HOMESTEAD
SMART HEALTH PLANS

Welcome to this year's open enrollment period!

What you need to know about your 2025 – 2026 Health Plan:

- Your new plan year begins on **July 1, 2025** and is effective through **June 30, 2026.**
- Any amount you paid toward your Medical/Prescription deductible and/or out-of-pocket maximum between January 1, 2025 and June 30, 2025 **will apply to the new plan year**.

Please review the attached documents for additional important information about Open Enrollment and your health plan.

This packet also includes everything you need to know to get the most from your Claim Watcher+ health benefits plan. We encourage you to review all the enclosed materials carefully and take full advantage of the benefits available to you.

Your health and well-being are our top priorities.

If you have any questions or need help, please don't hesitate to call your concierge Member Services team at **(855) 897-4816**, Monday – Friday from 8 a.m. – 6 p.m. ET. or email us at **customerservice@homesteadplans.com.**

You can also visit **www.woodsindecs.com** for more information.

LEGACY
TREATMENT SERVICES
An Affiliate of Woods

HOMESTEAD
SMART HEALTH PLANS

Claim Watcher+ Plan

Your New Health Plan Starts On July 1, 2025

The plan year for your Claim Watcher+ Plan is changing. Find out what that means for you.

Care.
Not Just Coverage.

Woods is moving all benefits to a 7/1 Plan Year

Important Highlights:

- Your current health plan **ends on June 30**.
- The new plan year **starts on July 1, 2025** and will be effective through **June 30, 2026**.
- If you're currently enrolled, **you will be automatically enrolled** for the new plan year.

It's important to understand **how the transition to a new plan year impacts your deductibles and out-of-pocket maximums.**

This guide highlights everything you need to know, including examples and answers to frequently asked questions.

We're here to help!

If you have questions, call us at **(855) 897-4816**, Monday – Friday, 8 AM – 6 PM or email us at **customerservice@homesteadplans.com**

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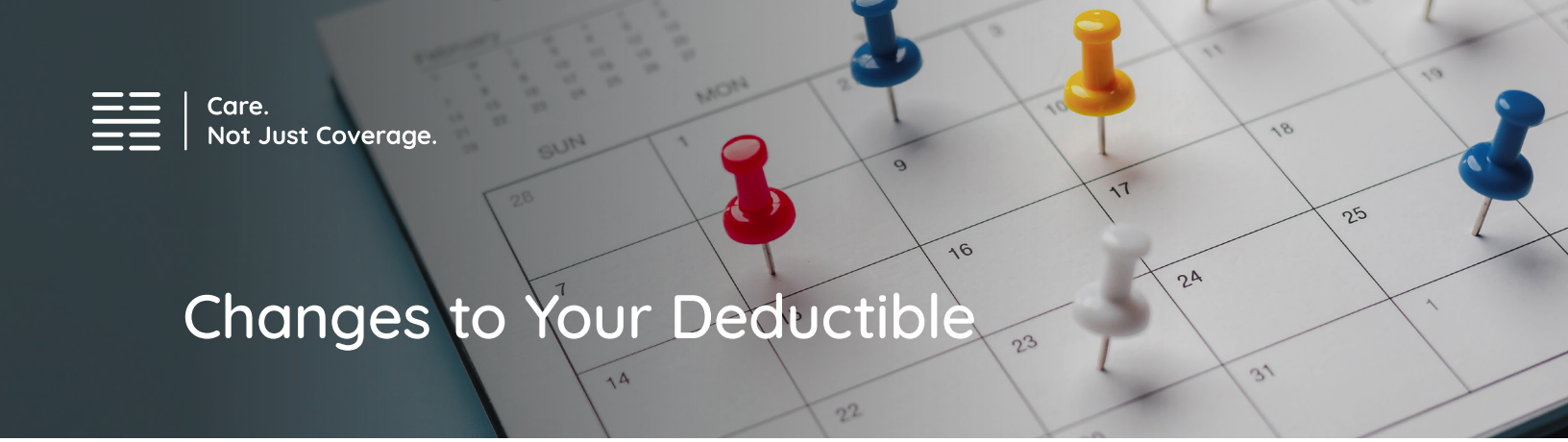


Changes to Your Deductible

Your deductible is the amount you must pay for certain covered services* before your health plan begins to pay. So at the start of each plan year, you pay the full cost for those covered services until you reach the amount of your deductible. Once you reach the deductible, your coverage kicks in and you only pay a copay for those services for the remainder of the plan year, unless you reach your out-of-pocket maximum first.

***Note:** With the Homestead Claim Watcher+ Plan, the deductible applies to covered services such as inpatient hospital care, emergency room visits, and outpatient surgery. The exception is services received at a Penn Medicine or Atlantic Health System facility or hospital. You pay **no deductible** and **no coinsurance** for covered services at Penn Medicine and Atlantic Health System. Review your **Summary of Benefits and Coverage** for information on covered services and the applicable deductible and/or coinsurance amounts. Also, deductibles do not apply to pharmacy benefits.

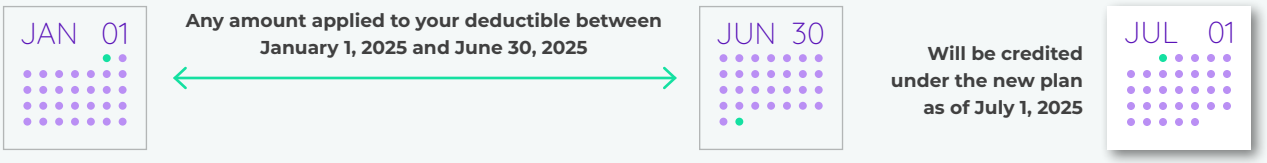
Your Annual Deductible

	Claim Watcher+ Plan (Effective 7/01/25 - 6/30/26)
Individual Deductible	$500
Family Deductible	$1,000

How transitioning to a new plan year affects your annual deductible and any amount already paid toward your deductible since January 1, 2025

Individual and Family Deductibles accumulate over the 12-month plan year. This means employees covered under the current Claim Watcher plan would have paid toward their deductible for certain covered services, such as an inpatient hospital stay or outpatient surgery, that occurred on or after January 1, 2025.

Because the current plan year is ending on June 30, 2025, rather than having the deductible reset on July 1, 2025, **any amount applied to the deductible between January 1, 2025, and June 30, 2025, will be credited under the new plan as of July 1, 2025.**



Examples of Individual Deductible Credits

Example 1

An employee met their individual deductible of **$500** prior to the new effective date of **July 1, 2025**.

A medical claim of **$500** is received for a covered service provided on **August 8, 2025** and the cost of the service applies to their deductible.

How the Individual Deductible will be credited

Because the deductible under the new plan is **$500** and the employee already met the deductible in the previous plan year, **they would not need to pay anything toward the individual deductible for the new claim**.

They have no remaining deductible and will now only pay the applicable copay for covered services until the next plan year starts on July 1, 2026.

Example 2

An employee met **$250** of their individual deductible of **$500** prior to the new effective date of **July 1, 2025**.

A medical claim of **$300** is received for a covered service provided on **September 20, 2025** and the cost of the service applies to their deductible.

How the Individual Deductible will be credited

Because the deductible under the new plan is **$500** and the employee already paid **$250** toward the deductible of their previous plan, **they will only pay an additional $250 to meet their individual deductible of $500.**

After this, the deductible is considered met and they will only pay the applicable copay for covered services until the next plan year starts on July 1, 2026.

Example 3

A new employee's health plan started on **April 1, 2025**. The employee had a few doctor visits, but the deductible did not apply to those services. On **February 1, 2026** the employee visits the emergency room.

How the Individual Deductible will be credited

The full **$500** deductible will apply to the ER visit since there were no claims that previously had a deductible applied.

Thereafter, the deductible will be considered met and no additional deductible will apply until the new plan year begins July 1, 2026.

Examples of Family Deductible Credits

Example 1

A family met **$300** of their **$1,000 family deductible** before the new effective date of **July 1, 2025**.

On **July 15, 2025**, a family member receives a covered medical service billed at **$400**.

How the Family Deductible will be credited

Because the new plan has a **$1,000 family deductible** and the family already paid **$300** toward their old deductible, **only $300 carries over**. That means **$700 of deductible still needs to be met**.

The full $400 cost of the new claim applies to the deductible. After that, the family has **$300** left to meet under the new plan before benefits start paying at the level covered by the plan.

Example 2

A family met their **$1,000 family deductible** prior to the new effective date of **July 1, 2025**.

On **August 10, 2025**, a family member receives a covered medical service billed at **$700**.

How the Family Deductible will be credited

Because the new plan has a **$1,000 family deductible** and the family already paid **$1,000** toward their prior plan's deductible, **no additional deductible is required**.

The individual would pay the applicable copay for that service and the family owes no further deductible until the new plan begins on July 1, 2026.

All examples provided presume the services rendered were covered under the Plan. Please consult your applicable Summary Plan Description for detailed information on plan benefits to include covered services, limitations and exclusions and other important requirements.

Deductible Q&A

Q:
If I met $250 of my $500 Individual deductible before June 30, 2026, I'll still have to pay an additional $250 toward my deductible between July 1, 2025, and June 30, 2026, correct?

