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.anglehealth.com or call [TBD]. 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.anglehealth.com or call [TBD] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $7,000 individual or $14,000 family; for out-of-network providers $20,000 individual or $40,000 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 services and Maternity and Newborn routine office visits 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. There are no other specific deductibles.	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 / $14,000 family; for out-of-network providers $20,000 individual / $40,000 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 www.anglehealth.com or call [TBD] 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?	No.	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	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copayment after deductible	$0 copayment after deductible	None
	Specialist visit	$0 copayment after deductible	$0 copayment after deductible	None
	Preventive care/screening/ immunization	No charge; Deductible does not apply	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.
If you have a test	Diagnostic test (x-ray, blood work)	$0 copayment after deductible	$0 copayment after deductible	Preauthorization may be required for Complex Imaging Services (CT/PET scans, MRI).
	Imaging (CT/PET scans, MRIs)	$0 copayment after deductible	$0 copayment after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anglehealth.com	Generic drugs (Tier 1)	$0 copayment after deductible / prescription (retail & mail order)	Not Covered	Covers up to a 30-day supply (retail subscription); Covers up to a 90-day supply (mail order prescription). Tier 4 Specialty Drugs limited to a 30-day supply.
	Preferred brand drugs (Tier 2)	$0 copayment after deductible / prescription (retail & mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	$0 copayment after deductible / prescription (retail & mail order)	Not Covered	
	Specialty drugs (Tier 4)	$0 copayment after deductible / prescription (retail & mail order)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 copayment after deductible	$0 copayment after deductible	Preauthorization may be required.
	Physician/surgeon fees	$0 copayment after deductible	$0 copayment after deductible	Preauthorization may be required.
If you need immediate medical attention	Emergency room care	$0 copayment after deductible	$0 copayment after deductible	Emergency room copayment (Facility & Physician Fee) is waived if admitted as in-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	$0 copayment after deductible	$0 copayment after deductible	patient. Preauthorization required for non-emergency ambulance transportation.
	Urgent care	$0 copayment	$0 copayment after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 copayment after deductible	$0 copayment after deductible	Preauthorization is required. However, preauthorization is not required for emergency admissions.
	Physician/surgeon fees	$0 copayment after deductible	$0 copayment after deductible	Preauthorization is required. However, preauthorization is not required for emergency admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copayment after deductible	$0 copayment after deductible	Preauthorization for Inpatient Mental Health Care may be required. However, preauthorization is not required for emergency admissions.
	Inpatient services	$0 copayment after deductible	$0 copayment after deductible	
If you are pregnant	Office visits	$0 copayment after deductible	$0 copayment after deductible	Covers 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section.
	Childbirth/delivery professional services	$0 copayment after deductible	$0 copayment after deductible	
	Childbirth/delivery facility services	$0 copayment after deductible	$0 copayment after deductible	
If you need help recovering or have other special health needs	Home health care	$0 copayment after deductible	$0 copayment after deductible	100 visits/year; Preauthorization may be required.
	Rehabilitation services	$0 copayment after deductible	$0 copayment after deductible	Includes physical therapy, speech therapy, and occupational therapy. Preauthorization may be required. Up to 20 visits per plan year, combined, for outpatient therapies.
	Habilitation services	$0 copayment after deductible	$0 copayment after deductible	
	Skilled nursing care	$0 copayment after deductible	$0 copayment after deductible	60 days/year; Preauthorization is required.
	Durable medical equipment	$0 copayment after deductible	$0 copayment after deductible	Preauthorization may be required.
	Hospice services	$0 copayment after deductible	$0 copayment after deductible	Preauthorization may be required.

If your child needs dental or eye care	Children's eye exam	$0 copayment after deductible	Not Covered	Coverage limited to One (1) exam per 12 months.
	Children's glasses	$0 copayment after deductible	Not Covered	Coverage limited to one (1) prescribed lenses and frames per 12 months.
	Children's dental check-up	$0 copayment after deductible	Not Covered	One (1) visit per 6 months

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Orthodontia
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Prosthetics
- Residential Treatment Centers

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or contact the Plan. 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: : Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or dol.gov/ebsa/healthreform; you may also contact the Utah Insurance Department, Office of Consumer Assistance, Suite 3110, State Office Building, Salt Lake City, Utah 84114.

To contact Angle Member Services, please call [TDB], or visit us at anglehealth.com.

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.

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	$0
Specialist copayment	$75
Hospital (facility) copayment	$1500
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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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	$50
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	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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

The plan's overall deductible	$500
Specialist copayment	$50
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*	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: [TBD].
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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