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 (855) 937-1855. 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.healthcare.gov/sbc-glossary or call (855) 937-1855 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 per individual / $4,000 per family for network providers; $5,000 per individual / $10,000 per family for out-of-network providers.	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 is 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-carebenefits
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $4,000 individual / $8,000 family; for out-of-network providers $10,000 individual / $20,000 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 limit 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 (855) 937-1855 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	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at www.anglehealth.com.

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	$20 copayment	50% coinsurance after deductible	
	Specialist visit	$50 copayment	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge	Not covered	Coverage is limited to one visit per year for some services. 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)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required for certain services except in the case of an emergency. Please refer to the Certificate of Coverage for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance 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	$20 copayment retail $50 copayment mail order	Not covered retail Not covered mail order	Covers up to a 31-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription).
	Preferred brand drugs	$60 copayment retail $150 copayment mail order	Not covered retail Not covered mail order	
	Non-preferred brand drugs	$85 copayment retail $212.50 copayment mail order	Not covered retail Not covered mail order	
	Specialty drugs	20% coinsurance after deductible retail	Not covered retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required for certain services. Please refer to the Certificate of Coverage for details.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required for certain services. Please refer to the Certificate of Coverage for details.

If you need immediate medical attention	Emergency room care	$250 copayment after deductible	$250 copayment after deductible	
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Preauthorization may be required for non-emergency transportation.
	Urgent care	$75 copayment	50% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required except in the case of an emergency.
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required except in the case of an emergency.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment	50% coinsurance after deductible	Preauthorization may be required except in the case of an emergency.
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	20% coinsurance after deductible	50% coinsurance after deductible	Covers 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required. Coverage limited to 100 days per calendar year.
	Rehabilitation services	$50 copayment	50% coinsurance after deductible	Coverage limits per calendar year: Physical, Occupational, and Speech Therapy: 20 visits each for Outpatient therapies. Preauthorization may be required. Up to 40 days per plan year, combined, for Inpatient therapies.
	Habilitation services	$50 copayment	50% coinsurance after deductible	Coverage limits are combined with Rehabilitation services above.
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization may be required for certain services. Please refer to the Certificate of Coverage for details.
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	

If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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.)
• Cosmetic surgery • Dental care (Adult and Child) • Infertility treatment • Long-term care • Private duty-nursing • Routine foot care • Vision 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.)
• Acupuncture • Bariatric surgery • Chiropractic Care • Non-emergency care when traveling outside the U.S.

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 Member Services, please call (855) 937-1855, 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 plans overall deductible	**$2,000**
Specialist copayment	**$50.00**
Hospital (facility) coinsurance	**20.00%**
Other coinsurance	**20.00%**
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	**$2,000**
Copayments	**$340**
Coinsurance	**$1,660**
What isn't Covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$4,060**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well- controlled condition)	
The plans overall deductible	**$2,000**
Specialist copayment	**$50.00**
Hospital (facility) coinsurance	**20.00%**
Other coinsurance	**20.00%**
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	**$864**
Copayments	**$1,260**
Coinsurance	**$0**
What isn't Covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$2,144**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plans overall deductible	**$2,000**
Specialist copayment	**$50.00**
Hospital (facility) coinsurance	**20.00%**
Other coinsurance	**20.00%**
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	**$1,971**
Copayments	**$170**
Coinsurance	**$0**
What isn't Covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,141**

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

Nondiscrimination Notice

Discrimination is Against the Law. Angle Insurance Company of Utah does not exclude people or treat them differently on the basis of race, color, national origin, age, disability or sex in its health programs or activities.

Angle Insurance Company of Utah provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (audio, accessible electronic formats, large prints). The administrator also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, you can call the Member Services number on the back of your ID card or email careteam@anglehealth.com. If you are hearing impaired call 855-200-0571. If you believe that Angle Insurance Company of Utah has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you have the right to file a grievance by mail PO BOX 21428, Eagan, MN 55121, fax 855-938-4540, or email ag@anglehealth.com.

You also have the right to file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail: U.S. Department of Health and Human Services 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; phone: 1-800-368-1019, 800-537-7697 (TTY); or electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a 855- 200-0571.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言 援助服務。請致電 855-200-0571.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-200-0571.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855- 200-0571.. 번으로 전화해 주십시오.

Navajo
Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dę□ę□', t'áá jiik'eh, éí ná hól□', kojį' hódíílnih 855-200-0571.

Nepali
यान ि◌◌दनुहोस : तपाइर्ंलेनेपाली बो नु◌ छ भनेतपाइर्को ि◌◌◌न त भाषा सहायता सेवाह ि◌◌न:शुक पमा उपल ध छ । 855-200-0571. मा फोन गनुहोस।

Tongan
FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he 855-200-0571.

Serb-Croatian
ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите 855-200-0571.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-200-0571.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 855-200-0571.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните 855-200-0571.

Arabic
ةظوحلم ةكرشب لصتا :ةظوحلم ةكرشب لصتا اذإ ثدحتت تنك ،ةيبرعلا نإف ةدعاسملا تامدخ ناجملاب كل رفاوتت ةيوغللا 855–200–0571..

Mon-khmer, Cambodian
សគ ល់៖ ◌◌◌បើសិនអនកនិយ ◌◌◌ខម រ ◌◌◌ស ជំនួ ◌◌យផនក ◌◌◌យមិនគិតថល គឺចន សំប់ អន ក។ សូមទូរស័ពទមក 855–200– 0571.

French
ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez 855-200-0571.

Japanese
注意事項：日本語を話される場合、無料の言語 支援をご利用いただけます。855-200-0571. まで□ ANGLE-UT NDN 07/21 お電話にてご連絡ください