
# Schedule of Benefits

## AHP Hometown Bronze PPO HSA

*HIOS Plan ID: 85266NV0040006*

Benefit period: From 01/01/2024 through 12/31/2024 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 Network of In-Network Providers both in the state of Nevada as well as close surrounding areas 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 the health plan 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. 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 schedule 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:**<br>- Per Calendar Year<br>- Medical and Drug Combined<br>- Some services do not apply to the deductible, as indicated below. | $4,025/Individual<br>$8,050/Family | $10,000/Individual<br>$20,000/Family |
| **Out-of-Pocket Maximum:**<br>- Per Calendar Year<br>- Medical and Drug Combined | $8,050/Individual<br>$16,100/Family | $20,000/Individual<br>$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 $60/Visit | Subject to deductible, then 60% Coinsurance |
| Primary Care Visit to Treat an Injury or Illness | Subject to deductible , then $60/Visit | Subject to deductible, then 60% Coinsurance |
| Specialist Visit | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Physician to Physician eConsult | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |

| Benefit | In Network | Out of Network |
|---|---|---|
| Surgical Services performed in a Physician's Office | Subject to deductible , then $200/Visit | Subject to deductible, then 60% Coinsurance |
| **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<br>*120 visit(s) per year* | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Outpatient Rehabilitation Services<br>*120 visit(s) per year* | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Rehabilitative Occupational and Rehabilitative Physical Therapy<br>*120 visit(s) per year* | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Rehabilitative Speech Therapy<br>*120 visit(s) per year* | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Infusion Therapy<br>*Does not include the cost of special pharmaceuticals used in infusion therapy.* | Subject to deductible , then $200/Visit | Subject to deductible, then 60% Coinsurance |
| Chemotherapy | Subject to deductible , then $200/Visit | Subject to deductible, then 60% Coinsurance |
| Radiation | Subject to deductible , then $200/Visit | Subject to deductible, then 60% Coinsurance |
| Cardiac and Pulmonary Rehabilitation | Subject to deductible , then $100/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 $100/Visit | Subject to deductible, then 60% Coinsurance |
| X-rays and Diagnostic Imaging | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| **Outpatient Care** | | |
| Mental/Behavioral Health Outpatient Services | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Subject to deductible , then $350/Visit | Subject to deductible, then 60% Coinsurance |
| Outpatient Surgery Physician/Surgical Services | Subject to deductible , then $250/Visit | Subject to deductible, then 60% Coinsurance |
| Substance Abuse Disorder Outpatient Services | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |

| Benefit | In Network | Out of Network |
|---|---|---|
| **Inpatient Care** | | |
| Childbirth/Delivery Facility Services | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Childbirth/Delivery Professional Services | Subject to deductible , then $250/Visit | Subject to deductible, then 60% Coinsurance |
| Inpatient Hospital Services (e.g., Hospital Stay) | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Inpatient Physician and Surgical Services | Subject to deductible , then $250/Visit | Subject to deductible, then 60% Coinsurance |
| Mental/Behavioral Health Inpatient Services | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Skilled Nursing Facility<br>*60 days per year* | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Substance Abuse Disorder Inpatient Services | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| **Hospice Care** | | |
| Hospice Respite Services<br>*5 days per 90 days* | Subject to deductible , then $0/Visit | Subject to deductible, then 60% Coinsurance |
| **Home Health Care** | | |
| Home Health Care Services | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered |
| Private-Duty Nursing | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| **Urgent Care** | | |
| Urgent Care Centers or Facilities | Subject to deductible , then $50/Visit | Subject to deductible, then 60% Coinsurance |
| **Emergency Care/Ambulance** | | |
| Emergency Room Services | Subject to deductible , then 40% Coinsurance | |
| Emergency Transportation/Ambulance<br>*(Ground, Air, Water)* | Subject to deductible , then 40% Coinsurance | |
| **Durable Medical Equipment** | | |
| Durable Medical Equipment<br>*1 item(s) per 3 years* | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Prosthetic Devices<br>*1 item(s) per 3 years* | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Hearing Aids<br>*1 item(s) per 3 years* | Not Covered | Subject to deductible, then 60% Coinsurance |
| **Dental Care** | | |
| Accidental Dental | Subject to deductible , then $200/Visit | Subject to deductible, then 60% Coinsurance |

| Benefit | In Network | Out of Network |
|---|---|---|
| Basic Dental Care – Child | Not Covered | Not Covered |
| Basic Dental Care – Adult | Not Covered | Not Covered |
| **Vision Care** | | |
| Eye Glasses for Children<br>*1 item(s) per year* | Not Covered | Subject to deductible, then 60% Coinsurance |
| Routine Eye Exam for Children<br>*1 exam(s) per year* | Not Covered | Subject to deductible, then 60% Coinsurance |
| Routine Eye Exam (Adult) | Not Covered | Not Covered |
| **Additional Services** | | |
| Abortion<br>*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 $100/Visit | Subject to deductible, then 60% Coinsurance |
| Bariatric Surgery<br>*1 Procedure(s) per lifetime* | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Cosmetic Surgery | Not Covered | Not Covered |
| Diabetes Education | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Dialysis | Subject to deductible , then $200/Visit | Subject to deductible, then 60% Coinsurance |
| Reconstructive Surgery | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Transplant | Subject to deductible , then 40% Coinsurance | Subject to deductible, then 60% Coinsurance |
| Treatment for Temporomandibular Joint Disorders | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Weight Loss Programs | Not Covered | Not Covered |
| Remote Monitoring<br>*Copay paid once per 30-day period.* | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Special Food Products<br>*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 $100/Visit | Subject to deductible, then 60% Coinsurance |
| Nutritional Counseling<br>*1 visit(s) per episode* | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |
| Chiropractic Care<br>*20 visit(s) per year* | Subject to deductible , then $100/Visit | Subject to deductible, then 60% Coinsurance |

| Benefit | In Network | Out of Network |
|---|---|---|
| Infertility Treatment<br>*6 Procedure(s) per lifetime* | Not Covered | 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 |

# Prescription Drugs

**Rx Deductible and Out of Pocket Maximum (OOPM)**

| Rx Cost Share & Features | In Network | Out of Network |
|---|---|---|
| Deductible<br>(Integrated with Medical Deductible) | $4,025/Individual<br>$8,050/Family | Not Applicable |
| Maximum Out of Pocket<br>(Integrated with Medical Maximum Out of Pocket) | $8,050/Individual<br>$16,100/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 $20 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | Deductible then $200 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | Deductible then 50% Coinsurance | 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 $40 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | Deductible then $400 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | Deductible then 50% Coinsurance | 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 $20 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | Deductible then $200 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | Deductible then 50% Coinsurance | Not Covered |
| Specialty Drugs (Tier 4) | Deductible then 50% Coinsurance | Not Covered |