraceptives
- prenatal vitamins.

Some prescriptions require prior authorization before they can be filled. Your pharmacist will notify you if that is the case. If it is, your doctor will need to contact CVS Caremark at **(800)294-5979** for approval.

In addition, tobacco cessation medications such as Chantix and Zyban will be covered at the Tier 1 generic copay level.

Drugs and supplies not covered by the program include:

- medical devices and appliances
- experimental drugs
- drugs whose sole purpose is to promote or stimulate hair growth
- Retin A (for those over age 28)
- anorexiants (drugs for weight reduction)
- immunization agents, biological sera, blood or blood plasma
- infertility medications
- over-the-counter drugs and nutritional supplements
- ostomy supplies

More specific information about the prescription drug program (such as the preferred brand drugs list and mail order forms) will be sent to you with your prescription drug card.

Generic Drug Incentive

You are encouraged to use generic drugs rather than the more expensive brand name drugs, whenever that option exists. If a generic drug is available and you choose to have the prescription filled with brand name drug, you will pay the brand name coinsurance, plus the difference in ingredient cost between the generic and brand name drug. This is true even if your doctor has indicated "Dispense As Written" or "No Substitutions". All participating pharmacies have a copy of the formulary, so your pharmacist can check whether your medication is included before dispensing the prescription. You can also access the formulary listing at the CVS Caremark website at **www.caremark.com** or call customer service at **(877) 636-0406**.

Specialty Rx Program exists for certain high cost specialty drugs, including select injectables and oral medications. Employees and dependents using such specialty drugs will be able to obtain them exclusively through Caremark Connect Specialty Pharmacy Services at 1-800-237-2767. Expedited mail service and other services are available to the participants in the program. Your copay will be:

TIER 4

40% coinsurance per prescription ($95 maximum) up to 30-day supply for specialty drugs.

STEP THERAPY PROGRAM

Effective January 1, 2012, the step therapy program offered by CVS Caremark will be expanded to include 12 classes of drugs (the PPI class was implemented on January 1, 2011), including medications that treat high cholesterol, high blood pressure, sleep aids, depression and others. If you are currently taking, or are newly prescribed, a brand name drug in any of the 12 classes, you will be required to use a generic drug first before receiving coverage of the brand name drug.

Vision Care Coverage

With the importance so many of us place on good eyesight, it is good to know that a vision care plan is available to you. This coverage will help pay for certain vision care expenses, such as eye exams, corrective lenses, frames and contact lenses. The plan is administered by **Vision Service Plan (VSP)** and its national network of vision care providers.

Vision care coverage is selected separately from medical and dental coverage. You may elect a different coverage category than you elect for those plans:

- Employee (yourself only)
- Employee + Spouse; Civil Union Partner
- Employee + 1 Child (yourself and one child)
- Family (yourself and two or more family members)

If you elect coverage, the benefit you receive is based on the vision care service or product you receive and whether you use an in-network or out-of-network provider.

By choosing an in-network provider – a provider affiliated with VSP – you get the highest level of benefits available from the plan, as indicated on the chart that follows.

Find a VSP in-network provider at **www.vsp.com** or call **1-800-877-7195**

	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Eye Exam	Covered in full every 12 months after a $15 copay.	Covered up to $45 every 12 months.
Corrective Lenses	Standard lenses (including glass or plastic single vision, bifocal or trifocal) are covered in full every 12 months after a $15 copay for lenses and frames.	Up to $45 for single vision lenses; bifocals up to $60 and trifocal up to $73 every 12 months.
Frames	Large selection of frames are covered in full (up to $155) every 24 months. Plus, 20% discount off any out-of-pocket costs.	Up to $47 every 24 months.
Contact Lenses	$155 allowance every 12 months when you choose contacts instead of glasses. Plus, the VSP doctor provides a 15% discount off his/her professional services.	Up to $105 every 12 months when you choose contacts instead of glasses.

Additional informaton about the vision care coverage is available in your Benefits Office or online at **www.vsp.com**.