A:
Correct.
The amount paid toward your deductible accumulates during a specifically defined plan year – typically 12 months. It then resets to zero at the start of the next plan year. Since you are transitioning to a new plan mid-plan year, Woods is allowing the deductible to accumulate over 18 months.

Q:
Does the deductible apply to all services under the Woods plan?

A:
No.
Services such as doctor's visits, labs, and x-rays, only have a co-payment. No deductible applies. Also, the deductible does not apply to pharmacy benefits.

The deductible applies to services such as inpatient hospital care, emergency room visits, and outpatient surgery. Check your plan documents for more information.

Q:
Is the deductible going up?

A:
No.
The annual deductible limits are staying the same.

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Changes to Your Out-of-Pocket Maximum

An out-of-pocket maximum is the cap, or limit, on the amount of money you may pay for covered health care services in a plan year. If you meet that limit, your health plan will pay 100% of all covered health care costs for the rest of the plan year. The out-of-pocket maximum includes any co-payments, coinsurance, and deductibles.

Your Out-of-Pocket Maximum	Claim Watcher+ Plan (Effective 7/01/25 - 6/30/26)	
Individual OOP Max	Medical	$1,500
	Pharmacy	$1,000
Family OOP Max	Medical	$3,000
	Pharmacy	$2,000

Examples of Individual Out-of-Pocket Maximum Credits

Example 1

An employee paid **$500** toward their **$1,500 individual medical out-of-pocket maximum prior to July 1, 2025**. An employee's individual out-of-pocket medical maximum of **$1,500** had not been met, **so expenses were not being paid at 100% yet.**

After the new plan year begins, a claim is received for covered medical services provided on **August 5, 2025**.

How the Individual Out-of-Pocket Maximum will be credited

Since the employee previously met **$500** of the **$1,500 medical out-of-pocket maximum**, the medical claim for **August 5, 2025** will only be subject to an additional **$1,000 out-of-pocket maximum**, then all subsequent covered medical claims will be paid at **100%** until the plan year ends on **June 30, 2026**.

Example 2

An employee met their **$1,500** individual medical out-of-pocket maximum prior to **July 1, 2025** but has not met the **$1,000 pharmacy out-of-pocket maximum.**

A pharmacy claim is filed on **September 20, 2025**.

A medical claim for the same employee was then received on **October 20, 2025**.

How the Individual Out-of-Pocket Maximum will be credited

For the pharmacy claim, the employee would be responsible for paying the applicable coinsurance amount, which would then be applied toward the $1,000 individual pharmacy out-of-pocket maximum of the new plan.

For the medical claim, since the employee already met the out-of-pocket maximum, the medical claim for **October 20, 2025** and all subsequent covered medical expenses for services received through the end of the plan year on **June 30, 2026** would be payable by the health plan at **100%**.

Examples of Family Out-of-Pocket Maximum Credits

Example 1

A family paid **$600** toward their **$3,000 family medical out-of-pocket maximum** before **July 1, 2025**.

On **July 18, 2025**, a covered pharmacy claim is submitted with a **$250** cost.

How the Family Out-of-Pocket Maximum will be credited

The **$250 pharmacy claim** will be credited toward the **$2,000 family pharmacy out-of-pocket maximum** of the new plan. The family now has **$1,750** left to meet the family out-of-pocket maximum for pharmacy expenses.

The **$600** paid toward the family medical out-of-pocket maximum of the previous plan will carry over separately toward the **$3,000 family medical out-of-pocket maximum** of the new plan. The family now has **$2,400** of out-of-pocket medical expenses to meet before their plan pays **100%** of covered medical expenses.

Example 2

A family met their **$3,000 family medical out-of-pocket maximum** before **July 1, 2025**.

On **August 12, 2025**, a family member receives covered medical services.

How the Family Out-of-Pocket Maximum will be credited

Since the family already paid **$3,000** toward their medical out-of-pocket maximum under the previous plan, **the claim on August 12—and all subsequent medical claims—will be covered at 100% through June 30, 2026.**

Family members will still pay the applicable coinsurance amount for any pharmacy claims until the separate **$2,000 pharmacy out-of-pocket maximum is met.**

All examples provided presume the services rendered were covered under the Plan. Please consult your applicable Summary Plan Description for detailed information on plan benefits to include covered services, limitations and exclusions and other important requirements.

Out-of-Pocket Maximum Q&A

Q:
I didn't meet either of my out-of-pocket maximums yet, but I have paid a few hundred dollars towards it so far. How does this impact my out-of-pocket maximums as of July 1, 2025?

A:
Any money you paid towards medical and pharmacy out-of-pocket maximums in the current plan year will carry over and be applied toward the out-of-pocket maximum of the new plan that begins on July 1, 2025.

Q:
How does the family out-of-pocket maximum work? Does each family member have to meet the individual out-of-pocket maximum?

A:
NO.
For example, while each family member has an individual medical out-of-pocket maximum of $1,500, once the family as a whole reaches the family medical out-of-pocket maximum of $3,000, the plan then pays 100% for all family members for the rest of the plan year, even if all family members have not met their individual out-of-pocket maximum yet.

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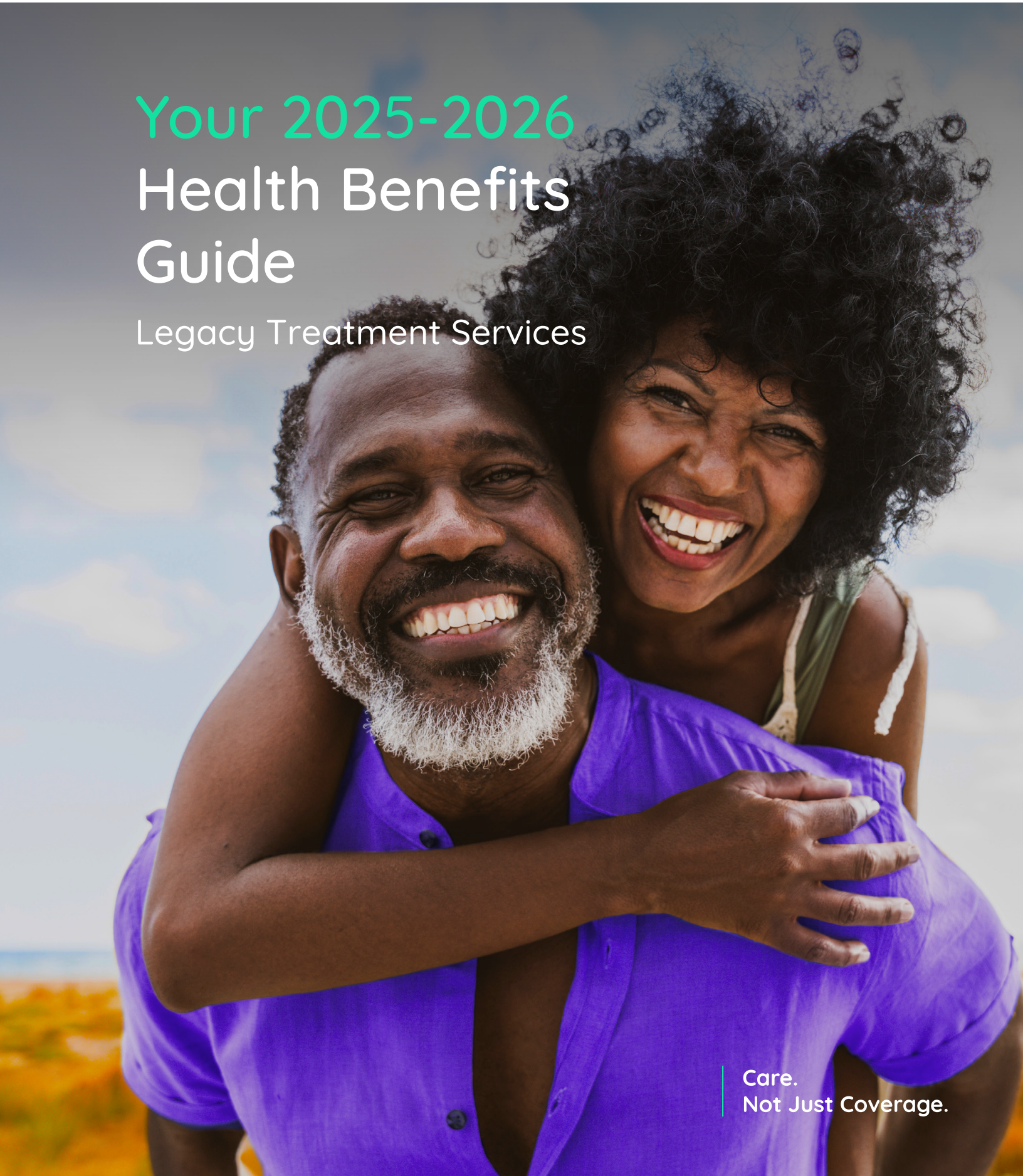
Claim Watcher+ Plan

