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, www.sidecarhealth.com or 1-855-282-0822. 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 https://www.healthcare.gov/glossary/ or call 1-855-282-0822 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$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 services are covered before you meet your deductible. This plan covers also the following item and services before you meet the deductible: primary care provider office visits, telehealth visits, specialist provider office visits, mental health provider office visits, and generic outpatient prescription drugs.	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For pharmacy, facility, and provider charges at or below the Benefit Amount $1,500 / individual or $3,000 / family; for pharmacy, facility, and provider charges in excess of the Benefit Amount Not Applicable.	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, pharmacy, facility, and provider charges in excess of the Benefit Amount and health care this plan	Even though you pay these expenses, they don't count toward the out-of-pocket limit. You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.

*For more information about limitations and exceptions, see the plan or policy document at www.sidecarhealth.com
**You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.

Important Questions	Answers	Why This Matters:
	doesn't cover.	
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
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
		Provider charges at or below Benefit Amount (You will pay the least)	Provider charges above Benefit Amount (You will pay more)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Any amount charged by a provider in excess of the Benefit Amount.	You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.
	Specialist visit	No charge	Any amount charged by a provider in excess of the Benefit Amount.	
	Preventive care/screening/ immunization	No charge	Any amount charged by a provider in excess of the Benefit Amount.	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)	No charge	Any amount charged by a provider in excess of the Benefit Amount.	You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.
	Imaging (CT/PET scans, MRIs)	No charge	Any amount charged by a provider in excess of the Benefit Amount.	

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**You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Provider charges at or below Benefit Amount (You will pay the least)	Provider charges above Benefit Amount (You will pay more)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sidecarhealth.com.	Any medically necessary FDA-approved drug.	No charge	Any amount charged by a pharmacy or provider in excess of the Benefit Amount.	Covers up to a 30-day supply (retail subscription). You may view the Benefit Amount for each covered drug on our website at http://www.sidecarhealth.com.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Any amount charged by a provider in excess of the Benefit Amount.	You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.
	Physician/surgeon fees	No charge	Any amount charged by a provider in excess of the Benefit Amount.	
If you need immediate medical attention	Emergency room care	No charge	Any amount charged by a provider in excess of the Benefit Amount, as limited by federal balance billing regulations.	You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.
	Emergency medical transportation	No charge		
	Urgent care	No charge	Any amount charged by a provider in excess of the Benefit Amount.	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Any amount charged by a provider in excess of the Benefit Amount.	You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.
	Physician/surgeon fees	No charge	Any amount charged by a provider in excess of the Benefit Amount.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Any amount charged by a provider in excess of the Benefit Amount.	You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.
	Inpatient services	No charge	Any amount charged by a provider in excess of the Benefit Amount.	

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**You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Provider charges at or below Benefit Amount (You will pay the least)	Provider charges above Benefit Amount (You will pay more)	
If you are pregnant	Office visits	No charge	Any amount charged by a provider in excess of the Benefit Amount.	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).**
	Childbirth/delivery professional services	No charge	Any amount charged by a provider in excess of the Benefit Amount.	
	Childbirth/delivery facility services	No charge	Any amount charged by a provider in excess of the Benefit Amount.	
If you need help recovering or have other special health needs	Home health care	No charge	Any amount charged by a provider in excess of the Benefit Amount.	100 visits/year.**
	Rehabilitation services	No charge	Any amount charged by a provider in excess of the Benefit Amount.	20 visits/year. Includes physical therapy, speech therapy, and occupational therapy.**
	Habilitation services	No charge	Any amount charged by a provider in excess of the Benefit Amount.	20 visits/year. Includes physical therapy, speech therapy, and occupational therapy.**
	Skilled nursing care	No charge	Any amount charged by a provider in excess of the Benefit Amount.	90 visits/calendar year.**
	Durable medical equipment	No charge	Any amount charged by a provider in excess of the Benefit Amount.	Certain limitations apply, please check your plan or policy document.*, **
	Hospice services	No charge	Any amount charged by a provider in excess of the Benefit Amount.	To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician.**
If your child needs dental or eye care	Children's eye exam	No charge	Any amount charged by a provider in excess of the Benefit Amount.	Coverage limited to only to Preventive Care.
	Children's glasses	No charge	Any amount charged by a	Routine glasses are not covered. Glasses

*For more information about limitations and exceptions, see the plan or policy document at www.sidecarhealth.com
**You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Provider charges at or below Benefit Amount (You will pay the least)	Provider charges above Benefit Amount (You will pay more)	
			provider in excess of the Benefit Amount.	coverage provided only after lens implantation or for conditions caused by cataract surgery or injury.**
	Children's dental check-up	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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S., beyond 90 days
- Routine eye care
- 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.)

- Chiropractic care
- Private-duty nursing

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: Ohio Department of Insurance, 50 W. Town Street, Third Floor Ste. 300, Columbus, OH 43215 or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Ohio Department of Insurance, http://www.insurance.ohio.gov/ or U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-282-0822.

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**You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-282-0822.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-282-0822.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-282-0822.

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:

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

**You may view the Benefit Amount for each covered service on our website at http://www.sidecarhealth.com.

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	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is*	**$1,500**

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	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is*	**$1,500**

Mia's Simple Fracture

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

The plan's overall deductible	**$1,500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is*	**$1,500**

*Note: This is the amount of the example cost that will accrue toward the total Deductible. **Examples described above assume the enrollee received services from provider that charges at or below the plan's Benefit Amount for those services.**
**Note: This plan does not include copayments or coinsurance.

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