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?	$5,500 / individual or $11,000 / 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 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 $5,500 / individual or $11,000 / 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 doesn't cover.	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:
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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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.	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.	48 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.	48 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
- 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
- Hearing Aids for children age 18 and under
- 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: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services, 2 Martin Luther King Jr. Dr., West Tower, Suite 716, Atlanta, GA, 30334 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: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services, 2 Martin Luther King Jr. Dr., West Tower, Suite 716, Atlanta, GA, 30334 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.

*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.

Language Access Services:

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

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.

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	**$5,500**
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	$5,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is*	**$5,500**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$5,500**
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	$5,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is*	**$5,500**

Mia's Simple Fracture

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

The plan's overall deductible	**$5,500**
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is*	**$2,800**

*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.

Sidecar Health

Notice of Non-Discrimination "Tagline"

Sidecar Health complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. Sidecar Health does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

Sidecar Health provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, Sidecar Health provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please call the Member Care number on your Benefit Card (also sometimes referred to as your Sidecar Health payment card).

If you believe that Sidecar Health has failed to provide the above-mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

Sidecar Health
Attn: Civil Rights Coordinator
440 N. Barranca Ave, #7028
Covina, CA 91723
877-653-6440
grievances@sidecarhealth.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you do not have your Benefit Card or you are not yet a member, we can help. (Please contact Member Care above).

If you, or someone you're helping, have questions about Sidecar Health, you have the right to get help and information in your language at no cost. Please call the Member Care number on your Benefit Card.

ARABIC

إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص Sidecar Health، فيحق لك الحصول على مساعدة ومعلومات مجانًا وباللغة التي تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، ُرجى الاتصال على رقم خدمة الأعضاء الموجود على بطاقة تعريف العضو الخاصة بك.

CHINESE

如果您或者您在帮助的人对 Sidecar Health 存有疑问，您有权免费获得 以您的语言提供的帮助和信息。 如果您需要与一位翻译交谈，请拨 打您的会员 ID 卡上的会员服务电话号码。

CUSHITE – OROMO

Isin yookan namni biraa isin deeggartan Sidecar Health irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, Maaloo lakkoofsa bilbilaa isa waraqaa eenyummaa keessan irra jiruun tajaajila miseensaatiif bilbilaa.

DUTCH

Als u, of iemand die u helpt, vragen heeft over Sidecar Health, hebt u het recht om kosteloos hulp en informatie te ontvangen in uw taal. Als u wilt spreken met een tolk. Bel naar het nummer voor ledendiensten op uw lidkaart

FRENCH (CANADA)

Des questions au sujet de Sidecar Health? Vous ou la personne
que vous aidez avez le droit d'obtenir gratuitement du soutien et de l'information dans votre langue. Pour parler à un interprète. Veuillez communiquer avec les services aux membres au numéro indiqué sur votre carte de membre.

GERMAN

Wenn Sie, oder jemand dem Sie helfen, eine Frage zu Sidecar Health haben, haben Sie das Recht, kostenfrei in Ihrer eigenen Sprache Hilfe und Information zu bekommen. Um mit einem Dolmetscher zu sprechen, Bitte rufen Sie die Mitglieder-Servicenummer auf Ihrer Mitglieder-ID-Karte an

ITALIAN

Se Lei, o qualcuno che Lei sta aiutando, ha domande su Sidecar Health, ha il diritto di avere supporto e informazioni nella propria lingua senza alcun costo. Per parlare con un interprete. Chiamare il numero dei servizi ai soci riportato sulla tessera di iscrizione.

JAPANESE

ご本人様、または身の回りの方で、Sidecar Health に関するご質問が ございましたら、ご希望の言語でサポートを受けたり、情報を入手 したりすることができます(無償)。 通訳をご利用の場合は、お 持ちの会員IDカードにある、会員サービスの電話番号までお問い合 わせ下さい。

KOREAN

귀하 본인이나 귀하께서 돕고 계신 분이 Sidecar Health에 대해 궁금한 점이 있으시면, 원하는 언어로 별도 비용 없이 도움을 받으실 수 있습니다. 통역사가 필요하시면 다음 번호로 전화해 귀하의 회원 ID 카드에 적힌 회원 서비스 팀 번호로 전화하십시오.

PENNSYLVANIA DUTCH

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Sidecar Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix.
Wann du mit me Interpreter schwetze witt, Bel alstublieft met het Ledenservice nummer op uw lid ID -kaart.

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-653-6440.

RUSSIAN

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы относительно Sidecar Health, Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для разговора с переводчиком. Пожалуйста, позвоните по телефону отдела обслуживания клиентов, указанному на вашей идентификационной карточке клиента.

SPANISH

Si usted o alguien a quien ayuda tienen preguntas sobre Sidecar Health, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete. Por favor, llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

UKRAINIAN

Якщо у вас, чи в особи, котрій ви допомагаєте, виникнуть запитання щодо Sidecar Health, ви маєте право безкоштовно отримати допомогу та інформацію вашою мовою. Щоб замовити перекладача, Зателефонуйте за номером обслуговування учасників, який вказано на вашому посвідченні учасника

VIETNAMESE

Nếu bạn hoặc ai đó bạn đang giúp đỡ, có thắc mắc về Sidecar Health, bạn có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên. Vui lòng gọi số dịch vụ thành viên trên thẻ ID thành viên của bạn.

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Sidecar Health
Attn: Civil Rights Coordinator
440 N Barranca Ave #7028
Covina, CA 91723

1-877-653-6440

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U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.