Hometown Health Providers Insurance Company, Inc.
Schedule of Benefits – BANN -
Silver Benefit Plan – 22 AP PPO 10-70 CINS U D1400X2 HSA

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). *Generally, Members who live or work in the State of Nevada will only have access to the Hometown Health and OneHealth networks of Providers at the In-Network benefit level; they will not have access to our national network at the In-Network benefit level.* Employees who live and work outside the State of Nevada will have access to both the Hometown Health network and our national network of Providers and will be able to receive services from those Providers at the In-Network benefit level.

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) whose employer has a physical business location in Carson City and Churchill, Clark, Douglas, Eureka, Esmeralda, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey and Washoe counties. Additional eligibility requirements are detailed in the Hometown Health Small Group 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.

High Deductible Health Plan. This Policy is a High Deductible Health Plan (HDHP) as described in IRS Publication 969 and IRS Revenue Procedure 2018-30 or its successor. As such, taxpayers enrolled in this Benefit Plan may be eligible to make pre-tax contributions to their qualified Health Savings Account (HSA). Contact your tax professional for more details.

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.

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Benefit Category	***Member Responsibility*** In-Network	Out-of-Network
Calendar Year Deductibles (CYD)		
Combined Medical, Pharmacy & Vision Calendar Year Deductible (CYD)		
- Individual enrolled with no other family members	$1,400	$6,000
- Individual enrolled with other family members (Umbrella Deductible)	$2,800	$12,000
- Family deductible	$2,800	$12,000
This plan has an Umbrella Deductible. Individuals enrolled with no other dependents must satisfy the individual Deductible before Hometown Health begins to pay for covered services (other than preventive services). If enrolled as a family, the family must satisfy the family Deductible each calendar year before Hometown Health begins to pay for covered services (other than preventive services).		
Calendar Year Out-of-Pocket Maximums		
Combined Out-of-Pocket Maximum (Medical, Pharmacy and Vision services)	Individual $7,000 Family $14,000	Individual $14,000 Family $28,000
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	CYD then 50%
Primary Care Provider (PCP) office visits with a Renown provider *(additional charges may apply for other services such as labs or diagnostic tests)*	CYD then $10	CYD then 50%
Primary Care Provider (PCP) office or virtual visits with a non-Renown Pediatrician or Geriatrician *(additional charges may apply for other services such as labs or diagnostic tests)*	CYD then $30	CYD then 50%
Convenient Care Facility services provided for Medically Necessary, non-urgent Illness or Injury	CYD then $30	CYD then 50%
Primary care wellness visits and preventive screenings	$0	CYD then 50%
Obstetrics and gynecology for ACA services	$0	CYD then 50%
Prenatal and postnatal office visits	CYD then $0	CYD then 50%
Specialist care virtual visits with a Renown provider	$60	CYD then 50%
Specialist care	CYD then $60	CYD then 50%
Imaging, surgery and other services provided in an office setting may have a higher copayment or coinsurance.		
Pharmacy Benefits		
Tier 1 - Generic Drugs	CYD then $20	N/A
Tier 2 - Preferred Brand Drugs *(May also include select Generic drugs. Refer to the EOC for Ancillary Charge.)*	CYD then $85	N/A
Tier 2 - Preferred Brand Oncological Drugs *(Preferred Brand Oncological Drugs require Prior Authorization* and must be purchased at a designated pharmacy.)*	CYD then $85	N/A
Tier 3 - Non-Preferred Brand or Generic Drugs	CYD then $135	N/A

Benefit Category	Member Responsibility In-Network	Member Responsibility Out-of-Network
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.)*	CYD then 30%	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	CYD then 30%	CYD then 50%
Inpatient stay for delivery, postpartum care and newborn care services	CYD then 30%	CYD then 50%
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	CYD then $1,200	CYD then 50%
Skilled nursing facility *(limited to 60 days per Calendar Year)*	CYD then 30%	CYD then 50%
Rehabilitation facility *(limited to 60 days per Calendar Year)*	CYD then 30%	CYD then 50%
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	CYD then $75	CYD then 50%
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)*	CYD then $75	CYD then $75
Emergency Room 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)*	CYD then 30%	CYD then 30%
Ambulance (ground)	CYD then 30%	CYD then 30%
Ambulance (air and water)	CYD then 30%	CYD then 30%
Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT, CTA) scan	CYD then $450	CYD then 50%
Positron Emission Tomography (PET) scan	CYD then $450	CYD then 50%
Magnetic Resonance Imaging (MRI/MRA)	CYD then $450	CYD then 50%
Nuclear Medicine	CYD then $450	CYD then 50%
Angiograms and Myelograms	CYD then $450	CYD then 50%
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)*	CYD then $30	CYD then 50%
Services provided in a Specialty Care Physician office *(except Specialty Imaging and Diagnostic Testing)*	CYD then $60	CYD then 50%