Dental Coverage

Dental coverage is selected separately from medical and vision care coverage, and you may elect a different coverage category than you elect for medical coverage:

- Employee (yourself only)
- Employee + Spouse; Civil Union Partner
- Employee + 1 Child (yourself and one child)
- Family (yourself and two or more family members).

TWO DENTAL OPTIONS

You are able to choose dental coverage under one of the following plans:

- Delta Dental Plus, or
- Delta Dental Basic.

Or, if you choose, you may elect to waive dental coverage.

Delta Dental Plus provides coverage for preventive, restorative, major, and orthodontic services. This option may be right for you if you want the higher level of coverage provided by this option and you're willing to pay the higher premiums for this coverage.

Delta Dental Basic provides coverage for preventive and restorative services. This option may be right for you if you believe you need a lower level of dental coverage. As a result, your premiums are lower for this coverage.

HOW THE OPTIONS COMPARE

This chart highlights the main features of the Dental Plan options, and shows how the benefits compare. Benefits may be subject to certain limits and restrictions.

PLAN PROVISIONS	DELTA DENTAL PLUS	DELTA DENTAL BASIC
PREVENTIVE SERVICES • Regular exams, cleanings twice per calendar year • Fluoride treatments for children under age 19 (once per calendar year) • Full mouth X-rays (once every 3 years) • Bite-wing X-rays (twice per calendar year) • Space maintainers for children under age 14 • Sealants for children under age 16 (once per lifetime per approved tooth)	100% of MAA, no deductible	100% MAA, no deductible
RESTORATIVE SERVICES • Consultations (once per specialty in a calendar year) • Fillings – composite and amalgam • Extractions, oral surgery • Repair of dentures (repair of existing prosthetic appliances) • Relining of removable appliances • Root canal therapy (once per 24 months) • Periodontics (frequency limitations apply)	80% of MAA, no deductible	80% of MAA, no deductible

PLAN PROVISIONS	DELTA DENTAL PLUS	DELTA DENTAL BASIC
MAJOR SERVICES • Crowns and crown-related procedures (once every 5 years, permanent teeth only, for ages 12 and older) • Bridgework (once every 5 years, for ages 16 and older) • Full and partial dentures • Inlays (in conjunction with an onlay) • Implants	50% of MAA, after deductible	No coverage
ORTHODONTIC SERVICES • Limited to once per lifetime per covered person	50% of MAA, up to lifetime maximum benefit	No coverage
TMJ SERVICES • Limited to once per lifetime per covered person	50% of MAA, up to lifetime maximum benefit	No coverage
CALENDAR YEAR DEDUCTIBLE (does not apply to preventive care)	$50 individual $100 family maximum	$50 individual $100 family maximum
INDIVIDUAL MAXIMUM CALENDAR YEAR BENEFIT (excluding orthodontic benefits)	$1,700	$1,000
INDIVIDUAL ORTHODONTIC LIFETIME MAXIMUM BENEFIT	$1,700	No coverage
INDIVIDUAL TMJ LIFETIME MAXIMUM BENEFIT	$1,700	No coverage

THE DENTAL PLAN NETWORK

Whether you choose coverage under the Delta Dental Plus or Delta Dental Basic option, the dental plan offers discounts if you use a dentist participating in the Delta Dental network. You'll generally pay less, because participating dentists have agreed to provide services at discounted rates. You'll also be able to receive services from dentists who don't participate in the network, although your out-of-pocket payments will generally be more.

In addition, you should know the following about Delta Dental coverage:

- **What is a Delta participating dentist?** In order for dentists to participate with Delta Dental, they must first prefile dental fees for all procedures. If the fees are consistent with Delta's reasonable and customary levels, the dentist is invited to participate. A participating dentist may not charge a Delta participant an amount that exceeds the fee that has been filed. Therefore, if you use a participating dentist, the problem of being billed for the difference in what a dentist charges and what the dental plan considers to be reasonable and customary for a particular procedure cannot occur.
- **Are there any other advantages to using a Delta participating dentist?** Yes. Participating dentists have Delta claim forms in their offices. They will file the claim directly to Delta for you. In turn, Delta will pay the dentist directly. You're responsible for paying the deductibles and coinsurance.
- **May I still use a dentist who doesn't participate in the Delta Dental network?** Yes. Delta will process the claim using the same plan provisions. The benefit payment, however, will be sent to you, and not the dentist. You'll be responsible for paying the dentist.
- **Are claim forms necessary?** Yes and no. Our dental plan still requires claim forms. Delta participating dentists, however, will have claim forms and will file the claim directly with Delta for you. In fact, many

Delta dentists file claims electronically without the use of claim forms. If your dentist isn't a Delta participating dentist, claim forms are available from your Benefits Department.