Your 2025-2026 Health Benefits Guide

Legacy Treatment Services



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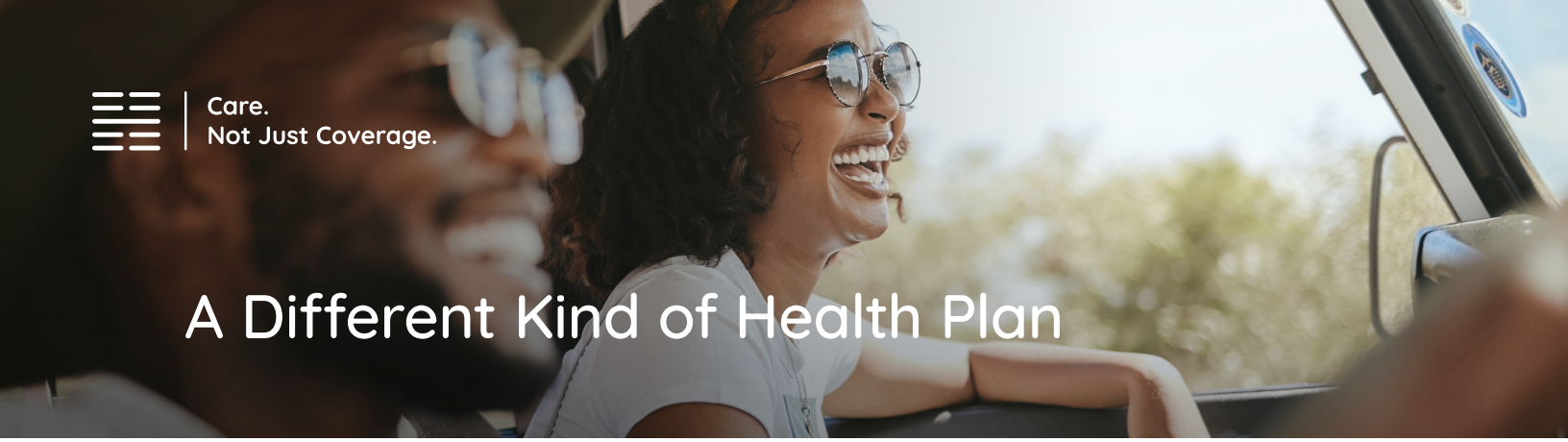

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A Different Kind of Health Plan

Your Claim Watcher+ Plan from Homestead is designed to give you comprehensive coverage and more choice, combined with greater transparency and lower costs.

Below is an overview of how your plan works. Check your plan documents, as well as the **Important Terms to Know** in this guide, for more information.

Here's how it works

1. Open Access

Your plan has no network restrictions. We help you see the provider of your choice. Before you schedule an appointment with a new provider visit **homesteadproviders.com** to see if your provider already accepts the plan. If your provider is listed in the directory, you're all set! You can call to make an appointment.

⚠ **IMPORTANT!** Provider information may change! The provider directory is updated regularly, but details can sometimes be outdated as providers make changes. If a listed provider says they do not accept the plan, please reach out for assistance.

2. We'll Clear the Path

If you don't see your provider in the directory, it's important for us to introduce the plan to them before you make an appointment or seek care. But don't worry, we make it easy for you and most providers accept the plan after it's introduced.

Just call us at **855-897-4816** or submit the provider's information to us online at **homesteadplans.com/providerassistance**. We'll do the rest!

3. Visit your doctor or facility for care

- At your appointment, present your member ID card. If the provider has questions about your plan ask them to call us at the number on your ID card. We'll verify your coverage with them.
- You are only responsible for paying any applicable copays at the time of service. You may also have to pay a coinsurance amount for certain prescriptions. You will be billed by the provider if you have a deductible that applies to any of the services provided. Check your plan documents for more information.
- If the provider asks you to pay more than your copay up front, do not pay. Instead, have them call member services so we can coordinate with them.

4. Review your medical bills and Explanation of Benefits (EOBs)

Balance bills are rare, but we want you to know what to do if you get one. Review your medical bills and compare against your EOBs. If you think there's a mistake or you're being charged more than your patient responsibility, contact us immediately at **855-897-4816**!

04/2025

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Support When You Need It

Concierge Member Services

Health care can be complicated. When you have questions, having the right support makes all the difference. That's why you have a Member Concierge team. Call us at **855-897-4816**, Monday – Friday, 8 AM – 6 PM or email us at **customerservice@homesteadplans.com**.

You can also visit our member portal 24/7 at **hs-plans.com/woods.**

Finding a provider

Visit **homesteadproviders.com** to view our provider directory. If you can't find a provider or have concerns about an upcoming appointment, call us at **855-897-4816**. We'll explain your plan to the provider so you have no issues when you go. See **page 3** for more information about finding a provider.

Virtual care from anywhere

You have access to **free** telemedicine services through Teladoc®. Connect with a provider by video, phone or app for **non-emergency medical care 24/7** for things like colds, flu, allergies and urinary tract infections.

Protection from surprise medical bills

With Homestead, you're protected from balance billing. In the rare event you get a bill for more than what you owe based on your plan, we provide full legal defense and will manage the end-to-end process— at no cost to you.

Learn more about **Balance Bill Protection** on **page 6**.

Finding a Provider

With Homestead, we help you visit the providers you choose for your care.

We'll introduce the plan to providers before you make an appointment or visit, to confirm they will accept the plan and ensure you have convenient access and a smooth transition.

We also give you access to a growing community of providers who already accept your plan.

Before you make an appointment

Visit homesteadproviders.com to see if your provider is already listed in our directory or find a provider near you.

If your provider is listed in the directory:
You're all set! They are already actively working with our members and you can make an appointment. Providers in the directory participate in the **MultiPlan® PHCS Practitioner Only** program or our **Claim Watcher+** program. The directory indicates the program affiliation of the provider. Please mention the appropriate logo on your ID card when scheduling an appointment after your plan's effective date.

If your existing provider is not listed:
Contact us so we can introduce the plan to your provider and confirm they accept the plan.

- Scan the QR code on this page or visit **homesteadplans.com/providerassistance**. This will bring you directly to our Provider Assistance page. There you will be able to list providers you plan on seeing in the next 90 days so we can contact them to introduce the plan and confirm your benefits before your visit. We'll also follow up with you to confirm you're all set!
- You can also call us at **855-897-4816**, or email **customerservice@homesteadplans.com.**
- **Do not pay full charges at time of service.** There are no additional costs to see a provider outside the MultiPlan PHCS Practitioner Only or Claim Watcher+ programs, as long as you fill out the Provider Assistance form or call your Member Concierge prior to your appointment. We will work with your provider to ensure that you are not charged the full amount.

Support every step of the way

As long as you fill out the Provider Assistance form or call your Member Concierge prior to your appointment, we'll help you to see the provider of your choice.

On the rare occasion when a provider is not willing to work with us, our team will find you alternate providers willing to work with the plan.

04/2025

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Preferred Partners

Choose a preferred partner for added convenience when making appointments.

While we offer these preferred providers as a convenience, we will help you go to the provider or medical facility of your choice.

PHCS Practitioner Only

The MultiPlan® PHCS Practitioner Only program offers access in all states to over 700,000 healthcare professionals, including both primary care and specialist practitioners. To look up participating providers in the MultiPlan PHCS Practitioner Only program, visit **homesteadproviders.com**

Penn Medicine

Atlantic Health System

Experience significant savings and easy, straightforward access through two of the region's leading health systems. When you visit one of Penn Medicine or Atlantic Health System's doctors or nationally recognized facilities you pay **no deductible** and **no coinsurance.** To find providers and facilities near you visit **pennmedicine.org** or **findadoctor.atlantichealth.org**

minute clinic®

Visit any location inside select CVS Pharmacy® and Target stores to receive care for minor illnesses and injuries, physicals, screenings, chronic condition monitoring, vaccinations, and more. Visit **www.minuteclinic.com**

QuestSelect™
Formerly Lab Card®

While you can use any lab, we recommend Quest Diagnostics' QuestSelect program. For convenient locations, check out their website at **www.questselect.com**

