Hometown Health Providers Insurance Company, Inc.
Schedule of Benefits – 85266NV0030073
Benefit Plan – 22 Hometown Gold PPO

This Schedule of Benefits describes your health insurance Policy provided by Hometown Health Providers Insurance Company, Inc. (Hometown Health), an insurance company licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members.

Network. This Policy is an open access Preferred Provider Organization (PPO) plan that provides access to a large, state-wide network of Preferred Providers who have contracts with Hometown Health. Services from Preferred Providers will generally be paid at the In-Network Benefit level. Members may also seek services from Non-Preferred Providers (Out-of-Network), generally at a reduced benefit level (higher cost to the Member).

Prescription Drug Coverage. Members must utilize the HometownRx Signature Pharmacy Network. *This Policy does not cover drugs which are purchased from pharmacies that are not part of the HometownRx Signature Pharmacy Network.* Members must work with their doctors to select drugs that are included in the HometownRx Drug Formulary. *This Policy does not cover drugs which are not included in the HometownRx Drug Formulary.*

Pediatric Coverage. This Benefit Plan includes pediatric vision coverage for those members under the age of 19, with a corresponding vision network of Preferred Providers. A list of Preferred Providers for this network and the medical and pharmacy networks are available at www.hometownhealth.com. This Benefit Plan does not include pediatric dental coverage.

Geographic Service Area. This Policy is available only to those individuals and families who live in Carson City, Douglas County, Lyon County, Storey County or Washoe County. Additional eligibility requirements are detailed in the Hometown Health Individual and Family PPO Evidence of Coverage (EOC).

Minimum Essential Coverage. This Benefit Plan is considered Minimum Essential Coverage as defined by 26 U.S.C. § 5000A(f) and its implementing regulations.

Additional Requirements. This Schedule of Benefits describes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures. This document is summary in nature. It does not contain all of the Prior Authorization requirements and specific restrictions, exclusions and limitations associated with this Benefit Plan. Refer to the EOC for a more comprehensive list of Prior Authorization requirements and specific cost sharing information, restrictions, exclusions and limitations.

Benefit Category	***Member Responsibility*** In-Network	Out-of-Network
Calendar Year Deductibles (CYD)		
Medical Calendar Year Deductible (CYD)	Individual $500 Family $1,000	Individual $4,000 Family $8,000
Pharmacy Calendar Year Deductible (CYD)	Individual $0 Family $0	Combined with Medical
This plan has an Embedded Deductible. Hometown Health will begin to pay for non-preventive covered services for a Member once that Member has met the individual Deductible or when the family meets the family Deductible, whichever comes first (for those services applicable to the Deductible).		
Calendar Year Out-of-Pocket Maximums		
Combined Out-of-Pocket Maximum (Medical, Pharmacy and Vision services)	Individual $5,000 Family $10,000	Individual $10,000 Family $20,000
The In-Network Out-of-Pocket Maximum includes Deductibles, Copayments and Coinsurance. The Out-of-Network Out-of-Pocket Maximum includes only Coinsurance. The Out-of-Pocket Maximum does not include Premiums, expenses associated with non-covered services or denied claims, Ancillary Charges and amounts that Non-Participating Providers bill and are payable that are greater than the Allowed Amount.		
Physician Office Visits		
Primary Care Provider (PCP) virtual visits with a Renown provider	$0	CYD then 40%
Primary Care Provider (PCP) office visits with a Renown provider *(additional charges may apply for other services such as labs or diagnostic tests)*	$10	CYD then 40%
Primary Care Provider (PCP) office or virtual visits with a non-Renown PCP *(additional charges may apply for other services such as labs or diagnostic tests)*	$30	CYD then 40%
Convenient Care Facility services provided for Medically Necessary, non-urgent Illness or Injury	$30	CYD then 40%
Primary care wellness visits and preventive screenings	$0	CYD then 40%
Obstetrics and gynecology for ACA services	$0	CYD then 40%
Prenatal and postnatal office visits	$0	CYD then 40%
Specialist care virtual visits with a Renown provider	$60	CYD then 40%
Specialist care	$60	CYD then 40%
Physician to Physician eConsult *Coverage is provided for eConsults initiated by Your Primary Care Physician (PCP) to a Specialist in order to receive advice or treatment recommendation for Your care.*	$10	CYD then 40%
Remote Monitoring *Coverage is provided for Medically Necessary remote patient monitoring, including the collection, storage, and evaluation of health information through live monitoring via devices that transmit information from the home or care facility to Your provider. Copay paid once per 30-day period*	$10	CYD then 40%
Imaging, surgery and other services provided in an office setting may have a higher copayment or coinsurance.		