- **How can I find the names of Delta participating dentists?** Call Delta at 1-800-335-8265 for the most current information on participating dentists in your area. In addition, a list of participating dentists is available online at www.deltadentalnj.com.
- **Does Delta Dental have a toll-free member services number I can call if I have questions about my dental coverage?** Delta's automated voice response system is available for your use 24 hours a day. By calling 1-800-452-9310, you can obtain information about eligibility, benefit plan provisions, or the status of a claim. If you'd like to speak to a Benefit Services representative, call the voice response system and enter "*." Delta representatives are available to answer any questions you may have from Monday through Friday, 8:00 a.m. to 6:30 p.m. Eastern time.

Special Enrollment Rule

Dental coverage elections can be changed only for even plan years (e.g. 2012, 2014....) unless there's a qualified "change-in-status" event (see page 25). This rule is intended to help control plan costs by limiting the ability to switch dental plan options based on current dental expenses, which can increase the cost of dental coverage for everyone.

PREDETERMINATION OF BENEFITS

Whenever the cost of any dental procedure will exceed $300, you should request a predetermination from Delta. A predetermination will let you and your dentist know how much the plan will pay for that procedure and how much you'll have to pay.

COORDINATION OF BENEFITS

Refer to page 11 for rules on how dental plans will coordinate benefits when you are covered by two dental plans.

The Health Care Reimbursement Account

A Health Care Reimbursement Account lets you pay, with pre-tax dollars, eligible health care expenses that aren't reimbursed elsewhere. This means that you'll save money when you pay for such expenses from a Health Care Reimbursement Account compared with paying for these expenses with after-tax dollars.

Contributions to a Health Care Reimbursement Account are free from federal income, Social Security (FICA) and Medicare, and state taxes. You make pre-tax contributions to the account and then reimburse yourself from the account after you pay an eligible expense. You aren't taxed on the reimbursements you receive from the account.

Each year during the annual enrollment period you decide whether or not to contribute money to a Health Care Reimbursement Account for the following calendar year. If you choose to waive contributions for any year, you may start contributions as of January 1 of any subsequent year, provided you're eligible for the plan at that time. In addition, changes to Health Care Reimbursement Account contributions during the year may be made only if there's a qualified "change-in-status" event (see page 25).

HOW MUCH YOU MAY CONTRIBUTE

You may contribute up to **a maximum of $5,000 per calendar year** on a pre-tax basis into a Health Care Reimbursement Account to pay for eligible health care expenses for you or any eligible dependents you claim on your federal income tax return. Neither you nor your dependents need to be covered under Yale-New Haven Health's medical or dental plan to be eligible for reimbursement under the Health Care Reimbursement Account.

Contributions you make to a Health Care Reimbursement Account aren't subject to Social Security (FICA) taxes. If your pay is at or below the Social Security taxable wage base, however, your Social Security wages for the year will be lower, which could result in slightly reduced

Social Security benefits in the future. If you have any questions on how Social Security benefits are affected, you should contact a qualified tax advisor.

|| IMPORTANT ||

Plan your contributions to a Health Care Reimbursement Account carefully – according to IRS rules, any amounts remaining in your account at year-end must be forfeited. In addition, once you make an election to contribute to the Health Care Reimbursement Account, you may change it during a calendar year only for qualified "change-in-status" events and provided the status change requires a contribution change consistent with that event. See page 25 for more information on qualified "change-in-status" events.

