




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](http://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](http://www.anglehealth.com) or call [TBD] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$2,000 individual or \$4,000 family; for <a href="#">out-of-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> 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. There are no other specific <a href="#">deductibles</a> .	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> \$7,000 individual / \$14,000 family; for <a href="#">out-of-network providers</a> \$20,000 individual / \$40,000 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.anglehealth.com">www.anglehealth.com</a> or call [TBD] 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> ?	No.	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	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge; <a href="#">Deductible</a> does not apply	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> may be required for Complex Imaging Services (CT/PET scans, MRI).
	Imaging (CT/PET scans, MRIs)	\$200 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	
<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.anglehealth.com">www.anglehealth.com</a>	Generic drugs (Tier 1)	\$15 <a href="#">copay after deductible</a> /prescription (retail); \$30 <a href="#">copay after deductible</a> /prescription (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)	\$45 <a href="#">copayment after deductible</a> /prescription (retail); \$120 <a href="#">copayment after deductible</a> /prescription (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$75 <a href="#">copayment after deductible</a> /prescription (retail); \$210 <a href="#">copayment after deductible</a> /prescription (mail order)	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	30% <a href="#">coinsurance</a> up to \$250 <a href="#">after deductible</a>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least) (retail & mail order)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> may be required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$350 <a href="#">copayment after deductible</a> (Facility Fee); \$50 <a href="#">copayment</a> (Physician Fee)	\$350 <a href="#">copayment after deductible</a> (Facility Fee); \$50 <a href="#">copayment</a> (Physician Fee)	Emergency room <a href="#">copayment</a> (Facility & Physician Fee) is waived if admitted as inpatient. <a href="#">Preauthorization</a> required for non-emergency ambulance transportation.
	<a href="#">Emergency medical transportation</a>	\$350 <a href="#">copayment after deductible</a>	\$350 <a href="#">copayment after deductible</a>	
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment after deductible</a> /visit	50% <a href="#">coinsurance after deductible</a>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$350 <a href="#">copayment</a> per day up to 10 days after deductible	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> is required. However, <a href="#">preauthorization</a> is not required for emergency admissions.
	Physician/surgeon fees	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> is required. However, <a href="#">preauthorization</a> is not required for emergency admissions.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> for Inpatient Mental Health Care may be required. However, <a href="#">preauthorization</a> is not required for emergency admissions.
	Inpatient services	\$350 <a href="#">copayment</a> per day up to 10 days after deductible	50% <a href="#">coinsurance after deductible</a>	
<b>If you are pregnant</b>	Office visits	No Charge	50% <a href="#">coinsurance after deductible</a>	Covers 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section.
	Childbirth/delivery professional services	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	
	Childbirth/delivery facility services	\$350 <a href="#">copayment</a> per day up to 10 days after deductible	\$350 <a href="#">copayment after deductible</a> per day up to 10 days	
<b>If you need help recovering or have</b>	<a href="#">Home health care</a>	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	100 visits/year; <a href="#">Preauthorization</a> may be required.

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)	
<b>other special health needs</b>	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	Includes physical therapy, speech therapy, and occupational therapy. <a href="#">Preauthorization</a> may be required. Up to 20 visits per plan year, combined, for outpatient therapies.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	
	<a href="#">Skilled nursing care</a>	\$350 <a href="#">copayment</a> per day up to 10 days after deductible	50% <a href="#">coinsurance after deductible</a>	60 days/year; <a href="#">Preauthorization</a> is required.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance after deductible</a>	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> may be required.
	<a href="#">Hospice services</a>	\$50 <a href="#">copayment after deductible</a>	50% <a href="#">coinsurance after deductible</a>	<a href="#">Preauthorization</a> may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge after deductible	Not Covered	Coverage limited to One (1) exam per 12 months.
	Children's glasses	30% <a href="#">coinsurance after deductible</a>	Not Covered	Coverage limited to one (1) prescribed lenses and frames per 12 months.
	Children's dental check-up	No Charge <a href="#">after deductible</a>	Not Covered	One (1) visit per 6 months

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Orthodontia</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>Prosthetics</li> </ul>	<ul style="list-style-type: none"> <li>Residential Treatment Centers</li> </ul>

**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](http://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](http://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](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: : Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://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 [TBD], or visit us at [anglehealth.com](http://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.*

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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](#) \$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*)

<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>	\$500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,560</b>

### 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*)

<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>	\$800
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$100
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](#) \$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*)

<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>	\$500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$400
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

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.