This Schedule of Benefits describes your health insurance Policy provided by Hometown Health Plan, Inc., a Health Maintenance Organization (HMO) licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members, and Renown Health.

Network. This Policy is a closed network HMO plan that provides access to Renown Health and the Hometown Health Network for Specialty Care. There is no coverage for services outside the Network unless the services are rendered as part of an Emergency room visit, an Urgent Care Center visit received Out-of-Area, or they have been previously approved by Renown to be paid at the HMO Benefit Level. Additionally, you must receive a referral from your Renown Primary Care Physician prior to receiving services from a Specialty Care Physician.

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 Standard Drug Formulary. *This Policy does not cover drugs which are not included in the HometownRx Standard Drug Formulary.*

Pediatric Coverage. This Benefit Plan does not include pediatric dental or vision coverage.

Geographic Service Area. This Policy is available only to employees (and their eligible dependents) who live in Nevada and whose employer has a physical business location in Carson City, Douglas County, Lyon County, Storey County or Washoe County. Additional eligibility requirements are detailed in the Hometown Health Small Group HMO 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.

Renown HEALTH PLAN
Brought to you by Hometown Health

Benefit Category	***Member Responsibility***
Calendar Year Deductibles (CYD)	
Medical Calendar Year Deductible (CYD)	Individual $4,000 Family $8,000
Pharmacy Calendar Year Deductible (CYD)	Individual $0 Family $0
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 $8,000 Family $16,000
The Out-of-Pocket Maximum includes Deductibles, Copayments and 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
Primary Care Provider (PCP) office visits with a Renown provider *(additional charges may apply for other services such as labs or diagnostic tests)*	$30
Convenient Care Facility services provided for Medically Necessary, non-urgent Illness or Injury	$30
Primary care wellness visits and preventive screenings	$0
Obstetrics and gynecology for ACA services	$0
Prenatal and postnatal office visits	$0
Specialist care virtual visits with a Renown provider *(referral required)*	$60
Specialist care *(referral required)*	$60
Imaging, surgery and other services provided in an office setting may have a higher copayment or coinsurance.	
Pharmacy Benefits	
Tier 1 - Generic Drugs	$20
Tier 2 - Preferred Brand Drugs *(May also include select Generic drugs. Refer to the EOC for Ancillary Charge.)*	$80
Tier 2 - Preferred Brand Oncological Drugs *(Preferred Brand Oncological Drugs require Prior Authorization* and must be purchased at a designated pharmacy.)*	$80
Tier 3 - Non-Preferred Brand or Generic Drugs	$180
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.)*	30%
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.	

Hometown Health Plan, Inc.
Schedule of Benefits – BANN -
Silver Benefit Plan – 22 AP HMO 30-CO 3500 A D4000X2

Renown HEALTH PLAN
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Benefit Category	***Member Responsibility***
Hospital Facility Services	
Acute care hospital admission	$3,500
Inpatient stay for delivery, postpartum care and newborn care services	$3,500
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	$1,200
Skilled nursing facility *(limited to 60 days per Calendar Year)*	$3,500
Rehabilitation facility *(limited to 60 days per Calendar Year)*	$3,500
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
Urgent Care Center Services *(includes Out-of-Area Out-of-Network Urgent Care Center Services; 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; Out-of-Network Urgent Care is not covered in Nevada)*	$100
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)*	$1,500
Ambulance (ground)	CYD then 30%
Ambulance (air and water)	CYD then 30%
Specialty Imaging and Diagnostic Testing	
Computer Tomography (CT, CTA) scan	$475
Positron Emission Tomography (PET) scan	$475
Magnetic Resonance Imaging (MRI/MRA)	$475
Nuclear Medicine	$475
Angiograms and Myelograms	$475
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
Services provided in a Specialty Care Physician office *(except Specialty Imaging and Diagnostic Testing)*	$60
X-ray and all other diagnostic imaging services not performed in a Primary Care or Specialty office setting	$120
Diagnostic mammography	$120
Preventive mammography screening	$0
Laboratory Services	
Medically necessary general laboratory services *(unless covered as preventive)*	$50
Outpatient Speech, Occupational and Physical Therapy	
Speech therapy	$30

Benefit Category	***Member Responsibility***
Occupational therapy	$30
Physical therapy	$30
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	
Other Outpatient Therapy and Rehabilitation Services	
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 120 visits per Calendar Year all modalities combined.)*	$10
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
Chemotherapy in an outpatient hospital, outpatient facility or Physician's office	CYD then $120
Radiation therapy in an outpatient hospital, outpatient facility or Physician's office	CYD then $120
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
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*	$1,200
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	$1,200
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime.)*	$3,500
Diagnostic and/or therapeutic endoscopy	$1,200
*All surgical services require Prior Authorization.**	
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 30%
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 30%
Ostomy supplies *(Limited to 30 days' worth of supplies per month).*	CYD then 30%

Benefit Category	***Member Responsibility***
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 30%
Alcohol and Substance-Abuse Treatment	
Medically Necessary inpatient alcohol and substance abuse treatment services	$3,500
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
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 a referral or Prior Authorization.*	
Mental Health	
Medically Necessary inpatient services for mental health disorders	$3,500
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
Applied Behavioral Therapy for the treatment of Autism *(Limited to 1,250 hours, (approximately 260 visits), of therapy for habilitation per Calendar Year.)*	$30
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 a referral or 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
Spinal manipulations performed by a chiropractor or other physician *(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime)*	$60
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
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
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

Benefit Category	***Member Responsibility***
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
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
Any other covered medical service not listed in this Schedule of Benefits	CYD then 30%
Medical Drugs and Immunizations	
Specialty Pharmaceuticals	30%
Preventive immunizations *(as described in the Preventive Services section of the EOC)*	$0
Other covered immunizations	30%
All other Medical Benefit Drugs	30%
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	
This plan does not cover pediatric vision services.	
Gym Membership Benefit	
This plan does not include a gym membership.	
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, the service may not be covered, even if the service is Medically Necessary.* 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.

Minimum Wage. Section 16 of Article 15 of the Nevada Constitution allows an employer to pay a lower minimum wage if the employer provides eligible health benefits as described in NRS Chapter 608. This Benefit Plan does not meet the requirements of NRS Chapter 608. Therefore, an employer who offers this plan to his or her employees may not be able to pay those employees the lower minimum wage.

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