HOW YOU ARE REIMBURSED

When you have an eligible expense:

- Complete a Medical Care Reimbursement Request form and attach supporting documentation of your expense. This may be an explanation of benefits (EOB) statement, a paid bill or receipt for services, and must include the date the service was provided. Canceled checks alone aren't acceptable.
- Mail the reimbursement form with supporting documentation to the claims administrator:

  Crosby Benefit Systems, P.O. Box 25172, Lehigh Valley, PA 18002-5172.
- Claims are processed daily by Crosby and reimbursement checks are mailed directly to your home.
- Another option is to use the HC FSA debit card that is issued to you.

You'll have until March 31st after the plan year in which an eligible expense is incurred to file a claim for reimbursement. In addition, you have until March 15, to incur an eligible expense and have it applied to the previous year's account balance, if necessary.

ELIGIBLE HEALTH CARE EXPENSES

Eligible expenses that may be reimbursed from a Health Care Flexible Spending Account include your eligible health care expenses — and those of your eligible family members who you claim as dependents on your federal income tax return — that are not reimbursed by your YNHH health care coverage, or any other health care coverage you may have. However, the expense must have been incurred while you were a participant in the Plan. Typically, expenses eligible for reimbursement through your health care account include:

- Deductibles;
- Copayments and coinsurance for medical, dental, vision care and prescription drug expenses;
- Routine physical exams (except employment-related physicals);
- Well-baby care (not covered under the medical plan);
- Amounts over the Maximum Allowable Amount for health care expenses;
- Childbirth classes to address specific medical issues (reimbursable for the mother-to-be);
- Orthodontic expenses, unless for cosmetic purposes;
- Over-the-counter drugs being used to treat a specific medical condition, including cough and cold medicines and pain relief medications (require a prescription to be reimbursable);
- Smoking cessation programs and smoking cessation drugs that are prescribed by a physician;
- Birth control pills and devices prescribed by a doctor;
- Hearing aids;
- Hospitalization, including private room coverage;
- Eye exams, eyeglasses, lenses and frames, contact lenses and contact lens solution and supplies;
- Medical expenses to buy or rent crutches;
- Medical expenses paid for ambulance services;

- Mileage when you use your car for medical reasons;
- Most other unreimbursed health care expenses incurred during the plan year that could qualify as a deductible health care expense on your income tax return (except the premiums for coverage under another employer's plan);
- Breast reconstruction surgery after a mastectomy;
- Laser eye surgery;
- Non-prescription equipment, supplies, or diagnostic devices, including equipment such as crutches, bandages and diagnostic devices such as blood sugar test kits. The equipment, supplies or devices must be used to diagnose, cure, mitigate, treat or prevent disease, or be for the purpose of affecting any structure or function of the body;
- Participation in a weight-loss program as a treatment for the disease of obesity. A letter of medical necessity from your doctor is required for reimbursement of this expense; and,
- Surgery or procedures that ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

The Health Care Reimbursement Account may reimburse eligible health care expenses only; it may not be used to reimburse you for day care or home care expenses. These expenses may be covered by the Dependent Care Reimbursement Account.

INELIGIBLE EXPENSES

Expenses that are not eligible for the health care tax deduction under the Internal Revenue Code are not eligible for reimbursement through the health care account. Examples of ineligible expenses are:

- The cost of most types of cosmetic surgery, including breast augmentation, face lifts, hair transplants, hair removal (electrolysis), and liposuction;
- Premiums for another health care plan (such as your spouse's plan);
- Vitamins (unless prescribed by a physician);
- The cost of providing reduced-calorie diet foods or beverages that substitute for what you would normally consume to satisfy your nutritional needs is not a qualified medical expense;
- Transportation expenses to and from work–even if a physical condition requires special means of transportation;
- Health spas, health club dues and exercise classes;
- Custodial care in an institution;
- Weight reduction classes, except as part of the treatment of a specific disease diagnosed by a physician, such as obesity, hypertension or heart disease;
- Teeth whitening procedures;
- Maternity clothing or diaper services;
- Vacation or travel, even when taken for general health purposes;
- Telephone and television charges for hospital inpatients; and,
- Baby-sitting expenses to enable you to get to a doctors' appointment.
- Expenses incurred when you were not a participant in the Plan.

