

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to [www.ybenefits.org](http://www.ybenefits.org) or call 877-BEN-YMCA. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.ybenefits.org](http://www.ybenefits.org) or call 877-BEN-YMCA to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	Network: \$0 Individual / \$0 Family Non-Network: \$1,000 Individual / \$2,000 Family Per calendar year	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. The deductible does not apply to services listed with a copay, prescription drugs, and preventive care.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Network: \$3,500 Individual / \$7,000 Family Non-Network: \$13,000 Individual / \$26,000 Family Per calendar year	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members on the <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain prior authorization	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of network providers, see <a href="http://www.myuhc.com">www.myuhc.com</a> or call the Member Services number on the back of your ID Card.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No	You can see the specialist you choose without a <a href="#">referral</a> .



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 copay/office visit	40% coinsurance	None
	<a href="#">Specialist</a> visit	\$40 copay/office visit	40% coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Mammograms and pap smears: 40% coinsurance All other services: Not covered	You may have to pay for services that aren't preventive. Ask your provider if the needed services are preventive, then check what your plan will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	40% coinsurance	Some outpatient diagnostic tests require authorization – refer to the SPD for details. If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Authorization is required for imaging - refer to the SPD for details. If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myuhc.com">www.myuhc.com</a>	Tier 1 drugs	Retail: \$10 copay Mail order: \$25 copay	Not covered	Retail: up to a 31 day supply Mail order: up to a 90 day supply
	Tier 2 drugs	Retail: \$35 copay Mail order: \$85 copay	Not covered	Retail: up to a 31 day supply Mail order: up to a 90 day supply
	Tier 3 drugs	Retail: \$60 copay Mail order: \$150 copay	Not covered	Retail: up to a 31 day supply Mail order: up to a 90 day supply
	<a href="#">Specialty drugs</a>	\$60 copay, or deductible and 20% coinsurance if administered in an inpatient or outpatient setting	Not covered	Authorization is required and specialty drugs must be filled through the designated Specialty Pharmacy. Information is available on <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling 877-BEN-YMCA.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Authorization is required for outpatient surgeries-refer to the SPD for details.  If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Authorization is required for outpatient surgeries-refer to the SPD for details.  If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 copay (waived if admitted to the hospital within 24 hours)	\$250 copay (waived if admitted to the hospital within 24 hours)	You must notify UHC within 48 hours if admitted to a non-network hospital, or on the same day of admission if reasonably possible. If you are admitted to a non-network hospital and fail to notify UHC, you may be subject to a \$500 benefit reduction. Refer to the SPD for more details.*
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance	None

\* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at [www.ybenefits.org](http://www.ybenefits.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Urgent care</a>	\$50 copay	40% coinsurance	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Authorization is required for all scheduled admissions. If you are admitted to a non-network facility and fail to get authorization, you are subject to a \$500 benefit reduction.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Authorization is required for all scheduled admissions. If you are admitted to a non-network facility and fail to get authorization, you are subject to a \$500 benefit reduction.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	Authorization is required for partial hospitalization/day treatment, intensive outpatient program treatment, outpatient electro-convulsive treatment, psychological testing, transcranial magnetic stimulation, extended outpatient treatment visits beyond 45 - 50 minutes in duration (with or without medication management), and intensive behavioral therapy, including Applied Behavior Analysis (ABA).  If you use a non-network provider and fail to get authorization, you are a subject to a \$500 benefit reduction.
	Inpatient services	20% coinsurance	40% coinsurance	Authorization is required for inpatient services (including services at a residential treatment facility).  If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.
<b>If you are pregnant</b>	Office visits	\$25 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Authorization is required for maternity stays exceeding 48 hours for normal vaginal delivery and 96 hours for cesarean section delivery.  If you use a non-network facility and fail to get authorization, you are subject to a \$500 benefit reduction.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance	40% coinsurance	Authorization is required, 60 visit limit per calendar year.  If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.
	<a href="#">Rehabilitation services</a>	Outpatient: \$40 copay/office visit and 20% coinsurance for other outpatient services  Inpatient: 20% coinsurance	40% coinsurance	Outpatient: 30 visit limit per calendar year Inpatient: Authorization is required, 120 day limit per calendar year  If you use a non-network provider and fail to get authorization for inpatient rehabilitation or skilled nursing facility services, you are subject to a \$500 benefit reduction.
	<a href="#">Habilitative services</a>	\$40 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	Outpatient: 30 visit limit per calendar year
	<a href="#">Skilled nursing care</a>	20% coinsurance	40% coinsurance	Authorization is required, 120 day limit per calendar year  If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.

\* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at [www.ybenefits.org](http://www.ybenefits.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	20% coinsurance	40% coinsurance	Authorization is required for items obtained by a non-network provider that cost more than \$1,000 to purchase or rent. There is a \$2,000 calendar year limit for disposable medical supplies.  If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.
	<a href="#">Hospice services</a>	20% coinsurance	40% coinsurance	If you use a non-network provider and fail to get authorization, you are subject to a \$500 benefit reduction.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	1 visit per calendar year, up to age 6
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Children's glasses
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private duty nursing
- Routine eye care

**Your Rights to Continue Coverage:** Contact your Human Resources department. In addition, there are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also

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provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the number on the back of your ID card, or The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

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

**Does this plan meet the Minimum Value Standards? Yes**

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

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 877-BEN-YMCA

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-BEN-YMCA

Chinese (□ □): □ □ □ □ □ □ □ □ □ □ 请拨□ 这□ □ 码 877-BEN-YMCA

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 877-BEN-YMCA

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

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## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,570</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$720</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>