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, call 855-897-4816 or visit my.homesteadplans.com. 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/sbc-glossary/ or call 855-897-4816 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$500 Individual / $1,000 Family per plan year. Applies to Inpatient Hospitalization, Outpatient Surgery and Emergency Room. Deductible is embedded.	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. When Health Plan members go to a Penn Medicine or Atlantic Health System facility or hospital, services are NOT subject to the Deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, non-hospital and other 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?	Medical Limit - $1,500 Individual, $3,000 Family per plan year Prescription Drug Limit - $1,000 Individual, $2,000 Family per plan year	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, health care this plan doesn't cover; noncompliance penalties.	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?	Not Applicable	For help finding a provider, see www.my.homesteadplans.com, or call 855-897-4816.
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 my.homesteadplans.com.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	None
	Mental health care visit	$20 copay	None
	Specialist visit	$30 copay	None
	Telemedicine services	$0 copay	None
	Preventive care/screening/ immunization	No charge	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.
	Urgent Care	$30 copay	None
	Medical Center at Woods	$0 copay	None
If you have a test	Diagnostic test (x-ray, radiology)	$20 copay	Precertification required for all advanced imaging (CT, MRI, Pet Scans).
	Diagnostic test (lab, blood work)	$20 copay	
	Imaging (CT/PET scans, MRIs)	$50 copay	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at usrxcare.com/member.	Tier 1 – Preferred Generic Drugs	$5 copay for a 30-day supply at a Retail Pharmacy	Many oral contraceptives and contraceptive delivery devices (e.g. birth control patches) will be paid at 100% (i.e. copayment and deductible waived). Please see the Medical portion of your Plan for further details on contraception. Pre-Certification required for Specialty and/or injectable prescriptions, or penalty may apply. To receive Pre-Certification call US-Rx Care at (877) 200-5533. Please refer to the Prescription Drug Benefit section of the Plan SPD for further details.
	Tier 2 – Preferred Brand Drugs and Some Generic Drugs	20% coinsurance ($25 min/$50 max) for a 30-day supply at a Retail Pharmacy	
	Tier 3 – Non-Preferred Brand Drugs and Some Generic Drugs	30% coinsurance ($55 min to $80 max) for a 30-day supply at a Retail Pharmacy	
	Tier 4 – Specialty Medications	30% coinsurance ($55 min to $80 max) for a 30-day supply at a Retail	
If you have outpatient surgery	Outpatient facility fee (e.g., ambulatory surgery center)	$100 copay after deductible	Pre-certification required. Charges based on Allowable Claim Limits.
	Physician/Surgeon fees	No Charge	None

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

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$200 copay after deductible waived if admitted	Pre-certification required if admitted for inpatient services, or no coverage will be provided. Charges based on Allowable Claim Limits. Pre-certification required for non-emergency ambulance transport.
	Emergency medical transportation	No Charge	
If you have a hospital stay	Inpatient facility fee (e.g., hospital room)	$200 copay after deductible	Pre-certification required. Charges based on Allowable Claim Limits.
	Physician fees	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient facility services	$20 copay	Charges based on Allowable Claims Limits.
	Inpatient facility services	$200 copay after deductible	Pre-certification required, or no coverage will be provided. Charges based on Allowable Claims Limits.
If you are pregnant	Office visits	$20 copay for 1st visit	Pre-notification requested. Charges based on Allowable Claim Limits.
	Childbirth/delivery professional services	No charge	
	Childbirth/delivery Inpatient facility services	$200 copay after deductible	
If you need help recovering or have other special health needs	Home health care	No charge	Pre-certification required. Charges based on Allowable Claim Limits.
	Physical, Speech, Occupational Therapy	$20 copay	Pre-certification required after 12th visit. Charges based on Allowable Claim Limits.
	Skilled nursing facility	$200 copay	Coverage is limited to 180 days per calendar year max. Pre-certification required. Charges based on Allowable Claim Limits.
	Durable medical equipment	No charge	Pre-certification required for purchase over $1,500. Charges based on Allowable Claim Limits.
	Hospice Services	$200 copay	Pre-certification required
If your child needs dental or eye care	Children's eye exam	$10 copay	Coverage limited to one exam/year.
	Children's glasses	$100 maximum	Coverage limited to one pair of glasses/year.
	Children's dental check-up	N/A	Separate Coverage provided by employer

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

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 • Corrective Appliances • Hearing Aids	• Non-emergency care when traveling outside the U.S. • Dental care	• Custodial Care • Routine foot care • Long term care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic Care	• Bariatric Surgery

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 855-897-4816. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 612565 or www.cciio.cms.gov. 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: INDECS, Appeals Department at 855-897-4816 or the Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA 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 1-888-446-3327

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

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

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 pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (Facility) copayment	$200
Other	$2,650

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services, Childbirth/Delivery Inpatient Facility Services,
Diagnostic tests *(ultrasounds and blood work)*,
Specialist visit *(anesthesia)*

Total Example Cost	**$3,370**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$220
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$720**

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

The plan's overall deductible	$500
Specialist copayment	$30
Inpatient Facility copayment	$200
Other	$720

This EXAMPLE event includes services like:

Specialist office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$1,450**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$380**

Mia's Simple Fracture
(emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$30
Inpatient Facility copayment	$200
Other	$175

This EXAMPLE event includes services like:

Emergency room care *(includes medical supplies and diagnostic tests)*
Durable medical equipment *(crutches)*

Total Example Cost	**$905**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$680**

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