A complete listing of eligible and ineligible expenses is contained in IRS Publication 502, accessible through the internet at www.irs.ustreas.gov or by calling the IRS at 1-800-829-3676.

DECIDING HOW MUCH TO CONTRIBUTE

How much you should deposit for the year depends on the unreimbursed health care expenses you expect to have. Use the worksheet below to estimate your health care expenses for yourself and your eligible dependents. Consider your expenses for the current year and the expenses you think you will have for the coming year.

ESTIMATED HEALTH CARE COSTS		
	LAST YEAR	THIS YEAR
medical plan deductible	$	$
medical plan copay/coinsurance	$	$
dental plan deductible	$	$
dental plan coinsurance	$	$
vision care expenses	$	$
hearing care expenses	$	$
other health care expenses	$	$
total	$	$

WORKING OUT YOUR HEALTH CARE REIMBURSEMENT ACCOUNT CHOICES

Before making your choices for any year, consider the following:

- What have your health care expenses been in past years? Were these typical?
- What expenses do you anticipate for next year? (For example, orthodontia, eyeglasses, contact lenses, or hearing aids, etc.)
- What are the deductibles, coinsurance, copays, and other payments under the medical and dental plans?
- Have you estimated your expenses as accurately as possible?
- Remember to plan your contributions carefully — under IRS rules, any unused contributions remaining in your Health Care Reimbursement Account at the end of the year will be forfeited.
- If you choose to make contributions to a Health Care Reimbursement Account for the upcoming calendar year, decide on the amount you want to contribute for the full calendar year. Your contributions will be made on a pre-tax basis.

The Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account is designed to reimburse you for eligible day care or home care expenses related to the care of an eligible individual — a dependent child under age 13, a disabled parent or spouse, or other dependent while you and your spouse (if you're married) work, if your spouse is a full-time student, or if your spouse is unemployed and looking for work. **But this account may not be used to reimburse health care expenses or any expense other than eligible dependent care expenses**.

Contributions to a Dependent Care Reimbursement Account are free from federal income, Social Security (FICA) and Medicare, and state taxes. You make pre-tax contributions to the account and then reimburse yourself from the account after you pay an eligible expense. You aren't taxed on the reimbursements you receive from the account.

Each year during the annual enrollment period you decide whether or not to contribute money to a Dependent Care Reimbursement Account for the following calendar year. If you choose to waive contributions for any year, you may start contributions as of January 1 of any subsequent year, provided you're eligible for the plan at that time. In addition, changes to Dependent Care Reimbursement Account contributions during the year may be made only if there's a qualified "change-in-status" event (see page25).

HOW MUCH YOU MAY CONTRIBUTE

If you're married, you may contribute **up to $5,000 per calendar year** if you file a joint tax return or **up to $2,500 per year** if you're married and file separate returns.

If you're single, separated, or divorced, you may deposit **up to the full $5,000** per year.

In addition, IRS regulations limit the amount you may contribute to the lesser of your annual pay or your spouse's annual pay. For example, if you earn $50,000 and your spouse earns $4,000, you may not contribute more than $4,000.

Your contributions to a Dependent Care Reimbursement Account are made on a **pre-tax basis**.

Contributions you make to a Dependent Care Reimbursement Account aren't subject to Social Security (FICA) taxes. If your pay is at or below the Social Security taxable wage base, however, your Social Security wages for the year will be lower, which could result in slightly reduced Social Security benefits in the future. If you have any questions on how Social Security benefits are affected, you should contact a qualified tax advisor.

|| IMPORTANT ||

Plan your contributions to a Dependent Care Reimbursement Account carefully — according to IRS rules, any amounts remaining in your account at year-end must be forfeited. In addition, once you make an election to contribute to the Dependent Care Reimbursement Account, you may change it during a calendar year only for qualified "change-in-status" events and provided the status change requires a contribution change consistent with that event. See page 25 for more information on qualified "change-in-status" events.

