Schedule of Benefits

Hometown Bronze PPO HDHP

HIOS Plan ID: 85266NV0020120

Benefit period: From 01/01/2023 through 12/31/2023 Calendar Year.

About your Schedule of Benefits

This Schedule of Benefits describes your Preferred Provider Organization (PPO) health insurance policy provided by Hometown Health Providers Insurance Company, Inc. that is 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 Pharmacy Network. This Policy does not cover drugs which are purchased from pharmacies that are not part of the HometownRx Pharmacy Network. Members must work with their doctors to select drugs that are included in members plan specific HometownRx Drug Formulary. This Policy does not cover drugs which are not included in the HometownRx Drug Formulary.

Geographic Service Area

Please refer to your plan's Evidence of Coverage (EOC) for specific details about member eligibility, geographic service areas, and residency requirements.

Minimum Essential Coverage

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

Prior Approval / Prior Authorization

Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan. HMO members require a Referral and Prior Authorization from their Primary Care Physician (PCP). See Evidence of Coverage (EOC) for additional details.

Additional Requirements

This Schedule of Benefits describes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures. This document is a 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.

Your Deductible and Out-of-Pocket Maximum

This Benefit Overview describes your coverage and Cost Sharing Amounts, including Deductible and Out-of-Pocket Maximum.

General Cost Share & Features	In Network	Out of Network
Deductible: - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	$3,750/Individual $7,500/Family	$10,000/Individual $20,000/Family
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$7,500/Individual $15,000/Family	$20,000/Individual $40,000/Family

Deductible

If you are the Subscriber, and the only Member covered under Your Plan, the Individual Deductible amount applies. If You have other Family Members on Your Plan the Family Deductible amount applies. The Plan has an embedded Individual Deductible within the Family Deductible. If one Family Member meets the Individual Deductible his or her benefits will begin. Once the total Family coverage Deductible is met benefits are available for all Family Members. No one Member can contribute more than their Individual Deductible amount to the Family Deductible. Copayment or Coinsurance amounts a member pays for services shown as covered without a Deductible will not count toward meeting the Individual or Family Deductible.

Out of Pocket Maximum

If you are the Subscriber, and the only Member covered under Your Plan, the Individual maximum applies. If You have other Family Members on Your Plan the Family maximum applies. Under Family coverage the Individual maximum applies separately to each covered Family Member. Once the total Family coverage maximum is met the Family maximum amount is satisfied. No one Member can contribute more than their Individual maximum amount to the Family limit.

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.

Benefit Details

The following table provides information about your benefits.

Benefit	In Network	Out of Network
Primary & Specialist Office Visits		
Primary Care Visit to Treat an Injury or Illness with a Renown Medical Group (RMG) Provider	Subject to deductible, then $80/Visit	Subject to deductible, then 60% Coinsurance
Primary Care Visit to Treat an Injury or Illness	Subject to deductible, then $80/Visit	Subject to deductible, then 60% Coinsurance
Specialist Visit	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Other Practitioner Office Visit (Nurse, Physician Assistant)	Subject to deductible, then $80/Visit	Subject to deductible, then 60% Coinsurance
Physician to Physician eConsult	Subject to deductible, then $80/Visit	Subject to deductible, then 60% Coinsurance

Benefit	In Network	Out of Network
Preventive Care		
Prenatal and Postnatal Care	No Cost	Subject to deductible, then 60% Coinsurance
Preventive Care/Screening/Immunization	No Cost	Subject to deductible, then 60% Coinsurance
Well Baby Visits and Care	No Cost	Subject to deductible, then 60% Coinsurance
Therapy		
Habilitation Services *120 visit(s) per year*	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Outpatient Rehabilitation Services *120 visit(s) per year*	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Rehabilitative Occupational and Rehabilitative Physical Therapy *120 visit(s) per year*	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Rehabilitative Speech Therapy *120 visit(s) per year*	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Infusion Therapy *Does not include the cost of special pharmaceuticals used in infusion therapy.*	Subject to deductible, then $320/Visit	Subject to deductible, then 60% Coinsurance
Chemotherapy	Subject to deductible, then $320/Visit	Subject to deductible, then 60% Coinsurance
Radiation	Subject to deductible, then $320/Visit	Subject to deductible, then 60% Coinsurance
Diagnostic & Imaging		
Imaging (CT/PET Scans, MRIs)	Subject to deductible, then $500/Visit	Subject to deductible, then 60% Coinsurance
Laboratory Outpatient and Professional Services	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
X-rays and Diagnostic Imaging	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Outpatient Care		
Mental/Behavioral Health Outpatient Services	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Subject to deductible, then $500/Visit	Subject to deductible, then 60% Coinsurance
Outpatient Surgery Physician/Surgical Services	Subject to deductible, then $500/Visit	Subject to deductible, then 60% Coinsurance
Substance Abuse Disorder Outpatient Services	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Inpatient Care		
Childbirth/Delivery Facility Services	Subject to deductible, then $3,750/Stay	Subject to deductible, then 60% Coinsurance

