



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 \$1,500/individual or \$3,000/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 \$7,000/individual or \$14,000/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 | 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 copay /office visit. Deductible does not apply. | \$0 copay /office visit when referred by an Antidote virtual provider or \$15 copay /office visit. Deductible does not apply. | Not covered | Antidote: Unlimited \$0 copay /virtual visit for Antidote virtual providers. Tier-1: Up to 12 \$0 copay /office visits per Benefit Period. After 12 office visits, Tier-2 copay applies. Tier-2: Unlimited \$15 copay /office visit. |
| | Specialist visit | \$10 copay /office visit when referred by an Antidote virtual provider or \$25 copay /office visit. Deductible does not apply. | \$10 copay /office visit when referred by an Antidote virtual provider or \$45 copay /office visit. Deductible does not apply. | Not covered | Up to 4 \$10 copay /office visits in each Benefit Period. After 4 visits, Tier-1/Tier-2 copay applies. |
| | Preventive care/screening/immunization | No charge | 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) | Lab: \$0 copay /test when referred by an Antidote virtual provider or \$25 copay /test; deductible does not apply. X-ray: 20% coinsurance | Lab: \$0 copay /test when referred by an Antidote virtual provider or \$25 copay /test; deductible does not apply. X-ray: 30% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 30% coinsurance | 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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.antidotehealth.com/pharma | Generic drugs | \$0 copay /prescription when prescribed by an Antidote virtual provider or \$5 copay /prescription. Deductible does not apply. | \$0 copay /prescription when prescribed by an Antidote virtual provider or \$5 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 | \$15 copay /prescription when prescribed by an Antidote virtual provider or \$30 copay /prescription. Deductible does not apply. | \$15 copay /prescription when prescribed by an Antidote virtual provider or \$30 copay /prescription. Deductible does not apply. | Not covered | |
| | Non-preferred brand drugs Specialty drugs | 20% coinsurance /prescription 20% coinsurance /prescription | 20% coinsurance /prescription 20% coinsurance /prescription | 20% coinsurance /prescription 20% coinsurance /prescription | Not covered Not covered |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | Not covered | Tier-1: 20% coinsurance for anesthesia. Tier-2: 30% coinsurance for anesthesia. |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 30% coinsurance | 100% coinsurance | Out-of-network services must meet the criteria for emergency care. |
| | Emergency medical transportation | 20% coinsurance | 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 | \$0 copay /visit when referred by an Antidote virtual provider, deductible does not apply; or 20% coinsurance , deductible applies. | \$0 copay /visit when referred by an Antidote virtual provider, deductible does not apply; or 30% coinsurance , deductible applies. | \$0 copay /visit when referred by an Antidote virtual provider, deductible does not apply; or 30% coinsurance , deductible 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) | 20% coinsurance | 30% coinsurance | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | Not covered | Tier-1: 20% coinsurance for anesthesia. Tier-2: 30% coinsurance for anesthesia. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$0 copay /office visit. Deductible does not apply. | \$0 copay /office visit when referred by an Antidote virtual provider or \$15 copay /office visit. Deductible does not apply. | Not covered | Antidote: Unlimited \$0 copay /virtual visit for Antidote virtual providers. Tier-1: Up to 12 \$0 copay /office visits per Benefit Period. After 12 office visits, Tier-2 copay applies. |
| | Inpatient services | 20% coinsurance | 30% coinsurance | Not covered | Tier-2: Unlimited \$15 copay /office visit. |
| If you are pregnant | Office visits | \$0 copay /office visit when referred to OB by an Antidote virtual provider or \$25 copay /office visit. Deductible does not apply. | \$0 copay /office visit when referred to OB by an Antidote virtual provider or \$45 copay /office visit. Deductible does not apply. | Not covered | Up to 12 \$0 copay /office visits in each Benefit Period. After 12 visits, Tier-1/Tier-2 copay applies. |
| | Childbirth/delivery professional services | 20% coinsurance | 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 facility services | 20% coinsurance | 30% coinsurance | 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 need help recovering or have other special health needs | Home health care | 20% coinsurance | 30% coinsurance | Not covered | 42 visits/Benefit Period. |
| | Rehabilitation services | \$25 copay /office visit when referred by an Antidote virtual provider or \$50 copay /office visit. Deductible does not apply. | \$25 copay /office visit when referred by an Antidote virtual provider or \$50 copay /office visit. Deductible does not apply. | Not covered | Up to 8 \$25 copay /office visits in each Benefit Period. After 8 visits, Tier-1/Tier-2 copay applies. |
| | Habilitation services | \$25 copay /office visit when referred by an Antidote virtual provider or \$50 copay /office visit. Deductible does not apply. | \$25 copay /office visit when referred by an Antidote virtual provider or \$50 copay /office visit. Deductible does not apply. | Not covered | 60 visits/Benefit Period. Includes physical therapy, speech therapy, and occupational therapy. |
| | Skilled nursing care | 20% coinsurance | 30% coinsurance | Not covered | 90 visits/Benefit Period. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | Not covered | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. |
| | Hospice services | 20% coinsurance | 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 | 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% coinsurance | 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, 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.

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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](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$1,500 |
| Copayments | \$400 |
| Coinsurance | \$1,500 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,460 |

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](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$800 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,520 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$25
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$1,500 |
| Copayments | \$300 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

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