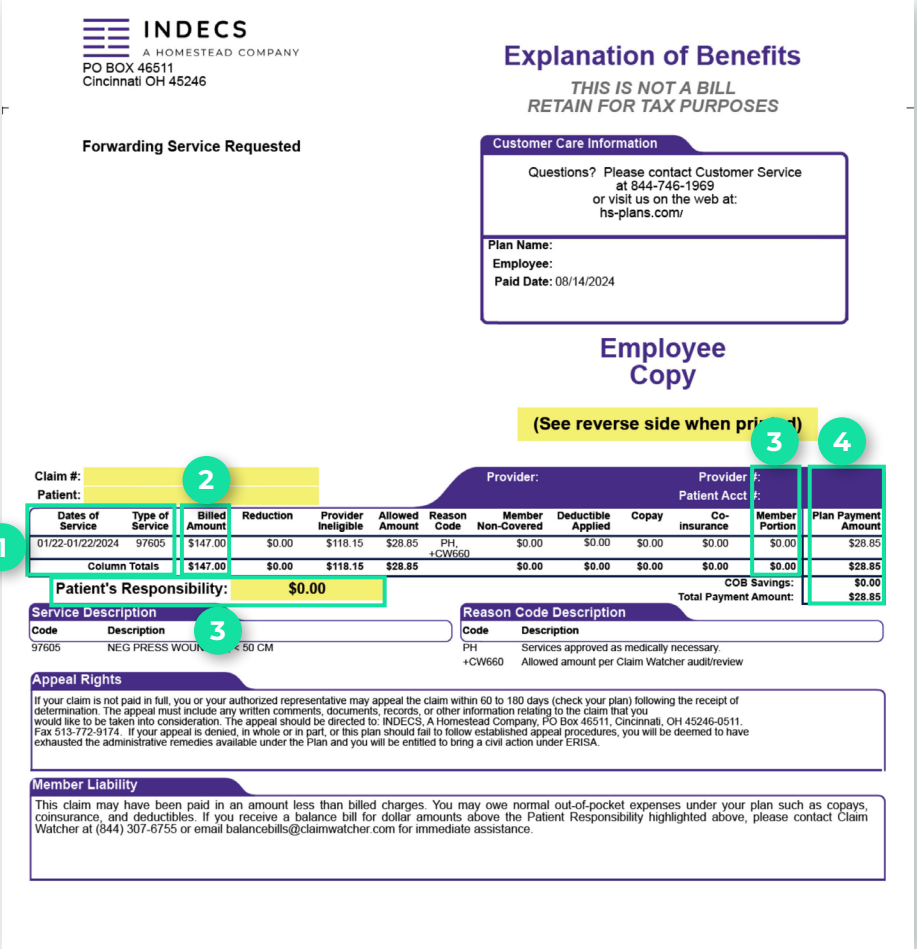
Understanding the EOB

After you use your plan, you'll receive an **Explanation of Benefits** (EOB). Look at your EOB carefully to make sure it's correct. If you owe anything, you'll receive a bill from your doctor or health care provider(s). If the amount of the bill from your doctor is more than the patient responsibility listed on the EOB, contact us immediately.

Your EOB will show:

1. **The service(s) provided, including the date of service.**
2. **The amount charged by the provider.**
3. **What you may owe or have already paid.**

   You must either pay the full amount or enter into a payment plan for this amount within 30 days of the date of the provider's bill.
4. **The amount paid by your plan.**



INDECS
A HOMESTEAD COMPANY
PO BOX 46511
Cincinnati OH 45246

Forwarding Service Requested

Explanation of Benefits

THIS IS NOT A BILL
RETAIN FOR TAX PURPOSES

Customer Care Information

Questions? Please contact Customer Service at 844-746-1969 or visit us on the web at: hs-plans.com/

Plan Name:
Employee:
Paid Date: 08/14/2024

Employee Copy

(See reverse side when pri[illegible])

Claim #:
Patient:

Provider:
Provider #:
Patient Acct #:

Dates of Service	Type of Service	Billed Amount	Reduction	Provider Ineligible	Allowed Amount	Reason Code	Member Non-Covered	Deductible Applied	Copay	Co-insurance	Member Portion	Plan Payment Amount
01/22-01/22/2024	97605	$147.00	$0.00	$118.15	$28.85	PH, +CW660	$0.00	$0.00	$0.00	$0.00	$0.00	$28.85
Column Totals		$147.00	$0.00	$118.15	$28.85		$0.00	$0.00	$0.00	$0.00	$0.00	$28.85

Patient's Responsibility: $0.00

COB Savings: $0.00
Total Payment Amount: $28.85

Service Description

Code	Description
97605	NEG PRESS WOU[illegible] < 50 CM

Reason Code Description

Code	Description
PH	Services approved as medically necessary.
+CW660	Allowed amount per Claim Watcher audit/review

Appeal Rights

If your claim is not paid in full, you or your authorized representative may appeal the claim within 60 to 180 days (check your plan) following the receipt of determination. The appeal must include any written comments, documents, records, or other information relating to the claim that you would like to be taken into consideration. The appeal should be directed to: INDECS, A Homestead Company, PO Box 46511, Cincinnati, OH 45246-0511. Fax 513-772-9174. If your appeal is denied, in whole or in part, or this plan should fail to follow established appeal procedures, you will be deemed to have exhausted the administrative remedies available under the Plan and you will be entitled to bring a civil action under ERISA.

Member Liability

This claim may have been paid in an amount less than billed charges. You may owe normal out-of-pocket expenses under your plan such as copays, coinsurance, and deductibles. If you receive a balance bill for dollar amounts above the Patient Responsibility highlighted above, please contact Claim Watcher at (844) 307-6755 or email balancebills@claimwatcher.com for immediate assistance.

Access anytime

Log in to your member portal at hs-plans.com/woods to view information about your EOBs anytime.

Protection from Surprise Medical Bills

Balance bills happen. **With Homestead, you're protected.**

We've got your back!
Receiving a balance bill is rare for our members.

In fact, less than **1.3%** of all Homestead claims result in a balance bill.

However, they do happen sometimes. Whether it's a billing mistake or the provider seeking to charge more than the amount allowed by your plan, you don't have to worry.

We will vigorously defend against any attempt to charge you more than your patient responsibility – *at no cost to you.*

What is a balance bill?

A balance bill is when you are asked to pay more than your patient responsibility.

When you receive medical care there is usually an amount you need to pay after your coverage is applied. This is called your patient responsibility and includes any copayment, coinsurance, or deductible amount as determined by your benefits plan.

Each time you receive care, you'll receive an Explanation of Benefits (EOB) from us that clearly outlines your patient responsibility **(see page 5 for more detail)**. This is not a bill. It's a document explaining the services billed by the provider, the amount paid by your plan, and your remaining patient responsibility (if there is any) for each claim submitted.

Review your EOBs carefully. If you've paid the patient responsibility shown on your EOB and the provider sends you a bill for an additional amount not covered by your plan, this is a balance bill.

What to do if you receive a balance bill

Contact us immediately at 855-897-4816 if you think you have received a balance bill!
We will verify the details of your claim and whether you are being charged more than your patient responsibility. If so, we will share more information with you and begin the balance bill defense process.

There is a 30-day deadline from the date of an initial bill for us to begin this process with you – so it's important for you to open your mail regularly to review any medical bills and contact us immediately if you think you have received a balance bill.

We know medical bills can be confusing. Let us help. If you receive a bill and have questions, or you're not sure about something, call us!

Have a question about a bill?

Call or email us at:

855-897-4816
Monday – Friday, 8 AM –6 PM ET.
customerservice@homesteadplans.com

Important Terms to Know

Here are common terms related to health plan benefits you may see in this guide and as you use your plan throughout the year.

Open Enrollment

The period of time each year when a health benefits plan allows members to enroll in or change their plan.

Premium

The amount you pay each month in exchange for your health benefits coverage.

Provider

The broad term for physicians or physician groups, health systems, laboratory services providers, ambulatory care centers, and other parties that provide health care services and seek payment for one or more claims from a payer.

Claim

A request from a provider to be paid by a health plan for health services given. An example would be the claim your doctor sends your health plan for an office visit.

Covered Services

When a health care service is included in your plan benefits. Some services are covered before you meet your deductible, while others might be covered only after you've met your deductible. Check your plan documents for these details.

Copay

The fixed amount you pay up front when you receive medical services. For example, some plans require a $25 copay for a visit to a Primary Care Physician and a $50 copay for a visit to a Specialist.

Coinsurance

The percentage of the bill you pay after you meet your deductible. After you have paid your deductible in full, you pay only a percentage of your health care expenses — your health plan pays the rest. For example, if the cost for an x-ray is $1,000 and your coinsurance is 20%, your health plan would cover $800 (80%) and you are responsible for paying the remaining $200 (20%). Coinsurance is paid until you reach the out-of-pocket maximum of your plan.

Deductible

The amount that you must pay for certain medical services before your health benefits plan begins to cover payment. After reaching this amount, the health plan covers their percentage of your services. The lower the deductible, the sooner the health plan starts to pay.

Out-Of-Pocket Maximum

The most you'll pay each year for covered medical expenses. After the maximum is reached, you are no longer responsible for paying coinsurance. The health plan pays 100% of expenses for covered services.

Explanation of Benefits (EOB)

After you receive health care services, and the doctor or facility sends the claim to your health plan for payment, you will receive an EOB. This is not a bill. It's similar to a financial statement from your health plan. It explains the details of the charges submitted, payments made by your plan, your patient responsibility, and any balance you may owe to the provider.

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 hs-plans.com/woods. 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. Deductible is WAIVED for Penn Medicine and Atlantic Health System facilities and hospitals.	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, their services are NOT subject to the Deductible. Note: Any amount applied to your Individual or Family deductible under your previous Woods System of Care health plan for medical services rendered through 6/30/25 will be credited to the July 1, 2025 – June 30, 2026 plan year.
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. Note: Any amount applied to your Individual or Family Out-of-Pocket under your previous Woods System of Care health plan for medical services rendered through 6/30/25 will be credited to the July 1, 2025 – June 30, 2026 plan year.
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.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 at hs-plans.com/woods.

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
	Teladoc/telemedicine services	$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	
	Medical Center at Woods	$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 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, Some Generic Drugs, and Specialty Medications	30% coinsurance ($55 min to $80 max) for a 30-day supply at a Retail Pharmacy	
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 hs-plans.com/woods.

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	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 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. Pre-certification required, or no coverage will be provided. Charges based on Allowable Claims Limits.
	Inpatient facility services	$200 copay after deductible	
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	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. 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 hs-plans.com/woods.

