

Schedule of Benefits

AHP Hometown Bronze EPO Plus

HIOS Plan ID: 41094NV0070005

Benefit period: From 01/01/2024 through 12/31/2024 Calendar Year.

About your Schedule of Benefits

This Schedule of Benefits describes your Exclusive Provider Organization (EPO) 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 Exclusive Provider (EPO) plan that provides access to providers throughout the state of Nevada for Primary and Specialty Care. There is no coverage for services outside the Network unless the services are rendered as part of an Emergency Rooms or Urgent Care Center visit, or they have been previously approved by Renown to be paid at the EPO Benefit Level.

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: - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	\$4,725/Individual \$9,450/Family	Not Applicable
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	\$9,450/Individual \$18,900/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	\$60/Visit, Deductible does not apply	Not Covered
Primary Care Visit to Treat an Injury or Illness	\$60/Visit, Deductible does not apply	Not Covered
Specialist Visit	\$100/Visit, Deductible does not apply	Not Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$100/Visit, Deductible does not apply	Not Covered
Physician to Physician eConsult	\$100/Visit, Deductible does not apply	Not Covered
Surgical Services performed in a Physician's Office	\$200/Visit, Deductible does not apply	Not Covered

Benefit	In Network	Out of Network
	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	\$100/Visit, Deductible does not apply	Not Covered
Outpatient Rehabilitation Services 120 visit(s) per year	\$100/Visit, Deductible does not apply	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy 120 visit(s) per year	\$100/Visit, Deductible does not apply	Not Covered
Rehabilitative Speech Therapy 120 visit(s) per year	\$100/Visit, Deductible does not apply	Not Covered
Infusion Therapy Does not include the cost of special pharmaceuticals used in infusion therapy.	\$200/Visit, Deductible does not apply	Not Covered
Chemotherapy	\$200/Visit, Deductible does not apply	Not Covered
Radiation	\$200/Visit, Deductible does not apply	Not Covered
Cardiac and Pulmonary Rehabilitation	\$100/Visit, Deductible does not apply	Not Covered
	Diagnostic & Imaging	
Imaging (CT/PET Scans, MRIs)	\$500/Visit, Deductible does not apply	Not Covered
Laboratory Outpatient and Professional Services	\$100/Visit, Deductible does not apply	Not Covered
X-rays and Diagnostic Imaging	\$100/Visit, Deductible does not apply	Not Covered
	Outpatient Care	
Mental/Behavioral Health Outpatient Services	\$100/Visit, Deductible does not apply	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$350/Visit, Deductible does not apply	Not Covered
Outpatient Surgery Physician/Surgical Services	\$250/Visit, Deductible does not apply	Not Covered
Substance Abuse Disorder Outpatient Services	\$100/Visit, Deductible does not apply	Not Covered
	Inpatient Care	
Childbirth/Delivery Facility Services	Subject to deductible, then 40% Coinsurance	Not Covered
Childbirth/Delivery Professional Services	\$250/Visit, Deductible does not apply	Not Covered
Inpatient Hospital Services (e.g., Hospital Stay)	Subject to deductible, then 40% Coinsurance	Not Covered
Inpatient Physician and Surgical Services	\$250/Visit, Deductible does not apply	Not Covered

Benefit	In Network	Out of Network	
Mental/Behavioral Health Inpatient Services	Subject to deductible , then 40% Coinsurance	Not Covered	
Skilled Nursing Facility 60 days per year	Subject to deductible, then 40% Coinsurance	Not Covered	
Substance Abuse Disorder Inpatient Services	Subject to deductible , then 40% Coinsurance	Not Covered	
	Hospice Care		
Hospice Respite Services 5 days per 90 days	\$0/Visit, Deductible does not apply	Not Covered	
	Home Health Care		
Home Health Care Services	\$100/Visit, Deductible does not apply	Not Covered	
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered	
Private-Duty Nursing	\$100/Visit, Deductible does not apply	Not Covered	
	Urgent Care		
Urgent Care Centers or Facilities	\$50/Visit, Deductible does not apply	Not Covered	
	Emergency Care/Ambulance		
Emergency Room Services	Subject to deductible, the	en 40% Coinsurance	
Emergency Transportation/Ambulance (Ground, Air, Water)			
	Durable Medical Equipment		
Durable Medical Equipment 1 item(s) per 3 years	40% Coinsurance, Deductible does not apply	Not Covered	
Prosthetic Devices 1 item(s) per 3 years	40% Coinsurance, Deductible does not apply	Not Covered	
Hearing Aids 1 item(s) per 3 years	Not Covered	Not Covered	
	Dental Care		
Accidental Dental	\$200/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	Not Covered	Not Covered	
Routine Eye Exam for Children <i>I exam(s) per year</i>	Not Covered	Not Covered	
Routine Eye Exam (Adult)	Not Covered	Not Covered	
	Additional Services		

Benefit	In Network	Out of Network
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	\$100/Visit, Deductible does not apply	Not Covered
Bariatric Surgery 1 Procedure(s) per lifetime	Subject to deductible, then 40% Coinsurance	Not Covered
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Education	\$100/Visit, Deductible does not apply	Not Covered
Dialysis	\$200/Visit, Deductible does not apply	Not Covered
Reconstructive Surgery	Subject to deductible, then 40% Coinsurance	Not Covered
Transplant	Subject to deductible, then 40% Coinsurance	Not Covered
Treatment for Temporomandibular Joint Disorders	\$100/Visit, Deductible does not apply	Not Covered
Weight Loss Programs	Not Covered	Not Covered
Remote Monitoring Copay paid once per 30-day period.	\$100/Visit, Deductible does not apply	Not Covered
Special Food Products 4 item(s) per year	40% Coinsurance, Deductible does not apply	Not Covered
Applied Behavioral Therapy for the treatment of Autism	\$100/Visit, Deductible does not apply	Not Covered
Nutritional Counseling 1 visit(s) per episode	\$100/Visit, Deductible does not apply	Not Covered
Chiropractic Care 20 visit(s) per year	\$100/Visit, Deductible does not apply	Not Covered
Infertility Treatment 6 Procedure(s) per lifetime	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 40% Coinsurance	Not Covered

Prescription Drugs

Rx Deductible and Out of Pocket Maximum (OOPM)

Rx Cost Share & Features	In Network	Out of Network
Deductible (Integrated with Medical Deductible)	\$4,725/Individual \$9,450/Family	Not Applicable
Maximum Out of Pocket (Integrated with Medical Maximum Out of Pocket)	\$9,450/Individual \$18,900/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)	\$20 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	\$200 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	50% Coinsurance	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)	\$40 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	\$400 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	50% Coinsurance	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)	\$20 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	\$200 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	50% Coinsurance	Not Covered
Specialty Drugs (Tier 4)	50% Coinsurance	Not Covered