HOW YOU ARE REIMBURSED

- When you have an eligible expense during the year, you'll first pay the expense. Then you may file a claim for reimbursement from your account. Dependent care providers may not be paid directly from your account.
- Complete a Dependent Care Reimbursement Request form and attach supporting documentation. On your form you must give your care provider's name, address, Social Security number (or taxpayer ID number), and dates care was provided. If the care provider is a church, religious organization, or other non-profit organization, the IRS doesn't require a taxpayer identification number, but you still must provide the name and address and a statement certifying the organization's tax exempt status.
- Mail the reimbursement form with supporting documentation to the claims administrator:

  Crosby Benefit Systems, P.O. Box 25172, Lehigh Valley, PA 18002-5172.
- Claims are processed daily by Crosby and reimbursement checks are mailed directly to your home.
- Dependent care expenses can be reimbursed only up to the amount contributed to your account when your claim is processed. If your claim is larger than your account balance, you'll be reimbursed for the balance as you make additional contributions during the year.

You'll have until March 31st after the plan year in which an eligible expense is incurred to file a claim for reimbursement.

ELIGIBLE DEPENDENT CARE EXPENSES

Typically, expenses eligible for reimbursement through your dependent care account include:

- Wages and taxes paid for a baby sitter, housekeeper or other care provider who comes to your home and provides care that permits you to work. Expenses for services necessary for you to run your home can be included if the majority of your expenses are for the well-being and protection of a qualifying dependent;
- Payments made to an individual who provides care in his/her home;
- Payment of payroll taxes in connection with compensation paid to a service provider; including Social Security, federal unemployment tax or similar state payroll taxes;
- Payments to a child or adult day care center, excluding nursing home charges.The facility must comply with all state and local regulations. In addition, if the qualifying person receiving care is mentally or physically disabled, he or she must spend at least eight hours a day in your home;
- Nursery school or private kindergarten (day care portion); and,
- Payments for after-school programs, summer day camp or school vacation programs for dependents through age 12.

You cannot be reimbursed for expenses paid to one dependent to care for another dependent if the provider is under age 19 or can be claimed as an exemption on your tax return.

You also **cannot** be reimbursed for dependent health care expenses through this account. Health care expenses for your dependents may be reimbursed through your health care account, as long as you have one.

INELIGIBLE EXPENSES

Certain expenses are not eligible for payment through the Dependent Care Flexible Spending Account, including expenses incurred before you were a participant in the Plan and the following:

- Expenses such as food, clothing or entertainment for the care of an eligible dependent, unless they are incidental and cannot be easily separated from the cost of dependent care;
- Education in kindergarten or higher;
- Expenses for transportation to or from the day care center;
- Expenses for 24-hour nursing home care;
- Expenses for an overnight camp;
- Health care expenses for a dependent; and,
- Payments made to any person caring for your dependent when you or your spouse are not working (unless he/she is a full-time student or disabled), or while you or your spouse are engaged in volunteer work.
- Expenses incurred when you were not a participant in the Plan.

A complete listing of eligible and ineligible expenses is contained in IRS Publication 503, accessible through the internet at www.irs.ustreas.gov or by calling the IRS at 1-800-829-3676.

DECIDING HOW MUCH TO CONTRIBUTE

How much you should deposit to a Dependent Care Reimbursement Account for the year depends on the unreimbursed dependent day care expenses you expect to have. Typically, these expenses are fairly predictable. Consider your expenses for the current year and the expenses you think you'll have for the coming year. Be sure you don't include any weeks where you'll be on vacation and with your children (in which case they wouldn't need day care).

ESTIMATED HEALTH CARE COSTS	LAST YEAR	THIS YEAR
weekly expense	$	$
multiplied by the number of weeks care is needed	$	$
total	$	$

WORKING OUT YOUR DEPENDENT CARE REIMBURSEMENT ACCOUNT CHOICES

When deciding whether or not to contribute to a Dependent Care Reimbursement Account for any year, consider the following:

- Are your dependent day care expenses predictable?
- Are you better off using the Dependent Care Reimbursement Account or the federal child care tax credit?
- Have you estimated your expenses as accurately as possible? (Remember not to count the time for vacations and holidays, for example, when day care may not be necessary.)
- Will you be able to provide a tax identification or Social Security number for your day care provider?
- Remember to plan your contributions carefully – under IRS rules, any unused contributions remaining in your Dependent Care Reimbursement Account at the end of the year will be forfeited.
- If you choose to make contributions to a Dependent Care Reimbursement Account for the upcoming calendar year, decide on the amount you want to contribute for the full calendar year. Your contributions will be made on a pre-tax basis.

