



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, visit <https://portal.yuzu.health> or call +18774200785. 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.healthcare.gov/sbc-glossary or call +18774200785 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall deductible? | In Network: Individual: \$2,500.00, Family: \$5,000.00 Out of Network: Individual: \$5,000.00, Family: \$10,000.00 | 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? | Pharmacy: Preferred drug (30 day supply), Non-Preferred drug (90 day supply), Specialty drug (30 day supply), Non-Preferred drug (30 day supply), Preferred drug (90 day supply), Generic drug (30 day supply), Generic drug (90 day supply) In Network: Many services. See the grid below for details. | 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? | In Network: Individual: \$7,350.00, Family: \$14,700.00 Out of Network: Individual: \$14,700.00, Family: \$29,400.00 | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this 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, pre-certification penalties, balance-billed charges, & health care this plan doesn't cover. | 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? | You may pay less if you use a network provider. | |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | In Network: \$30.00 Copay Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| | Specialist visit | In Network: \$60.00 Copay Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| | Preventive care/screening/immunization | In Network: No charge Out of Network: 40% Coinsurance after deductible | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | In Network: No charge after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| | Imaging (CT/PET scans, MRIs) | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling +18885893340 | Generic drugs | 30 Day Supply: \$15.00 Copay 90 Day Supply: \$45.00 Copay | |
| | Preferred brand drugs | 30 Day Supply: \$45.00 Copay 90 Day Supply: \$90.00 Copay | |
| | Non-preferred brand drugs | 30 Day Supply: \$85.00 Copay 90 Day Supply: \$150.00 Copay | |
| | Specialty drugs | 30 Day Supply: 50% Coinsurance 90 Day Supply: Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | |
| | Physician/surgeon fees | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| If you need immediate medical attention | Emergency room care | In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible | |
| | Emergency medical transportation | In Network: 20% Coinsurance after deductible Out of Network: 20% Coinsurance after deductible | Some procedures may need pre-certification. |
| | Urgent care | In Network: \$60.00 Copay Out of Network: 40% Coinsurance after deductible | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|
| | Physician/surgeon fees | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | In Network: \$30.00 Copay Out of Network: 40% Coinsurance after deductible | |
| | Inpatient services | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| If you are pregnant | Office visits | In Network: \$30.00 Copay Out of Network: 40% Coinsurance after deductible | |
| | Childbirth/delivery professional services | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | |
| | Childbirth/delivery facility services | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| If you need help recovering or have other special health needs | Home health care | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | 60 visits per year. Some procedures may need pre-certification. |
| | Rehabilitation services | In Network: \$30.00 Copay Out of Network: 40% Coinsurance after deductible | 20 visits per year. Some procedures may need pre-certification. |
| | Habilitation services | In Network: \$30.00 Copay Out of Network: 40% Coinsurance after deductible | 20 visits per year. Some procedures may need pre-certification. |
| | Skilled nursing care | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | 60 days per year. |
| | Durable medical equipment | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | Some procedures may need pre-certification. |
| | Hospice services | In Network: 20% Coinsurance after deductible Out of Network: 40% Coinsurance after deductible | |
| If your child needs dental or eye care | Children's eye exam | \$0 | Limited to one exam every 24 months except if required more frequently under the Affordable Care Act |
| | Children's glasses | Not Covered | Glasses are not covered. |
| | Children's dental check-up | Not Covered | Dental services are not covered. |

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](#).)

Specialty drug (90 day supply), Infertility,
Hearing Aids, Experimental Therapies,

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

Electroconvulsive Therapy, Abortion,
Sterilization Reversal, Impotence, Massage,
Reporting Codes, Biofeedback, Surrogacy,
Gender Affirming Care, Obesity Treatment,
Orthopedic Shoes (Except Diabetics)

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

Injections, Adult Eye Exam, Private Duty
Nursing, Radiation and Chemotherapy,
Hospital Outpatient, Chiropractic Services,
Freestanding Laboratory,
Laboratory/Diagnostics, Cardiac
Rehabilitation, Acupuncture

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA. 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 provide complete information on how 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 Department of Labor's Employee Benefits Security Administration at www.dol.gov/ebsa/healthreform or 1-866-444-EBSA.

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](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next



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 pre-natal care and a hospital delivery)

■ The [plan's](#) overall [deductible](#)

\$2,500.00

| | |
|------------------------------------|------|
| ■ Specialist copay | \$60 |
| ■ 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 | \$12,700.00 |
|---------------------------|--------------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------------|
| Deductibles | \$2,500.00 |
| Copayments | \$120.00 |
| Coinsurance | \$2,040.00 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0.00 |
| The total Peg would pay is | \$4,660.00 |

Managing Joe's Type 2 Diabetes

(A year of routine care of a well-controlled condition)

■ The [plan's](#) overall [deductible](#)

\$2,500.00

| | |
|------------------------------------|------|
| ■ Specialist copay | \$60 |
| ■ 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](#) (*preferred brand*)
- [Durable medical equipment](#) (*glucose meter*)

| | |
|---------------------------|-------------------|
| Total Example Cost | \$5,600.00 |
|---------------------------|-------------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------------|
| Deductibles | \$2,500.00 |
| Copayments | \$75.00 |
| Coinsurance | \$620.00 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0.00 |
| The total Joe would pay is | \$3,195.00 |

Mia's Simple Fracture

(Emergency room visit and follow up care)

■ The [plan's](#) overall [deductible](#)

\$2,500.00

| | |
|------------------------------------|------|
| ■ Specialist copay | \$60 |
| ■ 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 | \$2,800.00 |
|---------------------------|-------------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|-------------------|
| Deductibles | \$2,500.00 |
| Copayments | \$30.00 |
| Coinsurance | \$60.00 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0.00 |
| The total Mia would pay is | \$2,590.00 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.