



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> \$1,500/individual or \$3,000/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> \$7,800/individual or \$15,600/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	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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	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)	25% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% <a href="#">coinsurance</a>	Not covered	
If you need drugs to treat your illness or condition 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	\$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 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	\$30 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	Non-preferred brand drugs	\$60 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Specialty drugs</a>	\$250 <a href="#">copay</a> /prescription. <a href="#">Deductible</a> does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	Not covered	25% <a href="#">coinsurance</a> 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	<a href="#">Emergency room care</a>	25% <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>	25% <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>	\$45 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	Not covered	25% <a href="#">coinsurance</a> for anesthesia.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	Inpatient services	25% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	25% <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 professional services	25% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	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
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	Not covered	42 visits/Benefit Period.
	<a href="#">Rehabilitation services</a>	\$30 <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="#">Habilitation services</a>	\$30 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply	Not covered	
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	Not covered	90 visits/Benefit Period.
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	Not covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<a href="#">Hospice services</a>	25% <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	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% <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
- 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, kwijigo holne' 1-866-256-2134.

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

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## 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](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,370</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$900
<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](#) \$1,500
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$100
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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