



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 [www.antidotehealth.com](http://www.antidotehealth.com) or call 1-866-256-2134. 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-866-256-2134 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$5,000/individual or \$10,000/family.	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. <a href="#">Preventive care</a> , specialist services, generic drugs, and primary care services are covered before you meet your <a href="#">deductible</a> .	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 must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$9,200/individual or \$18,400/family.	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 in this <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> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.antidotehealth.com">http://www.antidotehealth.com</a> or call 1-866-256-2134 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

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	Tier-1 In-Network Providers (You will pay the least)	Tier-2 In-Network Providers (You will pay more)	Out-of-Network Provider (You will pay the most)	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	\$0 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	\$0 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	Antidote: Unlimited \$0 <a href="#">copay</a> /virtual visit for Antidote virtual providers. Tier-1: Up to 12 \$0 <a href="#">copay</a> /office visits per Benefit Period. After 12 office visits, Tier-2 <a href="#">copay</a> applies. Tier-2: Unlimited \$30 <a href="#">copay</a> /office visit.
	<a href="#">Specialist</a> visit	\$15 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	\$15 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$60 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	Up to 4 \$15 <a href="#">copay</a> /office visits in each Benefit Period. After 4 visits, Tier-1/Tier-2 <a href="#">copay</a> applies.
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Well Woman and Well Man exams limited to 1 per Benefit Period.
If you have a test	<a href="#">Diagnostic test</a> (X-ray, blood work)	Lab: \$0 <a href="#">copay</a> /test when referred by an Antidote virtual provider or \$45 <a href="#">copay</a> /test; <a href="#">deductible</a> does not apply. X-ray: 30% <a href="#">coinsurance</a>	Lab: \$0 <a href="#">copay</a> /test when referred by an Antidote virtual provider or \$45 <a href="#">copay</a> /test; <a href="#">deductible</a> does not apply. X-ray: 40% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	

Common Medical Event	Services You May Need	Tier-1 In-Network Providers (You will pay the least)	Tier-2 In-Network Providers (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<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.antidotehealth.com/pharma">www.antidotehealth.com/pharma</a>	Generic drugs	\$0 <a href="#">copay</a> /prescription when prescribed by an Antidote virtual provider or \$15 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	\$0 <a href="#">copay</a> /prescription when prescribed by an Antidote virtual provider or \$15 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	Preventive drugs are \$0 cost share. Retail: Up to 30-day supply is 1x <a href="#">copay</a> ; 31-60 day supply is 2x <a href="#">copay</a> ; 61-90 day supply is 3x <a href="#">copay</a> .  Mail order: 61-90 day supply is 2.5x <a href="#">copay</a> .
	Preferred brand drugs	\$25 <a href="#">copay</a> /prescription when prescribed by an Antidote virtual provider or \$50 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	\$25 <a href="#">copay</a> /prescription when prescribed by an Antidote virtual provider or \$50 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	Non-preferred brand drugs  <a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a> /prescription  30% <a href="#">coinsurance</a> /prescription	30% <a href="#">coinsurance</a> /prescription  30% <a href="#">coinsurance</a> /prescription	30% <a href="#">coinsurance</a> /prescription  30% <a href="#">coinsurance</a> /prescription	Not covered  Not covered
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Tier-1: 30% <a href="#">coinsurance</a> for anesthesia. Tier-2: 40% <a href="#">coinsurance</a> for anesthesia.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100% <a href="#">coinsurance</a>	Out-of-network services must meet the criteria for emergency care.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100% <a href="#">coinsurance</a>	Requires preauthorization for certain services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, out-of-network and out of area transfers.
	<a href="#">Urgent care</a>	\$0 <a href="#">copay</a> /visit when referred by an Antidote virtual provider, <a href="#">deductible</a> does not apply; or 30% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies.	\$0 <a href="#">copay</a> /visit when referred by an Antidote virtual provider, <a href="#">deductible</a> does not apply; or 40% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies.	\$0 <a href="#">copay</a> /visit when referred by an Antidote virtual provider, <a href="#">deductible</a> does not apply; or 40% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies.	Not covered

Common Medical Event	Services You May Need	Tier-1 In-Network Providers (You will pay the least)	Tier-2 In-Network Providers (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Tier-1: 30% <a href="#">coinsurance</a> for anesthesia. Tier-2: 40% <a href="#">coinsurance</a> for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	\$0 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	Antidote: Unlimited \$0 <a href="#">copay</a> /virtual visit for Antidote virtual providers.  Tier-1: Up to 12 \$0 <a href="#">copay</a> /office visits per Benefit Period. After 12 office visits, Tier-2 <a href="#">copay</a> applies.
	Inpatient services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Tier-2: Unlimited \$30 <a href="#">copay</a> /office visit.
If you are pregnant	Office visits	\$0 <a href="#">copay</a> /office visit when referred to OB by an Antidote virtual provider or \$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	\$0 <a href="#">copay</a> /office visit when referred to OB by an Antidote virtual provider or \$60 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	Up to 12 \$0 <a href="#">copay</a> /office visits in each Benefit Period. After 12 visits, Tier-1/Tier-2 <a href="#">copay</a> applies.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	

Common Medical Event	Services You May Need	Tier-1 In-Network Providers (You will pay the least)	Tier-2 In-Network Providers (You will pay more)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	42 visits/Benefit Period.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$60 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	\$30 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$60 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	Up to 8 \$30 <a href="#">copay</a> /office visits in each Benefit Period. After 8 visits, Tier-1/Tier-2 <a href="#">copay</a> applies.
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$60 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	\$30 <a href="#">copay</a> /office visit when referred by an Antidote virtual provider or \$60 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	60 visits/Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	90 visits/Benefit Period.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Not covered	Covered when provided under an approved hospice care program to a member diagnosed by a Network Provider as having a terminal illness with a prognosis of 6 months or less to live.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	No charge	Not covered	Coverage limited to 1 exam/Benefit Period.
	Children's glasses	No charge	No charge	Not covered	Coverage limited to 1 pair of glasses/Benefit Period.
	Children's dental check-up	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Not covered	1 exam per 6 months. Max out-of-pocket is \$400 for single child; \$800 per family.

## 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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Infertility treatment (IVF, GIFT, ZIFT, artificial insemination, donor semen/egg storage, and related drugs.)
- Long term care
- Non-Emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Private duty nursing
- Routine foot care

**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: Arizona Department of Insurance and Financial Institutions, 100 North 15th Avenue, Suite 261, Phoenix, AZ 85007, (602) 364-3100. 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: Arizona Department of Insurance and Financial Institutions, 100 North 15th Avenue, Suite 261, Phoenix, AZ 85007, (602) 364-3100.

**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? Not applicable.**

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 1-866-256-2134.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-256-2134.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-256-2134.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-256-2134.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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](#) \$5,000
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$1,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,660</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,820</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist copayment](#) \$30
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,400</b>

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