



Schedule of Benefits

Hometown Silver EPO Plus

HIOS Plan ID: 41094NV0050002

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 Authorization

Authorization 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. | \$0/Individual \$0/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 | \$40/Visit, Deductible does not apply | Not Covered |
| Primary Care Visit to Treat an Injury or Illness | \$40/Visit, Deductible does not apply | Not Covered |
| Specialist Visit | \$80/Visit, Deductible does not apply | Not Covered |
| Other Practitioner Office Visit (Nurse, Physician Assistant) | \$80/Visit, Deductible does not apply | Not Covered |
| Physician to Physician eConsult | \$80/Visit, Deductible does not apply | Not Covered |

| Benefit | In Network | Out of Network |
|---|--|----------------|
| Surgical Services performed in a Physician's Office | \$160/Visit, Deductible does not apply | 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 <i>120 visit(s) per year</i> | \$80/Visit, Deductible does not apply | Not Covered |
| Outpatient Rehabilitation Services <i>120 visit(s) per year</i> | \$80/Visit, Deductible does not apply | Not Covered |
| Rehabilitative Occupational and Rehabilitative Physical Therapy <i>120 visit(s) per year</i> | \$80/Visit, Deductible does not apply | Not Covered |
| Rehabilitative Speech Therapy <i>120 visit(s) per year</i> | \$80/Visit, Deductible does not apply | Not Covered |
| Infusion Therapy <i>Does not include the cost of special pharmaceuticals used in infusion therapy.</i> | \$160/Visit, Deductible does not apply | Not Covered |
| Chemotherapy | \$160/Visit, Deductible does not apply | Not Covered |
| Radiation | \$160/Visit, Deductible does not apply | Not Covered |
| Cardiac and Pulmonary Rehabilitation | \$80/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 | \$80/Visit, Deductible does not apply | Not Covered |
| X-rays and Diagnostic Imaging | \$80/Visit, Deductible does not apply | Not Covered |
| Outpatient Care | | |
| Mental/Behavioral Health Outpatient Services | \$80/Visit, Deductible does not apply | Not Covered |
| Outpatient Facility Fee (e.g., Ambulatory Surgery Center) | \$300/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 | \$80/Visit, Deductible does not apply | Not Covered |
| Inpatient Care | | |
| Childbirth/Delivery Facility Services | 30% Coinsurance, 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) | 30% Coinsurance, Deductible does not apply | Not Covered |

| Benefit | In Network | Out of Network |
|---|---|-----------------------|
| Inpatient Physician and Surgical Services | \$200/Visit, Deductible does not apply | Not Covered |
| Mental/Behavioral Health Inpatient Services | 30% Coinsurance, Deductible does not apply | Not Covered |
| Skilled Nursing Facility <i>100 days per year</i> | 30% Coinsurance, Deductible does not apply | Not Covered |
| Substance Abuse Disorder Inpatient Services | 30% Coinsurance, Deductible does not apply | Not Covered |
| Hospice Care | | |
| Hospice Respite Services <i>5 days per 90 days</i> | \$0/Visit, Deductible does not apply | Not Covered |
| Home Health Care | | |
| Home Health Care Services | \$80/Visit, Deductible does not apply | Not Covered |
| Long-Term/Custodial Nursing Home Care | Not Covered | Not Covered |
| Private-Duty Nursing | \$80/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 | \$1,500/Visit Waived if Admitted, Deductible does not apply | |
| Emergency Transportation/Ambulance <i>(Ground, Air, Water)</i> | 30% Coinsurance, Deductible does not apply | |
| Durable Medical Equipment | | |
| Durable Medical Equipment <i>1 item(s) per 3 years</i> | 30% Coinsurance, Deductible does not apply | Not Covered |
| Prosthetic Devices <i>1 item(s) per 3 years</i> | 30% Coinsurance, Deductible does not apply | Not Covered |
| Hearing Aids <i>1 item(s) per 3 years</i> | 30% Coinsurance, Deductible does not apply | Not Covered |
| Dental Care | | |
| Accidental Dental | \$160/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 <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 |
| Additional Services | | |

| Benefit | In Network | Out of Network |
|---|--|----------------|
| 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 | \$80/Visit, Deductible does not apply | Not Covered |
| Bariatric Surgery <i>1 Procedure(s) per lifetime</i> | 30% Coinsurance, Deductible does not apply | Not Covered |
| Cosmetic Surgery | Not Covered | Not Covered |
| Diabetes Education | \$80/Visit, Deductible does not apply | Not Covered |
| Dialysis | \$160/Visit, Deductible does not apply | Not Covered |
| Reconstructive Surgery | 30% Coinsurance, Deductible does not apply | Not Covered |
| Transplant | 30% Coinsurance, Deductible does not apply | Not Covered |
| Treatment for Temporomandibular Joint Disorders | \$80/Visit, Deductible does not apply | Not Covered |
| Weight Loss Programs | Not Covered | Not Covered |
| Remote Monitoring <i>Copay paid once per 30-day period.</i> | \$80/Visit, Deductible does not apply | Not Covered |
| Special Food Products <i>4 item(s) per year</i> | 30% Coinsurance, Deductible does not apply | Not Covered |
| Applied Behavioral Therapy for the treatment of Autism | \$80/Visit, Deductible does not apply | Not Covered |
| Nutritional Counseling <i>1 visit(s) per episode</i> | \$80/Visit, Deductible does not apply | Not Covered |
| Chiropractic Care <i>20 visit(s) per year</i> | \$80/Visit, Deductible does not apply | Not Covered |
| Infertility Treatment <i>6 Procedure(s) per lifetime</i> | \$80/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 | 30% Coinsurance, Deductible does not apply | 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) | \$0/Individual \$0/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) | \$15 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | \$65 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | \$250 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) | \$30 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | \$130 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | \$500 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) | \$15 Copayment | Not Covered |
| Preferred Brand Drugs (Tier 2) | \$65 Copayment | Not Covered |
| Non-Preferred Drugs (Tier 3) | \$250 Copayment | Not Covered |
| Specialty Drugs (Tier 4) | 50% Coinsurance | Not Covered |