




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 +12032089898. 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](http://www.healthcare.gov/sbc-glossary) or call +12032089898 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>Coordinated Care: Individual: \$0.00, Family: \$0.00                      Uncoordinated Care: Individual: \$5,000.00, Family: \$10,000.00                      Coordinated Care: Individual: \$0.00, Family: \$0.00</p>	<p>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.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>FPC Coordinated Care: Many services. See the grid below for details.                      Pharmacy: Preferred drug (30 day supply), Non-Preferred drug (30 day supply), Specialty drug (30 day supply), Generic drug (30 day supply)                      Uncoordinated Care: Preventive Care</p>	<p>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>Coordinated Care: Individual: \$0.00, Family: \$0.00                      Uncoordinated Care: Individual: \$9,100.00, Family: \$18,200.00                      Coordinated Care: Individual: \$0.00, Family: \$0.00</p>	<p>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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Premiums, pre-certification penalties, balance-billed charges, &amp; health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of pocket limit.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the specialist you choose without a referral.

 All [copayment](#) and [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
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	25 visits per year. Coinsurance and deductible will apply after 25 sessions. Some procedures may need pre-certification.
	<a href="#">Specialist</a> visit	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	<a href="#">Preventive care/screening/immunization</a>	FPC Coordinated Care: No charge Uncoordinated Care: No charge	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	Imaging (CT/PET scans, MRIs)	FPC Coordinated Care: No charge Uncoordinated Care: 50% 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 +18447283479	Generic drugs	30 Day Supply: \$25.00 Copay, \$0 Copay (Magic Pill) 90 Day Supply: Not Covered	
	Preferred brand drugs	30 Day Supply: \$60.00 Copay 90 Day Supply: Not Covered	\$0 copay (if alternatively sourced).
	Non-preferred brand drugs	30 Day Supply: \$60.00 Copay 90 Day Supply: Not Covered	\$0 copay (if alternatively sourced).
	<a href="#">Specialty drugs</a>	30 Day Supply: \$100.00 Copay 90 Day Supply: Not Covered	\$0 copay (if alternatively sourced).

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
	Physician/surgeon fees	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	FPC Coordinated Care: \$500.00 Copay Uncoordinated Care: \$500.00 Copay	\$500 copay per visit (waived if admitted). If the visit is coordinated by First Primary Care (FPC), or if FPC subsequently confirms it met the prudent layperson standard for an emergency, the copay will be reimbursed to the member. Coverage of emergency services is not conditioned on FPC involvement .
	<a href="#">Emergency medical transportation</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
	<a href="#">Urgent care</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	Physician/surgeon fees	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	25 visits per year. Coinsurance and deductible will apply after 25 sessions.
	Inpatient services	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
<b>If you are pregnant</b>	Office visits	FPC Coordinated Care: No charge Uncoordinated Care: 50% 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
	Childbirth/delivery professional services	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	Childbirth/delivery facility services	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	100 visits per year. Some procedures may need pre-certification.
	<a href="#">Rehabilitation services</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	25 visits per year. Coinsurance and deductible will apply after 25 sessions. Some procedures may need pre-certification.
	<a href="#">Habilitation services</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	25 visits per year. Coinsurance and deductible will apply after 25 sessions. Some procedures may need pre-certification.
	<a href="#">Skilled nursing care</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	<a href="#">Durable medical equipment</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
	<a href="#">Hospice services</a>	FPC Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	180 visits per year. Some procedures may need pre-certification.
<b>If your child needs dental or eye care</b>	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:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>
Non-Preferred drug (90 day supply),

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

Preferred drug (90 day supply), Generic drug (90 day supply), Specialty drug (90 day supply), Obesity Treatment, Impotence, Sterilization Reversal, Massage, Travel Vaccines, Abortion, Orthopedic Shoes (Except Diabetics), Surrogacy, Biofeedback, Cosmetic Surgery

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

Hearing Aids, Acupuncture, Laboratory/Diagnostics, Chiropractic Services, Radiation and Chemotherapy, Hospital Outpatient, Infertility, Injections, Private Duty Nursing

**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](http://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](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 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist</a> copay	\$0
■ Hospital (facility) copay	\$0
■ Other copay	\$0

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>\$12,700.00</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$0.00
<a href="#">Coinsurance</a>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Peg would pay is</b>	<b>\$0.00</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist</a> copay	\$0
■ Hospital (facility) copay	\$0
■ Other copay	\$0

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*)

<b>Total Example Cost</b>	<b>\$5,600.00</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$60.00
<a href="#">Coinsurance</a>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$60.00</b>

### Mia's Simple Fracture

(Emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0.00
■ <a href="#">Specialist</a> copay	\$0
■ Hospital (facility) copay	\$0
■ Other copay	\$0

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>\$2,800.00</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0.00
<a href="#">Copayments</a>	\$500.00
<a href="#">Coinsurance</a>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Mia would pay is</b>	<b>\$500.00</b>

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