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: 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 855-89-4816 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 hs-plans.com/woods.

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**

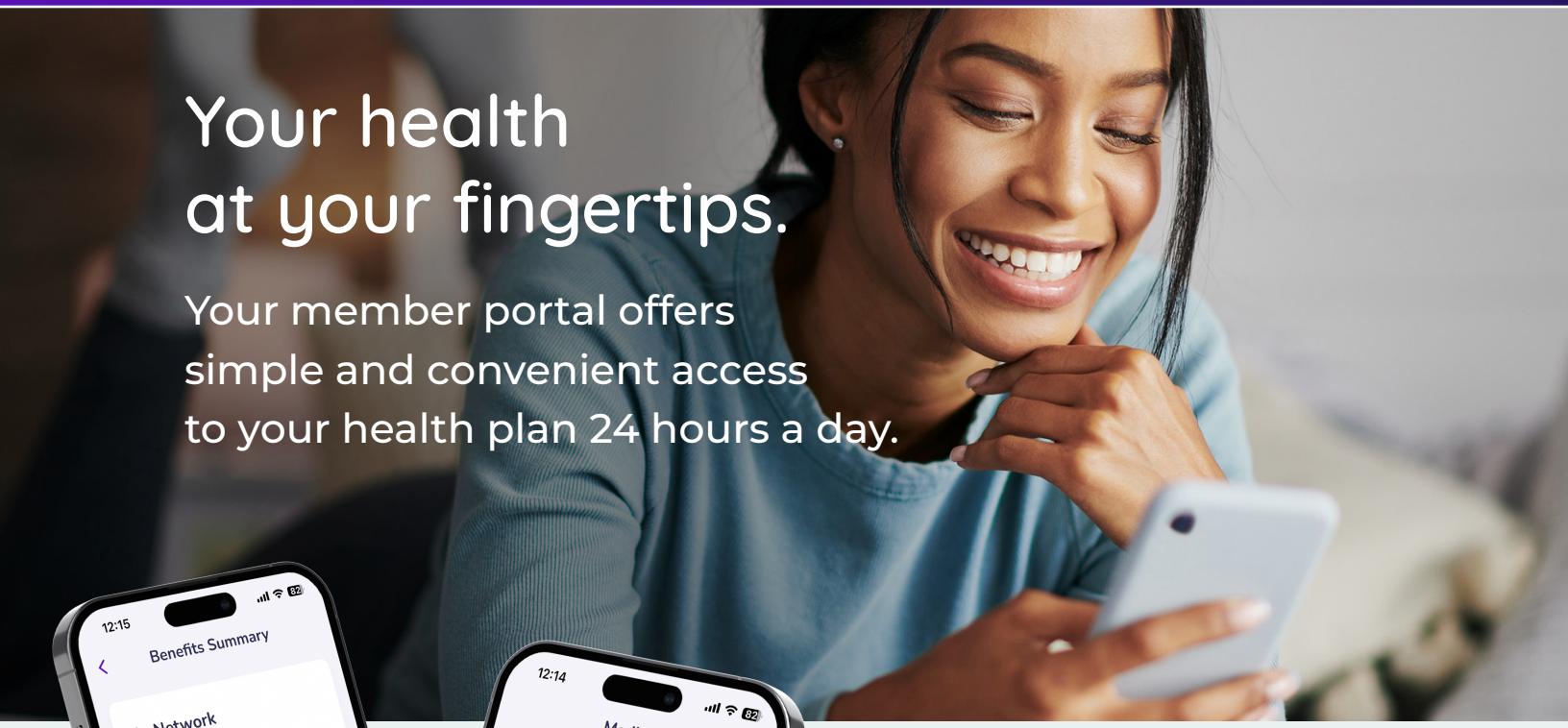
This EXAMPLE event includes services like:
Emergency room care *(includes medical supplies and diagnostic tests)*
Durable medical equipment *(crutches)*

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.

HOMESTEAD
SMART HEALTH PLANS

Member Portal
powered by Medxoom



Your health at your fingertips.

Your member portal offers simple and convenient access to your health plan 24 hours a day.

Download the app to access anytime.

Medxoom is available for download from the App Store or Google play.

Download on the App Store

ANDROID APP ON Google play

Register today to view and manage your benefits.

Visit **hs-plans.com/woods** today to view and manage your benefits.

Get your ID card

Never misplace your ID card again! With Medxoom, your ID card is a click away to view, download or print!

View claim status

A faster, easier way to view claims. Access claims status and EOBs in just a few swipes!

Track your spending

Knowing deductible and expense progress is important, the app shows where you are satisfying your plan year out-of-pocket spending and more!

Care.
Not Just Coverage.

TELADOC HEALTH

Frequently asked questions

What is Teladoc Health?
Teladoc Health is a virtual healthcare service that offers convenient, confidential access to quality providers 24/7, anytime, anywhere.

By scheduling a visit with a U.S. board-certified and licensed provider, you can be diagnosed, treated and prescribed medication if necessary.

What can I use Teladoc Health for?
Teladoc Health can help you with everyday, non-emergency healthcare issues, including sinus problems, allergies, flu symptoms and much more. Skip the waiting room and the trip to the ER. Teladoc Health is here to help you feel better, faster, and get you back to living your life.

Does Teladoc Health replace my doctor?
No. Teladoc Health doesn't replace your primary care doctor. Teladoc Health should be used for non-emergency illnesses when it is not convenient to get to the doctor, or it is outside of regular office hours.

How do I register?
Once the benefit is live, you will be able to register via the Teladoc Health app, visit the website or contact Member Support.

Is there a time limit when talking to the provider? And am I charged more for taking longer?
There is no time limit for visits, and there is no charge for longer provider visits.

How do I access Teladoc Health?
The service can be accessed by app, web or phone, and visits are available by phone or video.

Who are the Teladoc Health providers?
Teladoc Health providers are U.S. board-certified providers. They average 15 years of experience and are licensed to practice in your state.

Can Teladoc Health providers prescribe medications?
Yes, when medically appropriate, providers can prescribe medications. If a prescription is not required, the provider may provide the member with instructions for managing symptoms or following up with their primary care doctor.

Can my primary care doctor get a record of my Teladoc Health visit?
With your consent, an electronic copy of your Teladoc Health visit will be sent to your primary care doctor.

Can I use Teladoc Health while traveling?
Teladoc Health is available in all 50 states, so you can use the service while traveling within the United States. Some restrictions may apply.*

Who should I contact if I have questions or encounter an issue?
If you have any questions or encounter an issue once registered, you will be able to visit the Teladoc Health website or contact the Member Support team.

*Teladoc Health is not available internationally.

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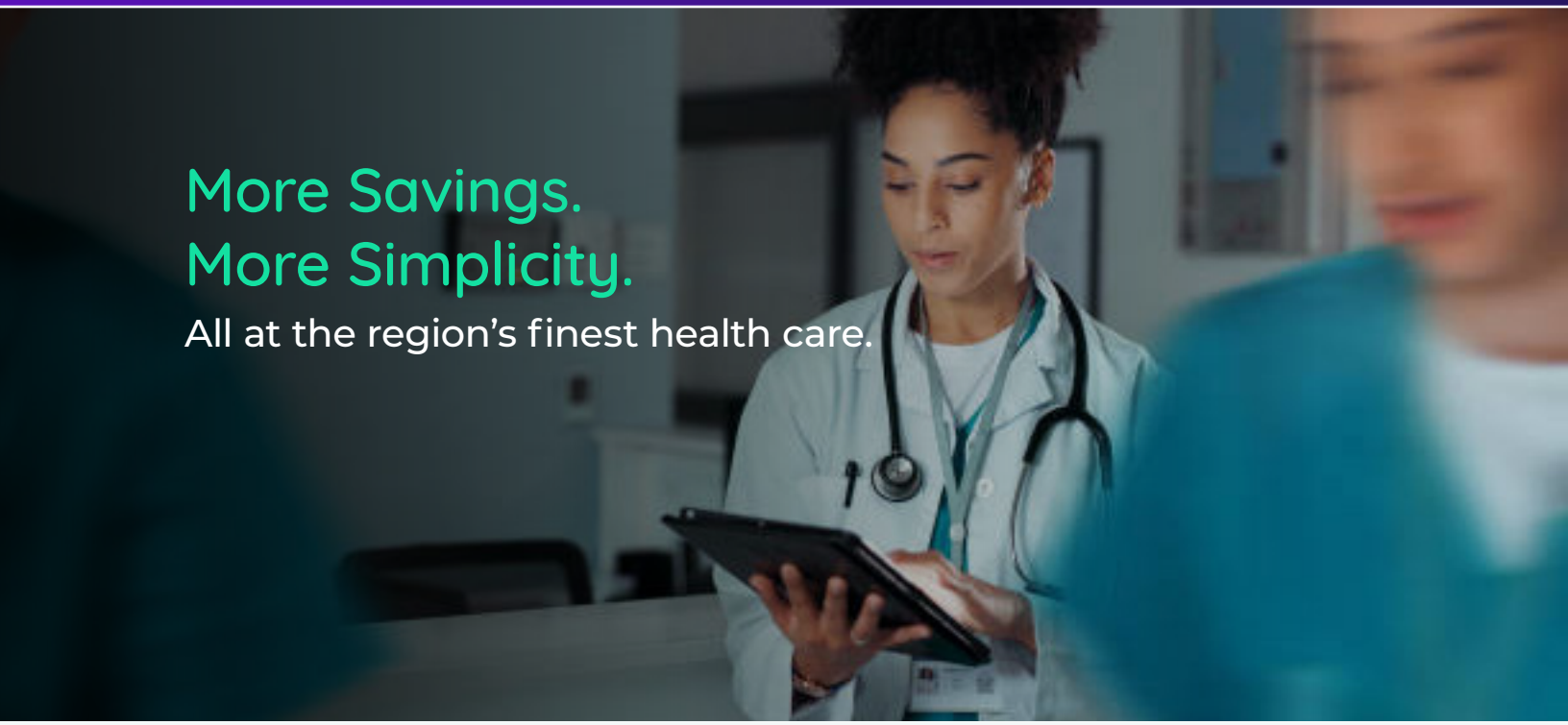
HOMESTEAD
SMART HEALTH PLANS

Claim Watcher+
Tier 1 Providers



More Savings.
More Simplicity.