Benefit	In Network	Out of Network
Childbirth/Delivery Professional Services	Subject to deductible, then $500/Visit	Subject to deductible, then 60% Coinsurance
Inpatient Hospital Services (e.g., Hospital Stay)	Subject to deductible, then $3,750/Stay	Subject to deductible, then 60% Coinsurance
Inpatient Physician and Surgical Services	Subject to deductible, then $500/Visit	Subject to deductible, then 60% Coinsurance
Mental/Behavioral Health Inpatient Services	Subject to deductible, then $3,750/Stay	Subject to deductible, then 60% Coinsurance
Skilled Nursing Facility *100 days per year*	Subject to deductible, then $3,750/Stay	Subject to deductible, then 60% Coinsurance
Substance Abuse Disorder Inpatient Services	Subject to deductible, then $3,750/Stay	Subject to deductible, then 60% Coinsurance
Hospice Care		
Hospice Services *5 days per episode*	Subject to deductible, then $0/Visit	Subject to deductible, then 60% Coinsurance
Home Health Care		
Home Health Care Services	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Urgent Care		
Urgent Care Centers or Facilities	Subject to deductible, then $50/Visit	
Emergency Care/Ambulance		
Emergency Room Services	Subject to deductible, then $2,500/Visit	
Emergency Transportation/Ambulance *(Ground, Air, Water)*	Subject to deductible, then 40% Coinsurance	
Durable Medical Equipment		
Durable Medical Equipment *1 item(s) per 3 years*	Subject to deductible, then 40% Coinsurance	Subject to deductible, then 60% Coinsurance
Prosthetic Devices *1 item(s) per 3 years*	Subject to deductible, then 40% Coinsurance	Subject to deductible, then 60% Coinsurance
Hearing Aids *1 item(s) per 3 years*	Subject to deductible, then 40% Coinsurance	Subject to deductible, then 60% Coinsurance
Dental Care		
Accidental Dental	Subject to deductible, then $320/Visit	Subject to deductible, then 60% Coinsurance
Basic Dental Care – Child	Not Covered	Not Covered
Basic Dental Care – Adult	Not Covered	Not Covered
Vision Care		

Benefit	In Network	Out of Network
Eye Glasses for Children *1 item(s) per year*	No Cost	Subject to deductible, then 60% Coinsurance
Routine Eye Exam for Children *1 exam(s) per year*	No Cost	Subject to deductible, then 60% Coinsurance
Routine Eye Exam (Adult)	Not Covered	Not Covered
Additional Services		
Abortion *Except in the case of rape, incest, or for a pregnancy which, as certified by a doctor, places the woman in grave danger*	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Allergy Testing	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Bariatric Surgery *1 Procedure(s) per lifetime*	Subject to deductible, then $3,750/Stay	Subject to deductible, then 60% Coinsurance
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Education	Subject to deductible, then $80/Visit	Subject to deductible, then 60% Coinsurance
Dialysis	Subject to deductible, then $320/Visit	Subject to deductible, then 60% Coinsurance
Reconstructive Surgery	Subject to deductible, then $2,500/Visit	Subject to deductible, then 60% Coinsurance
Transplant	Subject to deductible, then $3,750/Stay	Subject to deductible, then 60% Coinsurance
Treatment for Temporomandibular Joint Disorders	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Weight Loss Programs	Not Covered	Not Covered
Remote Monitoring *Copay paid once per 30-day period.*	Subject to deductible, then $80/Visit	Subject to deductible, then 60% Coinsurance
Special Food Products *4 item(s) per year*	Subject to deductible, then 40% Coinsurance	Subject to deductible, then 60% Coinsurance
Applied Behavioral Therapy for the treatment of Autism	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Nutritional Counseling *1 visit(s) per episode*	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Chiropractic Care *20 visit(s) per year*	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Infertility Treatment *6 Procedure(s) per lifetime*	Subject to deductible, then $160/Visit	Subject to deductible, then 60% Coinsurance
Routine Foot Care	Not Covered	Not Covered
Any other covered medical service not listed in this Schedule of Benefits	Subject to deductible, then 40% Coinsurance	Subject to deductible, then 60% Coinsurance

Benefit	In Network	Out of Network
Telemedicine - For more information, please visit www.hometownhealth.com/telehealth.		
General Med Urgent Care by Teladoc	Subject to deductible, then $0/Visit	
Dermatology by Teladoc	Subject to deductible, then $20/Visit	
Mental/Behavioral Health by Teladoc	Subject to deductible, then $20/Visit	

Prescription Drugs

Rx Deductible and Out of Pocket Maximum (OOPM)

Rx Cost Share & Features	In Network	Out of Network
Deductible (Integrated with Medical Deductible)	$3,750/Individual $7,500/Family	Not Applicable
Maximum Out of Pocket (Integrated with Medical Maximum Out of Pocket)	$7,500/Individual $15,000/Family	Not Applicable

Retail Pharmacy - 30 day supply (1*copay), 60 day supply (2*copay), 90 day supply (3*copay)		
Tier	**In Network**	**Out of Network**
Generic Drugs (Tier 1)	Deductible then $40 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $200 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then $500 Copayment	Not Covered
Specialty Drugs (Tier 4)	Deductible then 50% Coinsurance	Not Covered

Mail Order – 90 day supply (2*copay)		
Tier	**In Network**	**Out of Network**
Generic Drugs (Tier 1)	Deductible then $80 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $400 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then $1,000 Copayment	Not Covered
Specialty Drugs (Tier 4)	Deductible then 50% Coinsurance	Not Covered

Renown Pharmacy - 30 day supply (1*copay), 60 day supply (2*copay), 90 day supply (3*copay)		
Tier	**In Network**	**Out of Network**
Generic Drugs (Tier 1)	Deductible then $40 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $200 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then $500 Copayment	Not Covered
Specialty Drugs (Tier 4)	Deductible then 50% Coinsurance	Not Covered