Pharmacy Benefits		
Tier 1 - Generic Drugs	$10	N/A
Tier 2 - Preferred Brand Drugs *(May also include select Generic drugs. Refer to the EOC for Ancillary Charge.)*	$60	N/A
Tier 2 - Preferred Brand Oncological Drugs *(Preferred Brand Oncological Drugs require Prior Authorization* and must be purchased at a designated pharmacy.)*	$60	N/A
Tier 3 - Non-Preferred Brand or Generic Drugs	$120	N/A
Tier 4 - Specialty Pharmaceuticals *(May also include non-preferred high cost Generic drugs. Refer to the EOC for ancillary charge. Specialty Pharmaceuticals require Prior Authorization.* Most Specialty Pharmaceuticals must be obtained through a specialty pharmacy designated by HometownRx and are limited to a 30-day supply per fill.)*	20%	N/A
Member Responsibility reflects up to 30-day supply per fill. Cost sharing for diabetic supplies is based on the tier (Generic, Brand, etc.). Diabetic supplies include insulin, insulin syringes with needles, glucose blood-testing strips, lancets and lancet devices. Select preventive drugs are available with no member cost sharing.		
Hospital Facility Services		
Acute care hospital admission	$2,000	CYD then 40%
Inpatient stay for delivery, postpartum care and newborn care services	$2,000	CYD then 40%
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	$1,000	CYD then 40%
Skilled nursing facility *(limited to 100 days per Calendar Year)*	$2,000	CYD then 40%
Rehabilitation facility *(limited to 60 days per Calendar Year)*	$2,000	CYD then 40%
Most Hospital Facility Services require Prior Authorization. Refer to your EOC for additional details.*		
Urgent Care and Emergency Services		
Virtual Visits for Urgent Care Services *(available only through Hometown Health's preferred virtual visit provider; go to the Telehealth tab at HometownHealth.com to access these services).*	$0	Not Applicable
Urgent Care Center Services Received in Nevada	$70	CYD then 40%
Urgent Care Center Services Received Outside Nevada *(Because Hometown Health is not contracted with Out-of-Network Providers, Out-of-Network Providers may balance bill you for the amount charged in excess of the Allowed Amount)*	$70	$70
Emergency Room Services *(Copayment is waived if admitted; Because Hometown Health is not contracted with Out-of-Network Providers, Out-of-Network Providers may balance bill you for the amount charged in excess of the Allowed Amount)*	$1,000	$1,000
Ambulance (ground)	CYD then 20%	CYD then 20%
Billed charges for ground ambulance services in Nevada will reflect the in-network deductible and in-network maximum out of pocket accumulators. Charges for services outside of Nevada are subject to out-of-network deductibles and maximum out of pocket amounts.		
Ambulance (air and water)	CYD then 20%	CYD then 20%

Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT, CTA) scan	$280	CYD then 40%
Positron Emission Tomography (PET) scan	$280	CYD then 40%
Magnetic Resonance Imaging (MRI/MRA)	$280	CYD then 40%
Nuclear Medicine	$280	CYD then 40%
Angiograms and Myelograms	$280	CYD then 40%
All Other (Non-Specialty) Imaging and Diagnostic Testing (including X-rays and ultrasounds)		
Services provided in a Primary Care Physician office *(except Specialty Imaging and Diagnostic Testing)*	$30	CYD then 40%
Services provided in a Specialty Care Physician office *(except Specialty Imaging and Diagnostic Testing)*	$60	CYD then 40%
X-ray and all other diagnostic imaging services not performed in a Primary Care or Specialty office setting	$70	CYD then 40%
Diagnostic mammography	$70	CYD then 40%
Preventive mammography screening	$0	CYD then 40%
Laboratory Services		
Medically necessary general laboratory services *(unless covered as preventive)*	$45	CYD then 40%
Outpatient Speech, Occupational and Physical Therapy		
Speech therapy	$30	CYD then 40%
Occupational therapy	$30	CYD then 40%
Physical therapy	$30	CYD then 40%
Coverage for Medically Necessary speech therapy, occupational therapy and physical therapy are limited to 120 visits for all three therapy types combined, separately for both habilitative and rehabilitative services, per Calendar Year. Visit maximums are for both In-Network and Out-of-Network visits combined, and for outpatient facility/provider visits combined. Prior authorization required if more than 20 visits are required for each therapy type in a Calendar Year.		
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 120 visits per Calendar Year all modalities combined.)*	$10	CYD then 40%
Wound therapy in an outpatient hospital or outpatient facility setting *(For wound therapy in an office based setting, see the Physician Office Visits section of this Benefit Summary Table.)*	CYD then $120	CYD then 40%
Chemotherapy in an outpatient hospital, outpatient facility or Physician's office	CYD then $120	CYD then 40%
Radiation therapy in an outpatient hospital, outpatient facility or Physician's office	CYD then $120	CYD then 40%
Infusion therapy *(Includes home infusion therapy. Does not include the cost of special pharmaceuticals used in infusion therapy. For cost of the special pharmaceuticals used in infusion therapy, see the special pharmaceuticals benefit in the Medical Pharmacy and Immunizations section or the Pharmacy Benefits section below as appropriate.)*	CYD then $120	CYD then 40%

Rehabilitation services other than cardiac and pulmonary rehabilitation require Prior Authorization. Refer to your EOC for additional details.*		
Surgical Services		
Performed in a physician's office or outpatient facility *(if admitted, see the acute care hospital admission cost sharing in the Hospital Services section above)*	$1,000	CYD then 40%
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	$1,000	CYD then 40%
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime.)*	$2,000	CYD then 40%
Diagnostic and/or therapeutic endoscopy	$1,000	CYD then 40%
All surgical services require Prior Authorization. Refer to your EOC for additional details.*		
Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME) *(Limited to one purchase, repair or replacement of a specific item of DME every 3 years. Rental of DME follows Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME, including oxygen and oxygen-related equipment, in excess of $500 require Prior Authorization).**	CYD then 20%	CYD then 40%
Hearing Aids *(Limited to the purchase, repair or replacement of one hearing aid per ear every 3 years)*	CYD then 20%	CYD then 40%
Orthopedic and prosthetic devices *(Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years. Orthopedic or prosthetic devices in excess of $800 require Prior Authorization.*)*	CYD then 20%	CYD then 40%
Ostomy supplies *(Limited to 30 days' worth of supplies per month).*	CYD then 20%	CYD then 40%
Special Food Products *(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Calendar Year. Special food products require Prior Authorization.*)*	CYD then 20%	CYD then 40%
Alcohol and Substance-Abuse Treatment		
Medically Necessary inpatient alcohol and substance abuse treatment services	$2,000	CYD then 40%
Outpatient specialist office visits and withdrawal treatment, including intensive outpatient treatment programs, partial hospitalization and residential treatment programs *(Copayment will be charged for each visit)*	$30	CYD then 40%
Inpatient and outpatient programs for alcohol and substance abuse treatment require Prior Authorization. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require Prior Authorization.*		
Mental Health		
Medically Necessary inpatient services for mental health disorders	$2,000	CYD then 40%
Mental health outpatient and office visits, including intensive outpatient treatment programs, partial hospitalization and residential treatment programs *(Copayment will be charged for each visit)*	$30	CYD then 40%

