



Schedule of Benefits

AHP Hometown Silver HDHP EPO

HIOS Plan ID: 41094NV0070004

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

About your Schedule of Benefits

This Schedule of Benefits describes your Health Maintenance Organization (HMO) health insurance policy provided by Hometown Health Plan, 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 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 or Urgent Care Center visit, 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 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.

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.

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. | \$3,200/Individual \$6,400/Family | Not Applicable |
| Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined | \$6,400/Individual \$12,800/Family | Not Applicable |

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 \$50/Visit | Not Covered |
| Primary Care Visit to Treat an Injury or Illness | Subject to deductible, then \$50/Visit | Not Covered |
| Specialist Visit | Subject to deductible, then \$100/Visit | Not Covered |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | Subject to deductible, then \$50/Visit | Not Covered |
| Physician to Physician eConsult | Subject to deductible, then \$50/Visit | Not Covered |
| Preventive Care | | |

| Benefit | In Network | Out of Network |
|---|--|-----------------------|
| Prenatal and Postnatal Care | No Cost | Not Covered |
| Preventive Care/Screening/Immunization | No Cost | Not Covered |
| Well Baby Visits and Care | No Cost | Not Covered |
| Therapy | | |
| Habilitation Services <i>120 visit(s) per year</i> | Subject to deductible, then \$100/Visit | Not Covered |
| Outpatient Rehabilitation Services <i>120 visit(s) per year</i> | Subject to deductible, then \$100/Visit | Not Covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy <i>120 visit(s) per year</i> | Subject to deductible, then \$100/Visit | Not Covered |
| Rehabilitative Speech Therapy <i>120 visit(s) per year</i> | Subject to deductible, then \$100/Visit | Not Covered |
| Infusion Therapy <i>Does not include the cost of special pharmaceuticals used in infusion therapy.</i> | Subject to deductible, then \$200/Visit | Not Covered |
| Chemotherapy | Subject to deductible, then \$200/Visit | Not Covered |
| Radiation | Subject to deductible, then \$200/Visit | Not Covered |
| Diagnostic & Imaging | | |
| Imaging (CT/PET Scans, MRIs) | Subject to deductible, then \$500/Visit | Not Covered |
| Laboratory Outpatient and Professional Services | Subject to deductible, then \$100/Visit | Not Covered |
| X-rays and Diagnostic Imaging | Subject to deductible, then \$100/Visit | Not Covered |
| Outpatient Care | | |
| Mental/Behavioral Health Outpatient Services | Subject to deductible, then \$100/Visit | Not Covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | Subject to deductible, then \$500/Visit | Not Covered |
| Outpatient Surgery Physician/Surgical Services | Subject to deductible, then \$500/Visit | Not Covered |
| Substance Abuse Disorder Outpatient Services | Subject to deductible, then \$100/Visit | Not Covered |
| Inpatient Care | | |
| Childbirth/Delivery Facility Services | Subject to deductible, then \$3,200/Stay | Not Covered |
| Childbirth/Delivery Professional Services | Subject to deductible, then \$500/Visit | Not Covered |
| Inpatient Hospital Services (e.g., Hospital Stay) | Subject to deductible, then \$3,200/Stay | Not Covered |
| Inpatient Physician and Surgical Services | Subject to deductible, then \$500/Visit | Not Covered |
| Mental/Behavioral Health Inpatient Services | Subject to deductible, then \$3,200/Stay | Not Covered |
| Skilled Nursing Facility <i>60 days per year</i> | Subject to deductible, then \$3,200/Stay | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|----------------|
| Substance Abuse Disorder Inpatient Services | Subject to deductible, then \$3,200/Stay | Not Covered |
| Hospice Care | | |
| Hospice Services <i>5 days per episode</i> | Subject to deductible, then \$0/Visit | Not Covered |
| Home Health Care | | |
| Home Health Care Services | Subject to deductible, then \$100/Visit | Not Covered |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered |
| Private-Duty Nursing | Subject to deductible, then \$100/Visit | Not Covered |
| Urgent Care | | |
| Urgent Care Centers or Facilities | Subject to deductible, then \$50/Visit | |
| Emergency Care/Ambulance | | |
| Emergency Room Services | Subject to deductible, then \$2,000/Visit | |
| Emergency Transportation/Ambulance <i>(Ground, Air, Water)</i> | Subject to deductible, then 30% Coinsurance | |
| Durable Medical Equipment | | |
| Durable Medical Equipment <i>1 item(s) per 3 years</i> | Subject to deductible, then 30% Coinsurance | Not Covered |
| Prosthetic Devices <i>1 item(s) per 3 years</i> | Subject to deductible, then 30% Coinsurance | Not Covered |
| Hearing Aids <i>1 item(s) per 3 years</i> | Not Covered | Not Covered |
| Dental Care | | |
| Accidental Dental | Subject to deductible, then \$200/Visit | Not Covered |
| Basic Dental Care – Child | Not Covered | Not Covered |
| Basic Dental Care – Adult | Not Covered | Not Covered |
| Vision Care | | |
| Eye Glasses for Children <i>1 item(s) per year</i> | Not Covered | Not Covered |
| Routine Eye Exam for Children <i>1 exam(s) per year</i> | Not Covered | Not Covered |
| Routine Eye Exam (Adult) | Not Covered | Not Covered |
| Additional Services | | |
| Abortion <i>Except in the case of rape, incest, or for a pregnancy which, as certified by a doctor, places the woman in grave danger</i> | Not Covered | Not Covered |
| Acupuncture | Not Covered | Not Covered |
| Allergy Testing | Subject to deductible, then \$100/Visit | Not Covered |

