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 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 or call 1-866-256-2134 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $500/individual or $1,000/family.	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. Preventive care, specialist services, generic drugs, and primary care services are covered before you meet your deductible.	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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $3,000/individual or $6,000/family.	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, balance-billing charges, and 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?	Yes. See http://www.antidotehealth.com or call 1-866-256-2134 for a list of network providers.	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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the 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	In-Network Providers (You will pay the least)	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	$20 copay/office visit. Deductible does not apply.	Not covered	None
	Specialist visit	$40 copay/office visit. Deductible does not apply.	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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. Well Woman and Well Man exams limited to 1 per Benefit Period.
If you have a test	Diagnostic test (X-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.antidotehealth.com/pharma**	Generic drugs	$10 copay/prescription. Deductible does not apply.	Not covered	Preventive drugs are $0 cost share. Retail: Up to 30-day supply is 1x copay; 31-60 day supply is 2x copay; 61-90 day supply is 3x copay. Mail order: 61-90 day supply is 2.5x copay.
	Preferred brand drugs	$20 copay/prescription. Deductible does not apply.	Not covered	
	Non-preferred brand drugs	$60 copay/prescription	Not covered	
	Specialty drugs	$250 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	30% coinsurance for anesthesia.

Common Medical Event	Services You May Need	In-Network Providers (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	30% coinsurance	100% coinsurance	Out-of-network services must meet the criteria for emergency care.
	Emergency medical transportation	30% coinsurance	100% coinsurance	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.
	Urgent care	$30 copay/visit. Deductible does not apply.	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	30% coinsurance for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit. Deductible does not apply.	Not covered	None
	Inpatient services	30% coinsurance	Not covered	
If you are pregnant	Office visits	30% coinsurance	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	

Common Medical Event	Services You May Need	In-Network Providers (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	42 visits/Benefit Period.
	Rehabilitation services	$20 copay/office visit. Deductible does not apply	Not covered	60 visits/Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$20 copay/office visit. Deductible does not apply	Not covered	
	Skilled nursing care	30% coinsurance	Not covered	90 visits/Benefit Period.
	Durable medical equipment	30% coinsurance	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	30% coinsurance	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.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to 1 exam/Benefit Period.
	Children's glasses	No charge	Not covered	Coverage limited to 1 pair of glasses/Benefit Period.
	Children's dental check-up	50% coinsurance	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
- 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 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, kwiijigo holne' 1-866-256-2134.

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	$500
Specialist copayment	$40
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$500
Specialist copayment	$40
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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	$500
Specialist copayment	$40
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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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