All at the region's finest health care.

Your Homestead Smart Health Plan delivers significant savings and easy, straight-forward access when you visit **Atlantic Health System** or **Penn Medicine's** large networks of nationally recognized doctors and hospitals.

Access to high-quality health care shouldn't come at a high cost. That's why we've partnered with some of the leading providers of health care in the Mid-Atlantic region of Pennsylvania and Northern New Jersey.

When you receive care from **Atlantic Health System** or **Penn Medicine**, you can feel confident about getting the most value, and savings, from your health plan - without compromising first-class care.

$0 deductible + NO coinsurance

Any plans that include a copay, require payment at the time of service.

Zero deductible and no coinsurance

- Enjoy the benefit of no deductible or coinsurance when you choose any provider or facility within Atlantic Health System or Penn Medicine.
- Since hospital procedures and stays typically come with higher costs compared to office visits, you'll save the most when you choose to receive care from one of Atlantic Health System or Penn Medicine's many hospitals or broad network of facilities.

If your plan includes a copay, you are still responsible for paying that at the time of service.

Quality you can count on

Atlantic Health System and Penn Medicine medical centers are leaders in the Mid-Atlantic region and throughout the nation when it comes to delivering high quality care and superior patient outcomes across numerous specialties according to the Healthgrades 2024 Report to the Nation.

To find providers and facilities near you visit **pennmedicine.org** or **findadoctor.atlantichealth.org**

Greater confidence and convenience

Our established relationship with Atlantic Health System and Penn Medicine means you can feel confident when you seek care. There's no need to confirm your doctor's affiliation or contact us to coordinate before your visit. However, our Concierge Team is here to help if you have questions or need assistance.

Make sure to use your new ID card when calling or visiting an Atlantic Health System or Penn Medicine provider and mention Claim Watcher+®.

Continued flexibility and protection

- You still have the freedom to visit any doctor or healthcare facility under your plan. And you'll still receive a lower price because all claims are paid as in-network. However, choosing Atlantic Health System or Penn Medicine will maximize your savings even more without compromising quality!
- Regardless of which provider you choose, you should never receive a surprise bill, also called a balance bill. If you do, contact us at the number on the front of your ID Card.

Penn Medicine Bucks County

777 Township Line Road
Yardley, PA 19067
Phone: (215) 860-0775

You have access to high-quality Penn Medicine and Atlantic Health System facilities across Eastern PA and Northern NJ.

But for those based near the Woods Services Campus in Langhorne, PA, this location may be the most convenient and offers a wide range of services all in one place.

Featured Services:

- Primary health care (internal medicine and family medicine)
- Specialty care (cardiology, pulmonology, surgery, travel medicine, and more)
- Radiology services and more!

Penn Medicine Locations

PENNSYLVANIA

Multi-Specialty Sites and Services

Penn Medicine Bucks County
- Primary Care
- Cardiology
- Neurosurgery
- Radiology*
- Surgical Consults

... and more

Penn Medicine Valley Forge
- Primary Care
- Adolescent Medicine
- Cancer Services*
- Cardiology
- Ob/Gyn
- Orthopaedics

... and more

Penn Medicine Radnor
- Primary Care*
- Adolescent Medicine
- Cardiology*
- Orthopaedics*
- Radiology*
- Surgical Consults

... and more

Penn Medicine University City
- Primary Care***
- Musculoskeleta!Center***
- Outpatient Surgery***
- Otorhinolaryngology-Ear, Nose and Throat***

... and more

Penn Medicine Washington Square
- Primary Care**
- Cardiology**
- Otorhinolaryngology-Ear, Nose and Throat**
- Surgical Consults
- Women's Health

... and more

Penn Medicine Southern Chester County
- Primary Care
- Gastroenterology
- Physical Therapy
- Ob/Gyn
- Orthopaedics
- Radiology

... and more

Primary Care

- Delancey Internal Medicine Rittenhouse
- Delancey Internal Medicine Washington Square
- Penn Adolescent & Young Adult Medicine Radnor
- Penn Adolescent & Young Adult Medicine Valley Forge
- PennCare for Kids Phoenixville
- PennCare for Kids Limerick
- Penn Center for Primary Care
- Penn Consultative Internal Medicine
- Penn Family Care
- Penn Family Medicine Chestnut Hill
- Penn Family Medicine Kennett
- Penn Family Medicine Limerick
- Penn Family Medicine New Garden
- Penn Family Medicine Pennsylvania Hospital
- Penn Family Medicine Phoenixville
- Penn Family Medicine Southern Chester County
- Penn Family Medicine University City
- Penn Family Medicine Valley Forge
- Penn Family Medicine West Chester
- Penn Family and Internal Medicine Lincoln
- Penn Family and Internal Medicine Longwood
- Penn Internal and Family Medicine Bucks County
- Penn Internal Medicine Bala Cynwyd
- Penn Internal Medicine Mayfair
- Penn Internal Medicine Media
- Penn Internal Medicine Radnor
- Penn Internal Medicine University City
- Penn Internal Medicine Westtown
- Penn Medicine Bala Cynwyd
- Penn Presbyterian Internal Medicine Whiteland
- Spruce Internal Medicine

Hospitals

- Hospital of the University of Pennsylvania
- Penn Presbyterian Medical Center
- Pennsylvania Hospital
- Chester County Hospital
- Lancaster General Hospital

Note: This listing highlights key facilities and services. It is not all inclusive and is subject to change. To confirm a provider accepts the plan, mention Claim Watcher when making your appointment or call the Member Services number on your ID card.

*A facility of the Hospital of the University of Pennsylvania.
**A facility of Pennsylvania Hospital.
***A facility of Penn Presbyterian Medical Center

Penn Medicine Locations

NEW JERSEY

Multi-Specialty Sites and Services

Penn Medicine Cherry Hill

- Primary Care
- Hematology/Oncology
- Ob/Gyn***
- Orthopaedics***

... and more

Penn Medicine Mount Laurel

- Primary Care
- Cardiology
- Ob/Gyn
- ENT
- Neurology
- Podiatry

Penn Medicine Woodbury Heights

- Primary Care
- Cardiology
- Ob/Gyn
- Radiology

... and more

Primary Care

- Penn Family and Internal Medicine Cherry Hill
- Penn Family & Internal Medicine Mount Laurel
- Penn Family Medicine Voorhees
- Penn Internal Medicine Woodbury Heights

Hospitals

- Princeton Medical Center

Atlantic Health System

FACILITY	SERVICES
Physician Providers	
• Atlantic Medical Group	Multi-Specialty Physician Group
• Primary Care Partners	Primary Care Physician Group
• Maternal Fetal Medicine	High Risk Pregnancy Group
• Specialty Care at Practice Assoc	Trauma Physician Group
• Tertiary Specialists of Practice Assoc	Orthopedic Oncology Physician Group
• Ancillary Services of Practice Assoc	Radiology Professional Group
• Atlantic Health Partners	Specialist Physician Group
• Anesthesia Services of Practice Assoc	Anesthesia Physician Group
• Cardiovasc. Health Consul	Diagnostic Cardiology Reads (Mod 26)
• Atlantic Core Therapy & Wellness	Chiropractor Group
• Eye Care of Practice Associates	Ophthalmology Physician Group
• Thompson Healthcare & Sports Med	PT/OT/ST/Chiro

Atlantic Health System

FACILITY	SERVICES
Hospital Facilities	
• Morristown Medical Center	Acute Care Hospital
• Overlook Medical Center	Acute Care Hospital
• Chilton Medical Center	Acute Care Hospital
• Newton Medical Center	Acute Care Hospital
• Hackettstown Medical Center	Acute Care Hospital
• Goryeb Children's Hospital	Acute Care Hospital
• CentraState Medical Center	Acute Care Hospital
Step-Down Facilities	
• Monmouth Crossing (CS A. Living)	Assisted Living
• The Manor	Skilled Nursing/Sub-Acute Care
Ancillary & Ambulatory Providers	
• Atlantic Rehab	Inpatient Rehabilitation
• AtHome Medical	Durable Medical Equipment (Morris Plains)
• AtHome Medical	Durable Medical Equipment (Hackettstown)
• Atlantic Homecare & Hospice	Homecare
• Atlantic Homecare & Hospice	Hospice
• Atlantic Private Care	Private Duty Nursing
• Atlantic Ambulance	Air & Ground Ambulance
• Eagle Ambulance	Ground Ambulance
• Atlantic Advanced Urgent Care	High Acuity Urgent Care (ER-Level)
• Atlantic Urgent Care	Traditional Urgent Care
• Urgent Care Physicians of NJ	Traditional Urgent Care
• Immediate Care (Toms River)	Traditional Urgent Care
• Immediate Care (Hazlet)	Traditional Urgent Care
• Atlantic Imaging Services	Free-Standing Imaging Center
• Hunterdon Ambulatory Services	Free-Standing Imaging Center Ambulatory
• Atlantic Surgery Center at Union	Surgery Center
• Atlantic Surgery Center at Paramus	Ambulatory Surgery Center
• Atlantic Surgery Center at Phillipsburg	Ambulatory Surgery Center

Note: This listing highlights key facilities and services. It is not all inclusive and is subject to change. To confirm a provider accepts the plan, mention Claim Watcher when making your appointment or call the Member Services number on your ID card.

