



# **Schedule of Benefits**

Renown Bronze HMO HDHP

*HIOS Plan ID: 41094NV0020064*

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.

### 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
<b>Deductible:</b> - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	\$3,750/Individual \$7,500/Family	Not Applicable
<b>Out-of-Pocket Maximum:</b> - Per Calendar Year - Medical and Drug Combined	\$7,500/Individual \$15,000/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
<b>Primary &amp; Specialist Office Visits</b>		
Primary Care Visit to Treat an Injury or Illness with a Renown Medical Group (RMG) Provider	Subject to deductible, then \$80/Visit	Not Covered
Primary Care Visit to Treat an Injury or Illness	Subject to deductible, then \$80/Visit	Not Covered
Specialist Visit	Subject to deductible, then \$160/Visit	Not Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	Subject to deductible, then \$80/Visit	Not Covered
Physician to Physician eConsult	Subject to deductible, then \$80/Visit	Not Covered
<b>Preventive Care</b>		

<b>Benefit</b>	<b>In Network</b>	<b>Out of Network</b>
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
<b>Therapy</b>		
Habilitation Services <i>120 visit(s) per year</i>	Subject to deductible, then \$160/Visit	Not Covered
Outpatient Rehabilitation Services <i>120 visit(s) per year</i>	Subject to deductible, then \$160/Visit	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy <i>120 visit(s) per year</i>	Subject to deductible, then \$160/Visit	Not Covered
Rehabilitative Speech Therapy <i>120 visit(s) per year</i>	Subject to deductible, then \$160/Visit	Not Covered
Infusion Therapy <i>Does not include the cost of special pharmaceuticals used in infusion therapy.</i>	Subject to deductible, then \$320/Visit	Not Covered
Chemotherapy	Subject to deductible, then \$320/Visit	Not Covered
Radiation	Subject to deductible, then \$320/Visit	Not Covered
<b>Diagnostic &amp; Imaging</b>		
Imaging (CT/PET Scans, MRIs)	Subject to deductible, then \$500/Visit	Not Covered
Laboratory Outpatient and Professional Services	Subject to deductible, then \$160/Visit	Not Covered
X-rays and Diagnostic Imaging	Subject to deductible, then \$160/Visit	Not Covered
<b>Outpatient Care</b>		
Mental/Behavioral Health Outpatient Services	Subject to deductible, then \$160/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 \$160/Visit	Not Covered
<b>Inpatient Care</b>		
Childbirth/Delivery Facility Services	Subject to deductible, then \$3,750/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 \$3,750/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 \$3,750/Stay	Not Covered
Skilled Nursing Facility <i>100 days per year</i>	Subject to deductible, then \$3,750/Stay	Not Covered

Benefit	In Network	Out of Network
Substance Abuse Disorder Inpatient Services	Subject to deductible, then \$3,750/Stay	Not Covered
<b>Hospice Care</b>		
Hospice Services <i>5 days per episode</i>	Subject to deductible, then \$0/Visit	Not Covered
<b>Home Health Care</b>		
Home Health Care Services	Subject to deductible, then \$160/Visit	Not Covered
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing	Subject to deductible, then \$160/Visit	Not Covered
<b>Urgent Care</b>		
Urgent Care Centers or Facilities	Subject to deductible, then \$50/Visit	
<b>Emergency Care/Ambulance</b>		
Emergency Room Services	Subject to deductible, then \$2,500/Visit	
Emergency Transportation/Ambulance <i>(Ground, Air, Water)</i>	Subject to deductible, then 40% Coinsurance	
<b>Durable Medical Equipment</b>		
Durable Medical Equipment <i>1 item(s) per 3 years</i>	Subject to deductible, then 40% Coinsurance	Not Covered
Prosthetic Devices <i>1 item(s) per 3 years</i>	Subject to deductible, then 40% Coinsurance	Not Covered
Hearing Aids <i>1 item(s) per 3 years</i>	Subject to deductible, then 40% Coinsurance	Not Covered
<b>Dental Care</b>		
Accidental Dental	Subject to deductible, then \$320/Visit	Not Covered
Basic Dental Care – Child	Not Covered	Not Covered
Basic Dental Care – Adult	Not Covered	Not Covered
<b>Vision Care</b>		
Eye Glasses for Children <i>1 item(s) per year</i>	No Cost	Not Covered
Routine Eye Exam for Children <i>1 exam(s) per year</i>	No Cost	Not Covered
Routine Eye Exam (Adult)	Not Covered	Not Covered
<b>Additional Services</b>		
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 \$160/Visit	Not Covered

Benefit	In Network	Out of Network
Bariatric Surgery <i>1 Procedure(s) per lifetime</i>	Subject to deductible, then \$3,750/Stay	Not Covered
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Education	Subject to deductible, then \$80/Visit	Not Covered
Dialysis	Subject to deductible, then \$320/Visit	Not Covered
Reconstructive Surgery	Subject to deductible, then \$2,500/Visit	Not Covered
Transplant	Subject to deductible, then \$3,750/Stay	Not Covered
Treatment for Temporomandibular Joint Disorders	Subject to deductible, then \$160/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 \$80/Visit	Not Covered
Special Food Products <i>4 item(s) per year</i>	Subject to deductible, then 40% Coinsurance	Not Covered
Applied Behavioral Therapy for the treatment of Autism	Subject to deductible, then \$160/Visit	Not Covered
Nutritional Counseling <i>1 visit(s) per episode</i>	Subject to deductible, then \$160/Visit	Not Covered
Chiropractic Care <i>20 visit(s) per year</i>	Subject to deductible, then \$160/Visit	Not Covered
Infertility Treatment <i>6 Procedure(s) per lifetime</i>	Subject to deductible, then \$160/Visit	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 40% Coinsurance	Not Covered
<b>Telemedicine - For more information, please visit <a href="http://www.hometownhealth.com/telehealth">www.hometownhealth.com/telehealth</a>.</b>		
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