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 +1 (203) 208-9898. 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 +1 (203) 208-9898 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	First Primary Care Coordinated Care: Individual: $0.00, Family: $0.00 Uncoordinated Care: 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?	First Primary Care Coordinated Care: Many services. See the grid below for details. Uncoordinated Care: Urgent Care Pharmacy: Generic drug (30 day supply), Preferred drug (30 day supply), Non-Preferred drug (30 day supply)	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?	First Primary Care Coordinated Care: Individual: $0.00, Family: $0.00 Uncoordinated Care: Individual: $9,100.00, Family: $18,200.00	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?	Not applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to	No.	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

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 provider's office or clinic	Primary care visit to treat an injury or illness	First Primary Care Coordinated Care: No charge Uncoordinated Care: $55.00 Copay	
	Specialist visit	First Primary Care Coordinated Care: No charge Uncoordinated Care: $125.00 Copay	
	Preventive care/screening/ immunization	First Primary Care Coordinated Care: No charge Uncoordinated Care: No charge	
If you have a test	Diagnostic test (x-ray, blood work)	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Precert required. Failure to obtain pre-certification will result in a benefit reduction
If you need drugs to treat your illness or condition	Generic drugs	Pharmacy: $10.00 Copay	
	Preferred brand drugs	Pharmacy: $40.00 Copay	
	Non-preferred brand drugs	Pharmacy: $100.00 Copay	
	Specialty drugs	Pharmacy: Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
	Physician/surgeon fees	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
If you need immediate medical attention	Emergency room care	First Primary Care Coordinated Care: No charge Uncoordinated Care: $500.00 Copay	
	Emergency medical transportation	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Urgent care	First Primary Care Coordinated Care: N/A Uncoordinated Care: $95.00 Copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Precert required. Failure to obtain pre-certification will result in a benefit reduction
	Physician/surgeon fees	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Some procedures may need pre-certification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	25 visits per year.. Precert required. Failure to obtain pre-certification will result in a benefit reduction
	Inpatient services	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Precert required. Failure to obtain pre-certification will result in a benefit reduction
If you are pregnant	Office visits	First Primary Care Coordinated Care: No charge Uncoordinated Care: $125.00 Copay	
	Childbirth/delivery professional services	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
	Childbirth/delivery facility services	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	Precert required. Failure to obtain pre-certification will result in a benefit reduction
If you need help recovering or have other special health needs	Home health care	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	100 visits per year.. Precert required. Failure to obtain pre-certification will result in a benefit reduction
	Rehabilitation services	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	25 visits per year.. Precert required. Failure to obtain pre-certification will result in a benefit reduction
	Habilitation services	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
	Skilled nursing care	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	
	Durable medical equipment	First Primary Care Coordinated Care: No charge	Precert required if Claim exceeds $1,500.00

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
		Uncoordinated Care: 50% Coinsurance after deductible	or Claim duration 90 days. Failure to obtain pre-certification will result in a benefit reduction
	Hospice services	First Primary Care Coordinated Care: No charge Uncoordinated Care: 50% Coinsurance after deductible	180 visits per year.. Precert required. Failure to obtain pre-certification will result in a benefit reduction
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.)
Eye Exam, Specialty drug (30 day supply)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
Injections, Infertility, Chiropractic Services, Radiation and Chemotherapy, Laboratory, Private Duty Nursing, 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.

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	**$5,000.00**
Specialist copay	**$125.00**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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:	
Cost Sharing	
Deductibles	$5,000.00
Copayments	$250.00
Coinsurance	$3,850.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$9,100.00**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$5,000.00**
Specialist copay	**$125.00**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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:	
Cost Sharing	
Deductibles	$5,000.00
Copayments	$95.00
Coinsurance	$300.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$5,395.00**

Mia's Simple Fracture

(Emergency room visit and follow up care)

The plan's overall deductible	**$5,000.00**
Specialist copay	**$125.00**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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:	
Cost Sharing	
Deductibles	$2,800.00
Copayments	$500.00
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Mia would pay is	**$3,300.00**

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