HOMESTEAD
SMART HEALTH PLANS

Helping you manage major injuries, illness, and acute care needs.

Your health benefit plan has arranged case management services through Healthcare Strategies (HCS), for people who may be facing complex medical issues.

Who is HCS?

HealthCare Strategies has been providing health management services nationally for more than three decades.

HCS offers patient-focused programs and services to help you stay healthy and informed, including Case Management services.

This program is aligned with your health plan to provide these services to you at no cost. We urge you to take the call if HCS reaches out to you.

Pre-Certification Requirements*

HCS also manages your health plan's pre-certification process, which is required for the following:

- Hospitalization
- Out-Patient Mental Health/ Substance Abuse
- Organ Transplants
- Qualifying Clinical Trials
- Potential Cosmetic Procedures
- MRI
- MRA
- PET Scan

**List is not comprehensive.*
Please make sure your provider contacts HCS to ensure approval of coverage.

hcs
healthcare
STRATEGIES

08/2024

Care.
Not Just Coverage.

QuestSelect™

The QuestSelect Program offers you and your eligible dependents discounted outpatient laboratory testing* when your testing is sent under the QuestSelect Program to a participating Quest Diagnostics laboratory. To use this voluntary program, the testing must also be ordered by your physician, covered and approved by your health benefit plan.

**Provider collection and handling fees may apply, and are subject to health benefit plan provisions.*

How to Use QuestSelect

At a physician's office or QuestSelect collection site, show your member ID card with the QuestSelect logo and **ask to use the QuestSelect Program**. QuestSelect is optional. If you do not use the QuestSelect Program, your standard benefits for outpatient laboratory testing will apply.

If your physician is able to collect specimens in his/her office, they can continue to collect specimens for the QuestSelect Program. After the collection is complete, your physician must clearly mark QuestSelect on the paperwork and call **1-800-646-7788** to request a QuestSelect pick up.

If your physician does not collect specimens in his/her office, you may find an approved collection site at www.QuestSelect.com or by calling **1-800-646-7788**. Collection site information, including locations, site hours and any special instructions are updated daily, so please visit the website or call before any visit.

Quest Diagnostics' QuestSelect Program applies to diagnostic outpatient laboratory testing, which includes blood testing, urine testing, cytology and pathology, and cultures. The QuestSelect Program does not apply to lab work ordered during inpatient hospitalization; lab work needed on an emergency (STAT) basis, and time-sensitive, specialized outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests; nonlaboratory work such as mammography, x-ray, imaging and dental work; lab work performed by another lab; and testing that is not approved and/or covered by your health benefit plan.

Quest Diagnostics' QuestSelect Program helps control healthcare costs and provides members with an opportunity to save on covered outpatient laboratory testing. If you have any questions, please call QuestSelect Client Services at 1-800-646-7788.

FOR MORE INFORMATION CALL OR VISIT

1-800-646-7788 / www.QuestSelect.com

Common Questions About QuestSelect Program

QuestSelect is a service of Quest Diagnostics

What is QuestSelect?

QuestSelect is a voluntary program that allows you to obtain high quality, discounted outpatient laboratory testing.* To obtain the discounted services your physician or phlebotomist must indicate that you have the QuestSelect Program on the paperwork that accompanies your specimens to a participating Quest Diagnostics laboratory.

Does QuestSelect replace current healthcare benefits?

No. It simply provides you the option to receive discounted outpatient laboratory testing when you present your ID card with the QuestSelect logo and ask for the QuestSelect Program. However, if you choose not to use the QuestSelect Program, your standard benefits for outpatient laboratory testing will apply.

What tests are processed under QuestSelect?

The program covers diagnostic outpatient laboratory testing provided the tests have been ordered by your physician and you have requested to use your QuestSelect Program. Outpatient lab work includes:

- Blood testing (e.g., cholesterol, CBC).
- Urine testing (e.g., urinalysis).
- Cytology and pathology (e.g., pap smears, biopsies).
- Cultures (e.g., throat culture).

What tests are NOT processed under QuestSelect?

QuestSelect does not cover all lab work, including:

- Lab work ordered during hospitalization.
- Lab work needed on an emergency (STAT) basis and time-sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests.
- Nonlaboratory work such as mammography, x-ray, imaging and dental work.
- Lab work performed by another laboratory or non participating Quest Diagnostics laboratory.

Is there a charge for specimen collection?

Yes. When your specimen is collected at the physician's office, your health plan may be billed by the physician for collection services. When your collection is at an approved QuestSelect collection site, Quest Diagnostics will be responsible for billing your health plan. However, you may be responsible for coinsurance, copay and/ or deductible.

What if my physician doesn't collect specimens?

Most of the time, the physician or physician office staff collects your specimen(s) and calls QuestSelect Client Services for pick up. If the physician is unable to collect the specimens, check the website at **www.QuestSelect.com** or call **1-800-646-7788** to see if there is an approved collection site in your area. Please verify hours of collection for the QuestSelect Program and collection site capabilities, specifically glucose tolerance testing and pediatric draws.

If a collection site that meets your needs is available, you can take a completed test order from your physician or a Quest Diagnostics requisition outlining the tests to be performed to the collection site. Show your ID card with the QuestSelect logo to the office staff and verbally ask for the QuestSelect Program. Your physician or phlebotomist must indicate that you have the QuestSelect Program on the paperwork that accompanies your specimens. Specimens will be collected by a trained medical professional and sent to the laboratory for testing. Results will be sent to your physician, generally the next day. If you do not use your QuestSelect Program, you will continue to receive lab services as you always have — and your standard benefits for outpatient laboratory testing will apply.

What if a physician who does not collect specimens for the QuestSelect Program, wants to perform the testing in his or her own office, or have the specimens sent to a laboratory of his/her choice?

You may continue to have lab work performed at another laboratory without using the QuestSelect Program; however, your standard benefits for outpatient laboratory services will apply.

What if the physician or the office staff has not heard of QuestSelect?

Ask them to call QuestSelect Client Services at **1-800-646-7788** to speak with a client service representative who will explain the QuestSelect Program and fax a packet of information for their immediate use. You can also call the QuestSelect Client Services number or visit the website, **www.QuestSelect.com**, to ask that they contact your physician in advance of your next visit.

Can testing under the QuestSelect Program be sent to any Quest Diagnostics laboratory?

Yes. To ensure you receive the benefit of the QuestSelect Program, you must show your healthcare card with the QuestSelect logo and ask to use the QuestSelect Program. Your physician should clearly mark QuestSelect on your laboratory orders or Quest Diagnostics requisition and call **1-800-646-7788** for a QuestSelect pick up. Specimens will be sent to a Quest Diagnostics laboratory and results will be sent back to your physician, typically the next day.

Provider collection and handling fees may apply, and are subject to health benefit plan provisions. You may be responsible for coinsurance, copay and/or deductible.

IF YOU HAVE ANY ADDITIONAL QUESTIONS ABOUT QUESTSELECT, CALL OR VISIT

1-800-646-7788 / www.QuestSelect.com

HOMESTEAD
SMART HEALTH PLANS

Notice of Privacy Practices of Homestead Strategic Holdings Inc.

Please review this Notice carefully as it describes:

- How health information about you may be used and disclosed.
- Your rights with respect to your health information.
- How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information.

You have the right to receive a copy of this Notice (in paper or electronic form) **and to discuss it, if you have any questions, with:**

Compliance Officer
Homestead Smart Health Plans
201-460-3200
compliance@homesteadplans.com

Intent of Notice

This Notice describes the privacy practices of Homestead Strategic Holdings Inc. It applies to the health services you receive at Homestead Strategic Holdings Inc. Homestead Strategic Holdings Inc. will be referred to herein as “we” or “us.” We will share your health information among ourselves to carry out treatment, payment, and healthcare operations.

Our Privacy Obligations

We are required by law to maintain the privacy of your health information and to provide you with our Notice of Privacy Practices (‘Notice’) of our legal duties and privacy practices with respect to health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We may update our privacy practices and the terms of our Notice from time to time. If we make changes, we will provide you with a revised Notice and post it in our office. The new Notice will apply to all health information we maintain, including information created or received before the date of the revision.