| Benefit | In Network | Out of Network |
|--|--|----------------|
| Bariatric Surgery <i>1 Procedure(s) per lifetime</i> | Subject to deductible, then \$3,200/Stay | Not Covered |
| Cosmetic Surgery | Not Covered | Not Covered |
| Diabetes Education | Subject to deductible, then \$50/Visit | Not Covered |
| Dialysis | Subject to deductible, then \$200/Visit | Not Covered |
| Reconstructive Surgery | Subject to deductible, then \$2,000/Visit | Not Covered |
| Transplant | Subject to deductible, then \$3,200/Stay | Not Covered |
| Treatment for Temporomandibular Joint Disorders | Subject to deductible, then \$100/Visit | Not Covered |
| Weight Loss Programs | Not Covered | Not Covered |
| Remote Monitoring <i>Copay paid once per 30-day period.</i> | Subject to deductible, then \$50/Visit | Not Covered |
| Special Food Products <i>4 item(s) per year</i> | Subject to deductible, then 30% Coinsurance | Not Covered |
| Applied Behavioral Therapy for the treatment of Autism | Subject to deductible, then \$100/Visit | Not Covered |
| Nutritional Counseling <i>1 visit(s) per episode</i> | Subject to deductible, then \$100/Visit | Not Covered |
| Chiropractic Care <i>20 visit(s) per year</i> | Subject to deductible, then \$100/Visit | Not Covered |
| Infertility Treatment <i>6 Procedure(s) per lifetime</i> | Not Covered | Not Covered |
| Routine Foot Care | Not Covered | Not Covered |
| Any other covered medical service not listed in this Schedule of Benefits | Subject to deductible, then 30% Coinsurance | Not Covered |
| 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) | \$3,200/Individual \$6,400/Family | Not Applicable |
| Maximum Out of Pocket (Integrated with Medical Maximum Out of Pocket) | \$6,400/Individual \$12,800/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 \$80 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | Deductible then \$250 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 \$40 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | Deductible then \$160 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | Deductible then \$500 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 \$20 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | Deductible then \$80 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | Deductible then \$250 Copayment | Not Covered |
| Specialty Drugs (Tier 4) | Deductible then 50% Coinsurance | Not Covered |