Benefit Category	***Member Responsibility*** In-Network	Out-of-Network
X-ray and all other diagnostic imaging services not performed in a Primary Care or Specialty office setting	CYD then $75	CYD then 50%
Diagnostic mammography	CYD then $75	CYD then 50%
Preventive mammography screening	$0	CYD then 50%
Laboratory Services		
Medically necessary general laboratory services *(unless covered as preventive)*	CYD then $50	CYD then 50%
Outpatient Speech, Occupational and Physical Therapy		
Speech therapy	CYD then $30	CYD then 50%
Occupational therapy	CYD then $30	CYD then 50%
Physical therapy	CYD then $30	CYD then 50%
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.)*	CYD then $10	CYD then 50%
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 30%	CYD then 50%
Chemotherapy in an outpatient hospital, outpatient facility or Physician's office	CYD then 30%	CYD then 50%
Radiation therapy in an outpatient hospital, outpatient facility or Physician's office	CYD then 30%	CYD then 50%
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 30%	CYD then 50%
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*	CYD then $1,200	CYD then 50%
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	CYD then $1,200	CYD then 50%
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime.)*	CYD then 30%	CYD then 50%
Diagnostic and/or therapeutic endoscopy	CYD then $1,200	CYD then 50%
*All surgical services require Prior Authorization.**		

Benefit Category	***Member Responsibility*** In-Network	Out-of-Network
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%	CYD then 50%
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%	CYD then 50%
Ostomy supplies *(Limited to 30 days' worth of supplies per month).*	CYD then 30%	CYD then 50%
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%	CYD then 50%
Alcohol and Substance-Abuse Treatment		
Medically Necessary inpatient alcohol and substance abuse treatment services	CYD then 30%	CYD then 50%
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)*	CYD then $30	CYD then 50%
Outpatient specialist office visits and withdrawal treatment provided using telemedicine *(Copayment will be charged for each visit)*	$30	CYD then 50%
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	CYD then 30%	CYD then 50%
Mental health outpatient and office visits, including intensive outpatient treatment programs, partial hospitalization and residential treatment programs *(Copayment will be charged for each visit)*	CYD then $30	CYD then 50%
Mental health outpatient and office visits provided using telemedicine *(Copayment will be charged for each visit)*	$30	CYD then 50%
Applied Behavioral Therapy for the treatment of Autism *(Limited to 1,250 hours, (approximately 260 visits), of therapy for habilitation per Calendar Year.)*	CYD then $30	CYD then 50%
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)*	CYD then $60	CYD then 50%

Benefit Category	***Member Responsibility*** In-Network	Out-of-Network
Spinal manipulations performed by a chiropractor or other physician *(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime)*	CYD then 30%	CYD then 50%
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)*	CYD then 30%	CYD then 50%
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)* .	CYD then $30	CYD then 50%
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.	CYD then $0	CYD then 50%
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.	CYD then $60	CYD then 50%
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.	CYD then $0	CYD then 50%
Any other covered medical service not listed in this Schedule of Benefits	CYD then 30%	CYD then 50%
Medical Drugs and Immunizations		
Specialty Pharmaceuticals	CYD then 30%	CYD then 50%
Preventive immunizations *(as described in the Preventive Services section of the EOC)*	$0	CYD then 50%
Other covered immunizations	CYD then 30%	CYD then 50%
All other Medical Benefit Drugs	CYD then 30%	CYD then 50%
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.		

Benefit Category	Member Responsibility In-Network	Out-of-Network
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, 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.

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

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