Life Insurance

Life insurance provides financial assistance to your beneficiary if you should die while the coverage is in effect. The Hospital provides you with $100,000 life insurance coverage at no cost to you.

IMPUTED INCOME

Under IRS regulations, the value of employer-provided life insurance over $50,000 will be included in your gross pay as imputed income. That means you must pay taxes on the value of this coverage, as determined by IRS tables. The effect of imputed income depends on your age and the amount of your employer-provided life insurance coverage over $50,000. The overall tax impact of imputed income is relatively small.

Electing Changes During the Year

Payments you make for your coverage under FLEXplan are made with pre-tax dollars. Because the government is giving you a tax break, some restrictions apply on when you may change your coverage. Under federal law, you generally may elect changes to your FLEXplan coverage only once each year during the annual enrollment period. Choices made during an annual enrollment period will take effect on January 1 of the following year and will remain in effect for all of that year.

If you have any of the "change-in-status" events described at right, contact the Benefits Office for information on the changes you may elect to your FLEXplan coverage. **You must notify the organization within 31 days after a "change-in-status" event**. Once a coverage change is approved, it can take effect retroactive to the date of the "change-in-status" event.

According to IRS regulations, you may not change your benefit choices during the year unless you have a qualified "change-in-status" event, which include the following:

CHANGE IN STATUS EVENT	DESCRIPTION
MARITAL STATUS	A change in your legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment
NUMBER OF FAMILY	Events that change the number of eligible family members, including birth, adoption, or placement for adoption or death.
EMPLOYMENT STATUS	Any of the following events that change the employment status of you, your spouse (or civil union partner), or your child; termination or commencement of employment, a strike or lockout, the start of or return from an unpaid leave of absence, and a change in work site. In addition, if the eligibility conditions of this plan or another plan of the employer of you, your spouse (or civil union partner), or your child depend on the employment status of that individual and there is a change in that individual's employment status with the effect that the individual becomes eligible or ineligible under the plan, then that change constitutes a change in employment status.
FAMILY MEMBER MEETS OR NO LONGER MEETS THE ELIGIBILITY REQUIREMENTS	An event that causes a member of your family to meet or to no longer meet the plan's eligibility requirements for coverage. This may include, for example, a child reaching the maximum age for coverage, or a change in a child's student status.
RESIDENCE OR WORK SITE	A change in the place of residence or work site for you, your spouse (or civil union partner), or a child.

How to Enroll

THE ENROLLMENT PROCEDURE

The following information summarizes how to make your FLEXplan enrollment decisions during the annual enrollment period:

- Read the personalized benefits information mailed to you.
- Use the Benefits Planning Worksheet to select your benefits.
- Log on to www.ynhhsbenefits.com to elect your benefits.
- Contact the Benefits Office at 203-688-2401 if you have any enrollment questions or need assistance.

IF YOU DO NOT ENROLL

If you don't enroll, you'll lose the opportunity to make choices for yourself and your family, including the election of the "No Coverage" option. **In this case, you'll automatically have the following FLEXplan coverage**:

- If you're currently enrolled in the YNHH Advantage Plus Plan, you'll continue to be covered under that plan. Your current coverage category (Employee, Employee + Spouse/Civil Union Partner, Employee +1 Child, Family) will remain the same.
- If you aren't currently enrolled in the medical plan, you'll be enrolled with no coverage for your family (your coverage category will be Employee only).
- If you're currently enrolled in one of the dental plans or vision care plan, you'll continue to be covered under the plan(s). Your current coverage category (Employee, Employee + Spouse/Civil Union Partner, Employee +1 Child, Family) will remain the same.
- If you aren't currently enrolled in the dental plan or vision care plan, you won't be enrolled in the plan(s).
- Your current life insurance will remain in effect.
- You won't be able to participate in or contribute to the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account.