If there is a breach of your unsecured health information, we are required to notify you promptly. This means if your health information is accessed, used, or disclosed in a way that is not permitted by HIPAA, and poses a risk to your privacy, we will inform you about what happened and what steps you can take to protect yourself.

Care.
Not Just Coverage.

We take our legal responsibilities seriously and are dedicated to ensuring your health information is handled with the utmost care and respect. If you have any questions or concerns about your privacy rights, please feel free to contact us. We are here to help.

Federal and State Law Notice

Federal and state laws require we protect your health information and federal law requires us to describe to you how we handle this information. When federal and state laws differ, and the state law is more protective of your information or provides you with greater access to your information, then state law will override federal law.

Federal law (42 U.S.C. 290dd-2) does not override all state laws in the same area. If a use or disclosure is permitted by 42 CFR Part 2 but conflicts with state law, we will adhere to the more restrictive law. However, no state law can permit or require a use or disclosure that is prohibited by the 42 CFR Part 2 regulation.

How We May Use or Disclose Your Health Information

In order to provide TPA services for your health Plan, **Homestead** will need private information about you, and we obtain that information from many different sources – particularly your Plan Sponsor, other insurers, HMOs or third-party administrators (TPAs), and health care providers. We may use and disclose PHI about you in various ways in providing TPA services for your Plan, including:

Health Care Operations: We may use and disclose PHI during the course of running our TPA business – that is, during operations such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operations requiring use and disclosure include administration of reinsurance and stop loss; underwriting and rating; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; and other general administrative activities, including data and information systems management, billing, and customer service.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums or Plan payments; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the Plan Member or other covered dependent(s). In addition, claims information contained about Plan Members and their covered dependents is available on our secure **Homestead** web portal and through our customer service line.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who may provide you their services. For example, doctors may request medical information from us to supplement their own records. We also may use PHI in providing pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose PHI to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, we may disclose PHI to other health plans offered by your Plan Sponsor or employer if they have arranged for us to do so to have certain expenses reimbursed.

Health and Wellness Information: We may use or disclose PHI in order to provide you with information regarding treatment alternatives, treatment reminders, or other health-related benefits and services.

Plan Administration: We may disclose your PHI to your employer, or the Plan Sponsor of your benefit program.

Research; Death, Organ Donation: We may disclose your PHI to researchers, provided that certain measures (like de-identification) are taken to protect your privacy. We may disclose PHI, in certain instances, to coroners, medical examiners and in connection with organ donation.

Business Associates: We may disclose your PHI to third parties who provide services to **Homestead**, your employer or Plan Sponsor and others who assure us they will protect the information through a written Business Associate Agreement.

Public Health and Safety; Health Oversight: We may disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Any disclosure, however, would be to someone able to help prevent the threat. Examples of this include: preventing disease; helping with product recalls; reporting adverse reactions to medication; reporting suspected abuse, neglect, or domestic violence; and preventing or reducing a serious threat to anyone's health or safety.

Legal Process; Law Enforcement; Specialized Government Activities: We may disclose your PHI to federal, state and local law enforcement officials for such purpose as responding to a warrant or subpoena; in the course of legal proceedings; discovery request, or other lawful process.

Workers Compensation: We may disclose your PHI when authorized by workers' compensation laws. Family and Friends: We may disclose PHI about you to a relative, a friend, the subscriber of your health benefits or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the **Homestead** toll-free number on your ID card. If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the **Homestead** toll-free number on your ID card – or have your provider contact us.

Personal Representatives: Unless prohibited by law, we may disclose your PHI to your personal representative, if any. A personal representative is a person who has legal authority to act on your behalf regarding your health care or health care benefits. For example, an individual named in a durable power of attorney or a parent or guardian of an un-emancipated minor are personal representatives.

Comply with the law: We may use or disclose your PHI when we are required to do so by law. For example, we may disclose your health information to the representatives of the Office for Civil Rights of the U.S. Department of Health and Human Services so that they may ensure that we are appropriately protecting the privacy of your health information.

Disclosures We May Make Unless You Object

We may disclose your health information in the following situations unless you tell us not to:

Family Members, Friends, and Others Involved in Your Care. We may disclose your health information to designated family members, friends, and others who are involved in your care or in the payment for your care to facilitate that person's involvement in caring for you or paying for your care. If you are present and able to make decisions, we will give you the opportunity to object to these disclosures. If you are not present or are unable to make decisions, we may share your information if we determine it is in your best interest.

Disaster Relief Efforts. We may disclose limited health information to a public or private entity that is authorized to assist in disaster relief efforts to coordinate your care or notify your family about your location, condition, or death.

Appointments and Services. We may use and disclose your information to remind you of upcoming appointments. We may also inform you about treatment options, alternatives, or other health-related benefits and services that may be of interest of you.

School Immunization Requests. We may share your health information for purposes of school immunization requests if the school is required by law to have documentation of such immunization(s) for enrollment.

Uses and Disclosures That Require Authorization

We will obtain your written authorization before using or disclosing your health information for purposes not covered by this Notice or the laws that apply to us.

Special Protections for Reproductive Health Information

Reproductive Health Information. We are committed to protecting the privacy of your reproductive health information. This information includes details related to pregnancy, contraception, pregnancy termination, fertility treatments, and other related services. In line with federal and applicable state laws, we will not use or disclose your reproductive health information for certain purposes without your explicit written permission.

- We will not use or disclose your reproductive health information for any criminal, civil, or administrative investigation or proceedings. For example, if you seek reproductive health services that are legal in your state, we will not disclose your information to law enforcement or other authorities for the purpose of investigating or prosecuting you or your healthcare provider.
- We will not use or disclose your reproductive health information to impose liability on individuals seeking reproductive health care. For instance, if you travel out of state to obtain reproductive health services, we will not share your information with authorities in your home state who may seek to impose legal consequences on you or those who assisted you.

Attestation Requirement for Certain Uses and Disclosures. In some situations, we may be asked to share your health information with others, such as law enforcement, courts, or government agencies. Before we do, the person or group requesting your information must provide a statement, called an attestation, that certain conditions have been met. This ensures that your information is not used in ways that are against the law. Here is when we need an attestation:

- Law Enforcement Requests: If law enforcement asks for your reproductive health information for an investigation, we will only share it if they confirm that the information will not be used to investigate or prosecute you or your healthcare provider for legal reproductive health care.
- Court Orders or Subpoenas: If a court or lawyer requests your information for a legal case, we will require them to confirm that the information will be used properly and in accordance with the law.
- Government Investigations or Audits: If a government agency needs your information for auditing or investigating our healthcare practices, we will ask for an attestation to ensure the information is used only for that purpose.
- Coroners and Medical Examiners: If a coroner or medical examiner requests reproductive health information, we need them to provide a statement confirming that the information is needed for their official duties, such as investigating the cause of death or performing autopsies.

Your Rights Regarding Your Health Information

The following is a summary of your rights with respect to your PHI. You may ask us, in writing to:

Right to Request Confidential Communications: You have the right to request that your health information is received by an alternative means of communication, or at alternative locations. For example, if you are covered as an adult dependent, you might want us to send health information to a different address from that of your subscriber. We will accommodate reasonable requests.

Right to Receive an Accounting of Disclosures: You have the right to request that we provide a list of disclosures we have made about you. Your request must be in writing. If your request such an accounting, we may charge a reasonable fee.

Right to Receive a Privacy Breach Notice: You have the right to receive written notification if we discover a breach of your unsecured PHI.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Complaints

If you believe your privacy rights have been violated, you can file a complaint, in writing, to the contact person below. You may also file a complaint, in writing, with the Secretary of the Department of Health and Human Services (HHS) at the below address. There will be no retaliation for filing a complaint.

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.,
Washington, D.C. 20201
Toll-Free Call Center: **1-877-696-6775**

Or go online to:
https://www.hhs.gov/ocr/privacy/hipaa/complaints/

Homestead's Legal Obligations

The federal privacy regulations require your Plan Sponsor to keep personal information about you private and secure, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect. As a TPA providing services to your Plan Sponsor, this notice is an extension of the Plan Sponsor's obligation. The Plan may use information differently than as described in this notice and may have its own Privacy Practices.

Other Uses of Medical Information

Except as set forth above, we will not use or disclose information about you that is private but not considered to be PHI without first obtaining your written permission. If you give us written permission to use or disclose PHI of other private information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose the information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain in connection with claims paid on your behalf.

We must follow the privacy practices described in this Notice while it is in effect. This notice will remain in effect until we change it and replaces any other information you have previously received from us with respect to the privacy of your protected health information. We will publish the updated Notice on our website/web portal.

Contact

If you have questions, need further assistance regarding, or want to make a request related to this Notice, please contact our Compliance Officer for more information:

Phone:	201-460-3200
Address:	50 South 16th Street, Suite 3400, Philadelphia, PA 19102
E-mail:	compliance@homesteadplans.com

Effective Date

This Notice is effective as of **5/1/2025**.

HOMESTEAD
SMART HEALTH PLANS

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the member phone number on your medical benefits card.

08/2024