Schedule of Benefits

Renown Gold HMO

HIOS Plan ID: 41094NV0020053

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
Deductible: - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	$0/Individual $0/Family	Not Applicable
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$6,900/Individual $13,800/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	From Visit 1 to 3 - No Charge From Visit 4 and after - $20 Copayment Per Visit	Not Covered
Primary Care Visit to Treat an Injury or Illness	From Visit 1 to 3 - No Charge From Visit 4 and after - $20 Copayment Per Visit	Not Covered
Specialist Visit	$40/Visit, Deductible does not apply	Not Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	From Visit 1 to 3 - No Charge From Visit 4 and after - $20 Copayment Per Visit	Not Covered

Benefit	In Network	Out of Network
Physician to Physician eConsult	From Visit 1 to 3 - No Charge From Visit 4 and after - $20 Copayment Per Visit	Not Covered
Preventive Care		
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 *120 visit(s) per year*	$40/Visit, Deductible does not apply	Not Covered
Outpatient Rehabilitation Services *120 visit(s) per year*	$40/Visit, Deductible does not apply	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy *120 visit(s) per year*	$40/Visit, Deductible does not apply	Not Covered
Rehabilitative Speech Therapy *120 visit(s) per year*	$40/Visit, Deductible does not apply	Not Covered
Infusion Therapy *Does not include the cost of special pharmaceuticals used in infusion therapy.*	$80/Visit, Deductible does not apply	Not Covered
Chemotherapy	$80/Visit, Deductible does not apply	Not Covered
Radiation	$80/Visit, Deductible does not apply	Not Covered
Diagnostic & Imaging		
Imaging (CT/PET Scans, MRIs)	$250/Visit, Deductible does not apply	Not Covered
Laboratory Outpatient and Professional Services	$40/Visit, Deductible does not apply	Not Covered
X-rays and Diagnostic Imaging	$40/Visit, Deductible does not apply	Not Covered
Outpatient Care		
Mental/Behavioral Health Outpatient Services	$40/Visit, Deductible does not apply	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$200/Visit, Deductible does not apply	Not Covered
Outpatient Surgery Physician/Surgical Services	$200/Visit, Deductible does not apply	Not Covered
Substance Abuse Disorder Outpatient Services	$40/Visit, Deductible does not apply	Not Covered
Inpatient Care		
Childbirth/Delivery Facility Services	$3,000/Stay, Deductible does not apply	Not Covered
Childbirth/Delivery Professional Services	$200/Visit, Deductible does not apply	Not Covered
Inpatient Hospital Services (e.g., Hospital Stay)	$3,000/Stay, Deductible does not apply	Not Covered
Inpatient Physician and Surgical Services	$200/Visit, Deductible does not apply	Not Covered

Benefit	In Network	Out of Network
Mental/Behavioral Health Inpatient Services	$3,000/Stay, Deductible does not apply	Not Covered
Skilled Nursing Facility *100 days per year*	$3,000/Stay, Deductible does not apply	Not Covered
Substance Abuse Disorder Inpatient Services	$3,000/Stay, Deductible does not apply	Not Covered
Hospice Care		
Hospice Services *5 days per episode*	$0/Visit, Deductible does not apply	Not Covered
Home Health Care		
Home Health Care Services	$40/Visit, Deductible does not apply	Not Covered
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing	$40/Visit, Deductible does not apply	Not Covered
Urgent Care		
Urgent Care Centers or Facilities	$50/Visit, Deductible does not apply	
Emergency Care/Ambulance		
Emergency Room Services	$1,500/Visit, Deductible does not apply	
Emergency Transportation/Ambulance *(Ground, Air, Water)*	20% Coinsurance, Deductible does not apply	
Durable Medical Equipment		
Durable Medical Equipment *1 item(s) per 3 years*	20% Coinsurance, Deductible does not apply	Not Covered
Prosthetic Devices *1 item(s) per 3 years*	20% Coinsurance, Deductible does not apply	Not Covered
Hearing Aids *1 item(s) per 3 years*	20% Coinsurance, Deductible does not apply	Not Covered
Dental Care		
Accidental Dental	$80/Visit, Deductible does not apply	Not Covered
Basic Dental Care – Child	Not Covered	Not Covered
Basic Dental Care – Adult	Not Covered	Not Covered
Vision Care		
Eye Glasses for Children *1 item(s) per year*	No Cost	Not Covered
Routine Eye Exam for Children *1 exam(s) per year*	No Cost	Not Covered
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

Benefit	In Network	Out of Network
Acupuncture	Not Covered	Not Covered
Allergy Testing	$40/Visit, Deductible does not apply	Not Covered
Bariatric Surgery *1 Procedure(s) per lifetime*	$3,000/Stay, Deductible does not apply	Not Covered
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Education	From Visit 1 to 3 - No Charge From Visit 4 and after - $20 Copayment Per Visit	Not Covered
Dialysis	$80/Visit, Deductible does not apply	Not Covered
Reconstructive Surgery	$1,500/Visit, Deductible does not apply	Not Covered
Transplant	$3,000/Stay, Deductible does not apply	Not Covered
Treatment for Temporomandibular Joint Disorders	$40/Visit, Deductible does not apply	Not Covered
Weight Loss Programs	Not Covered	Not Covered
Remote Monitoring *Copay paid once per 30-day period.*	From Visit 1 to 3 - No Charge From Visit 4 and after - $20 Copayment Per Visit	Not Covered
Special Food Products *4 item(s) per year*	20% Coinsurance, Deductible does not apply	Not Covered
Applied Behavioral Therapy for the treatment of Autism	$40/Visit, Deductible does not apply	Not Covered
Nutritional Counseling *1 visit(s) per episode*	$40/Visit, Deductible does not apply	Not Covered
Chiropractic Care *20 visit(s) per year*	$40/Visit, Deductible does not apply	Not Covered
Infertility Treatment *6 Procedure(s) per lifetime*	$40/Visit, Deductible does not apply	Not Covered
Routine Foot Care	Not Covered	Not Covered
Any other covered medical service not listed in this Schedule of Benefits	20% Coinsurance, Deductible does not apply	Not Covered
Telemedicine - For more information, please visit www.hometownhealth.com/telehealth.		
General Med Urgent Care by Teladoc	$0/Visit, Deductible does not apply	
Dermatology by Teladoc	$20/Visit, Deductible does not apply	
Mental/Behavioral Health by Teladoc	$20/Visit, Deductible does not apply	

Prescription Drugs

Rx Deductible and Out of Pocket Maximum (OOPM)

Rx Cost Share & Features	In Network	Out of Network
Deductible (Integrated with Medical Deductible)	$0/Individual $0/Family	Not Applicable
Maximum Out of Pocket (Integrated with Medical Maximum Out of Pocket)	$6,900/Individual $13,800/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)	$10 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$50 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	$200 Copayment	Not Covered
Specialty Drugs (Tier 4)	50% Coinsurance	Not Covered

Mail Order – 90 day supply (2*copay)		
Tier	**In Network**	**Out of Network**
Generic Drugs (Tier 1)	$20 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$100 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	$400 Copayment	Not Covered
Specialty Drugs (Tier 4)	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)	$10 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$50 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	$200 Copayment	Not Covered
Specialty Drugs (Tier 4)	50% Coinsurance	Not Covered