Yale New Haven Health System Disclosure Notices

The passage of the Patient Protection and Affordable Care Act and the Health Care and the Education Reconciliation Act of 2010 have required Yale New Haven Health System to provide notices to employees pertaining to medical plan changes that took effect for plan years beginning after September 23, 2010. Based on the changes that have been made in medical plan design for the 2012 calendar year, the following new Disclosure Notices are required by the Department of Health and Human Services, the Department of Labor and the Internal Revenue Service.

RIGHT TO CHOOSE PROVIDER NOTICE

The Yale New Haven Health Advantage Plus and Advantage Medical Plans allow (but do not require) the designation of a primary care provider. You have the right to designate any primary care provider who participates in Anthem's Century-Preferred network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, 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.

For information on how to select a primary care provider or for a list of participating primary care providers or health care professionals who specialize in obstetrics or gynecology, contact Anthem Member Services at 1-888-266-2896.

CLAIMS APPEALS NOTICE

Under the Plan's internal claims and appeal process, you can appeal any claim denial and any retroactive rescission of coverage under the Plan (referred to as "adverse benefit determinations"). If your claim regarding benefits or retroactive rescission of coverage is denied, in whole or in part, you will receive notice of the adverse benefit determination, which will include information sufficient to identify the claim, including the date of service, the health care provider, and the claim amount (diagnosis and treatment codes will be available upon request).

The notice must also include any applicable denial code and the meaning of the code, a discussion of the decision (if the decision is the final internal decision) and a description of the Plan's standard, if any, in denying the claim (for example, if the adverse benefit determination is based on medical necessity, the internal claim denial notice must include a description of medical necessity as defined under the Plan). The notice must also include a description of the available internal and external claims review processes, including how to initiate an appeal.

Any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim or appeal or any new or additional rationale for denial at the internal appeals stage, will be provided to the claimant free of charge along with a reasonable time for the claimant to respond to such information.

In addition, a voluntary external review process, performed by an independent review organization, is available for any adverse benefit determination involving medical judgment. "Medical judgment" includes:

- Medical necessity
- Appropriateness of care
- Health care setting
- Level of care
- Effectiveness of a covered benefit and
- Determinations as to whether a treatment or procedure is experimental or investigational.

Retroactive rescissions of coverage are also eligible for review under the voluntary external review process. For more information about the Plan's claims and appeals procedures, please contact Anthem Member Services at **1-888-266-2896**.

NOTICE REGARDING DEPENDENT COVERAGE TO AGE 26

Coverage of dependent children is extended until age 26 regardless of whether the dependent child is eligible for employer-based coverage through his or her own employment or his or her spouse's employment.

Important Telephone Numbers and Web Sites

This booklet presents highlights of Yale-New Haven Hospital's FLEXplan, as well as the FLEXplan enrollment decisions available to eligible employees of Yale-New Haven Hospital and certain affiliated organizations.

The information included here is intended only to summarize the features of the Hospital's FLEXplan. More detailed descriptions of the individual plans that comprise FLEXplan can be found in the plan documents that legally govern these plans. If there's any discrepancy between the information in this booklet and the plan documents, the plan documents will govern. In addition, statements of Hospital policies, benefits, and regulations in this booklet don't constitute the terms and conditions of an employment contract, either expressed or implied.
Yale-New Haven Hospital and affiliated organizations reserve the right to change its policies, benefits, and regulations at any time, without notice.

HEALTH CARE VENDORS:

ANTHEM BLUE CROSS/BLUE SHIELD

888-266-2896

www.anthem.com

CVS CAREMARK

877-636-0406

www.caremark.com

VISION SERVICE PLAN (VSP)

800-877-7195

www.vsp.com

DELTA DENTAL OF NJ

800-452-9310

www.deltadentalnj.com

CROSBY BENEFIT SYSTEMS

(HEALTH, DEPENDENT CARE, FLEXIBLE SPENDING ACCOUNTS)

866-918-9711

www.crosbybenefits.com

BENEFITS OFFICE:

YALE-NEW HAVEN HOSPITAL

203-688-2401

www.ynhh.org


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