Applied Behavioral Therapy for the treatment of Autism *(Limited to 1,250 hours, (approximately 260 visits), of therapy for habilitation per Calendar Year.)*	$30	CYD then 40%
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. Mental health office visits that are not part of a mental health treatment program do not require Prior Authorization.*		
Other Medical Services		
Kidney dialysis received at home or in an outpatient or office setting *(for kidney dialysis received in an inpatient facility, see the inpatient facility benefit line)*	$60	CYD then 40%
Spinal manipulations performed by a chiropractor or other physician *(Limited to 20 office visits per Calendar Year)*	$60	CYD then 40%
Alternative/Complementary Medicine - Services or supplies related to alternative or complementary medicine including, acupuncture, acupressure, holistic medicine, homeopathy, hypnosis, herbal, vitamin or supplement therapies, naturopathy bio-feedback and neurofeedback *(Limited to $1,000 maximum benefit per Calendar Year)*	$60	CYD then 40%
Home health care *(Medically Necessary home health care is covered if such care is provided by an organization or Professional licensed by the state to render home health services).*	$30	CYD then 40%
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. *(Limited to one diagnostic evaluation for infertility every Calendar Year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the EOC. These limits and exclusions apply to both office based and non-office based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in this Benefit Summary Table.)*	$60	CYD then 40%
Hospice Services are covered for Members with a life expectancy of 6 months or 185 days or less as certified by his or her Provider *(Limited to a lifetime benefit maximum of 185 days)*:		
a. Part-time intermittent home health or respite care services totaling fewer than 8 hours per day and 35 or fewer hours per week.	$0	CYD then 40%
b. Outpatient counseling of the Member and his or her immediate family (limited to 5 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific Policy). Counseling must be provided by a psychiatrist, psychologist, or social worker. Members who are eligible for mental health benefits under their specific Policy should refer to the applicable description of such benefits to determine coverage. Medically Necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits described above.	$60	CYD then 40%

c. Hospice care providing nursing care for a maximum of five (5) inpatient days or five (5) outpatient visits per ninety (90) days of home hospice care. Inpatient respite care will be authorized only when we determine that home respite care is not appropriate or practical.	$0	CYD then 40%
Any other covered medical service not listed in this Schedule of Benefits	CYD then 20%	CYD then 40%
Medical Drugs and Immunizations		
Specialty Pharmaceuticals	20%	CYD then 40%
Preventive immunizations *(as described in the Preventive Services section of the EOC)*	$0	CYD then 40%
Other covered immunizations	20%	CYD then 40%
All other Medical Benefit Drugs	20%	CYD then 40%
Some medications, injection and infusion drugs require Prior Authorization. Medical Drugs are those Drugs that are covered under the medical benefit, typically because they must be administered by a Provider. There may be additional Member Cost Sharing in addition to the Drug administration.*		
Pediatric Vision		
Well Vision Exam *(Complete eye exam covered in full once per Calendar Year. One low vision exam is covered every 5 years)*	$0	N/A
Lenses *(Limited to once per Calendar Year. Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full. Polycarbonate, plastic, or glass covered in full. Scratch and UV resistant covered in full.)*	$0	N/A
Frame *(From Pediatric Exchange Collection covered in full.)*	$0	N/A
Elective Contact Lenses and materials are covered in full, in lieu of eyeglasses, with the following service limitations: Standard (one pair per Calendar Year) = 1 lens/eye (2 lenses) Monthly (6 month supply) = 6 lenses/eye (12 lenses) Bi-weekly (3 month supply) =6 lenses/eye (12 lenses) Dailies (1 month supply) = 30 lenses/eye (60 lenses) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction.	$0	N/A
Pediatric Dental		
This plan does not cover pediatric dental services.		

*Prior Authorization. *If you do not obtain a Prior Authorization for a service that requires Prior Authorization, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary.* The additional amount you are required to pay due to failure to obtain a Prior Authorization will not be counted toward your Deductible or Out-of-Pocket Maximum. This requirement applies to both in-network and out-of-network services.

Definitions. For a complete list of definitions, please refer to your Evidence of Coverage.

Exclusions. For a complete list of exclusions and covered benefits, please refer to your Evidence of Coverage.

Documents. In case of conflicts between the EOC and this Schedule of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents. Copies of EOCs, Schedules of Benefits, attachments, Preferred Provider lists and other associated documents are available online at www.hometownhealth.com. We will provide you with paper copies of these documents without charge upon your request to our customer services department.

Nondiscrimination. Hometown Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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For more information go to HometownHealth.com