UnitedHealthcare®

YMCA: Network 1000

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2025-12/31/2025

Coverage for: Individual / Individual + Family | **Plan Type:** PPO

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 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 or call 877-BEN-YMCA to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $1,000 Individual / $2,000 Family Non-Network: $3,000 Individual / $6,000 Family Per calendar year	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. The deductible does not apply to services listed with a copay, prescription drugs, and preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $5,000 Individual / $10,000 Family Non-Network: $15,000 Individual / $30,000 Family Per calendar year	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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 out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.myuhc.com 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.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit	40% coinsurance	None
	Specialist visit	$45 copay/office visit	40% coinsurance	None
	Preventive care/screening/ immunization	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.
If you have a test	Diagnostic test (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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myuhc.com	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: $45 copay Mail order: $110 copay	Not covered	Retail: up to a 31 day supply Mail order: up to a 90 day supply
	Tier 3 drugs	Retail: $70 copay Mail order: $175 copay	Not covered	Retail: up to a 31 day supply Mail order: up to a 90 day supply
	Specialty drugs	$70 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 www.myuhc.com or by calling 877-BEN-YMCA.
If you have outpatient surgery	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.
If you need immediate medical attention	Emergency room care	$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.*
	Emergency medical transportation	20% coinsurance	20% coinsurance	None

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at 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)	
	Urgent care	$50 copay	40% coinsurance	None
If you have a hospital stay	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.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$45 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.
If you are pregnant	Office visits	$30 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).

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.
If you need help recovering or have other special health needs	Home health care	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.
	Rehabilitation services	Outpatient: $45 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.
	Habilitative services	$45 copay/office visit and 20% coinsurance for other outpatient services	40% coinsurance	Outpatient: 30 visit limit per calendar year
	Skilled nursing care	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.

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)	
	Durable medical equipment	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.
	Hospice services	20% coinsurance	40% coinsurance	If you use a non-network provider and fail to get authorization, you are subject to a $500 benefit reduction.
If your child needs dental or eye care	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. 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 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

* For more information about limitations and exceptions, see the Summary Plan Description (SPD) at www.ybenefits.org.

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.

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, kwiijigo holne' 877-BEN-YMCA

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

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 plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,370**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,970**

The plan would be responsible for the other costs of these EXAMPLE covered services.