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. 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.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits 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 Applies to Inpat/Outpatient facility charges (including ER) Does not apply to preventive care.	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, 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 Rx 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; and 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.homesteadproviders.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 or go to member.medxoom.com If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits

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
	Specialist visit	$30 copay	None
	Teladoc	$0 copay	
	Teladoc Primary 360	$0 copay	
	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	
	Woods Health Services	$0 copay	
If you have a test	Diagnostic test (x-ray, radiology)	$20 copay	None
	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 your employer	Tier 1 – Preferred brands and Generics	$5 copay per prescription for retail up to 30-day supply	Covers up to a 30-day supply 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
	Tier 2 - Lower Cost Brands and Generics	20% coinsurance per prescription for retail up to 30-day supply ($25 min to $50 max)	
	Tier 3 - Non-Preferred Brand Drugs and Generics	30% coinsurance per prescription for retail up to 30-day supply ($55 min to $80 max)	
	Mail Order	2X retail copay	

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	$30 copay	Pre-certification required. Charges based on Allowable Claim Limits.
If you need immediate medical attention	Emergency room care	$200 copay after deductible waived if admitted	Benefit includes all related charges. Pre-certification required if admitted for inpatient services, or no coverage will be provided. Charges based on Allowable Claim Limits. Pre-certification required for air ambulance.
	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	Pre-certification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient facility services	$30 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	0% coinsurance	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 care – Inpatient facility	$200 copay after deductible	Coverage is limited to 180 days per calendar year max. Pre-certification required after 12th visit. Charges based on Allowable Claim Limits.
	Durable medical equipment	0% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Pre-certification required for purchase over $1500. Charges based on Allowable Claim Limits. Manual breast pumps are covered at 100%, deductible waived.

	Hospice services – Inpatient facility	$200 copay after deductible	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

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.)

- Acupuncture
- 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

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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.

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 yearly plan's overall deductible** **$500**
- **Specialist copayment** **$20**
- **Inpatient 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	
Yearly Plan Deductibles*	$500
Inpatient Facility Copayments	$200
Specialty Copayments	$20
Other	$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 yearly 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	
Yearly Plan Deductibles*	$0
Inpatient Facility Copayments	$0
Specialty Copayments	$120
Other	$550
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$670**

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

- **The yearly 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	
Yearly Plan Deductibles*	$500
Inpatient Facility Copayments	$0
Specialty Copayments	$180
Other	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$880**

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