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 1-855-937-1855. 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 http://www.healthcare.gov/sbc-glossary or call 1-855-937-1855 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 per individual / $0 family for Preferred network providers; $3,000 per individual / $6,000 per family for In-network providers; $6,000 per individual / $12,000 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-care-benefits/.
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?	$5,000 per individual / $10,000 per family for Preferred network providers; $5,000 per individual / $10,000 per family for In-network providers; $10,000 per individual / $20,000 per family for out-of-network providers.	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 for these expenses, they don't count toward the out-of-pocket limit.

(DT – OMB control number: 1545-0047/Expiration Date: 12/31/2019); (DOL – OMB control number: 1210-0147/Expiration Date: 5/31/2022); (HHS – OMB control number: 0938/1146/Expiration Date: 10/31/2022)

Will you pay less if you use a network provider?	Yes. See www.anglehealth.com or call 1-855-937-1855 for a list of network providers.	You pay the least if you a provider in Tier 1. You pay more if you use a provider in Tier 2. 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).
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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
		Preferred Network Provider (You will pay the least)	In- Network Provider (You will pay less than the Out-of-Network cost)	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	No charge	$20 copayment	50% coinsurance after deductible	None
	Specialist visit	No charge	$50 copayment	50% coinsurance after deductible	None
	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for certain services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anglehealth.com	Generic drugs	Refer to In- Network Provider benefits	$20 copayment retail $50 copayment mail order	Not covered retail Not covered mail order	Covers up to a 31-day supply (retail prescription); 90 day supply (mail order prescription). Specialty drugs are only available up to a 31-day supply.
	Preferred brand drugs	Refer to In-Network Provider benefits	$60 copayment retail $150 copayment mail order	Not covered retail Not covered mail order	
	Non-preferred brand drugs	Refer to In-Network Provider benefits	$85 copayment retail	Not covered retail	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In- Network Provider (You will pay less than the Out-of-Network cost)	Out-of-Network Provider (You will pay the most)	
			$212.50 copayment mail order	Not covered mail order	
	Specialty drugs	Refer to In-Network Provider benefits	20% coinsurance after In-Network deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for certain services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$500 copayment	$500 copayment	$500 copayment	None
	Emergency medical transportation	20% coinsurance	20% coinsurance after deductible	20% coinsurance after deductible	None
	Urgent care	$75 copayment	$75 copayment	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	No charge	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$20 copayment	50% coinsurance after deductible	None
	Inpatient services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity
	Childbirth/delivery professional services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In- Network Provider (You will pay less than the Out-of-Network cost)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required if the length of stay exceeds 48 hours for vaginal delivery or 96 hour for a caesarean section.
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for certain services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service. Limited to 100 days per plan year.
	Rehabilitation services	No charge	$50 copayment	50% coinsurance after deductible	Physical, Occupational, and Speech Therapy 20 visits each per plan year. Preauthorization is required for certain services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Habilitation services	No charge	$50 copayment	50% coinsurance after deductible	
	Skilled nursing care	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for certain services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice services	No charge	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for certain services. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In- Network Provider (You will pay less than the Out-of-Network cost)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

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
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Dental care (Adult)
- Long-term care
- Routine Eye care (Adult)
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Routine foot care

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

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 are the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 ext. 61565 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 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. To contact Member Services, please call 1-855-937-1855; or visit us at www.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.

Language Access Services:

Para obtener asistencia en Español, llame al 1-855-937-1855.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-937-1855.
如果需要中文的帮助，请拨打这个号码 1-855-937-1855.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-937-1855.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples: In-Network Providers (You may pay less if you use Preferred Network Provider.)

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	$3,000
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	$3,000
Copayments	$344
Coinsurance	$1,656
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
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 plan's overall deductible	$3,000
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	$1,614
Copayments	$670
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,284**

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