Schedule of Benefits

Hometown Gold PPO

HIOS Plan ID: 85266NV0020109

Benefit period: From 01/01/2025 through 12/31/2025 Calendar Year.

About your Schedule of Benefits

This Schedule of Benefits describes your Preferred Provider Organization (PPO) health insurance policy provided by Hometown Health Providers Insurance Company, 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

Hometown Health's PPO Network provides access to a large Network of In-Network Providers both in the state of Nevada as well as close surrounding areas who have contracts with Hometown Health. Services from In-Network Providers will generally be paid at the In-Network benefit level. Members may also seek services from Out-Of-Network Providers at a reduced benefit level (higher cost to the Member). You may select any PCP within the network and are not required by Hometown Health to receive a referral prior to receiving services for specialty care.

Prescription Drug Coverage

Members must utilize the Hometown Pharmacy Network. This Policy does not cover drugs which are purchased from pharmacies that are not part of the Hometown Pharmacy Network. Members must work with their doctors to select drugs that are included in members plan specific Hometown Drug Formulary. This Policy does not cover drugs which are not included in the Hometown 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	$8,000/Individual $16,000/Family
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$9,200/Individual $18,400/Family	$27,600/Individual $55,200/Family

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.

Amounts paid by a drug manufacturer which offer copayment offset programs (also called copay savings cards or coupons) do not count toward meeting the calendar year Deductible or Out-of-Pocket Maximum. You may continue to use these copay cards/coupons to help reduce Your out-of-pocket costs, however, the dollar value of the card/coupon does not apply toward your Deductible or Out-of-Pocket Maximum under Your plan since You don't pay that amount. Only the dollars You actually pay out of pocket will count toward Your annual Deductible or out-of-pocket totals.

Benefit Details

The following table provides information about your benefits.

Benefit	In Network	Out of Network
Primary Care Visit to Treat an Injury or Illness	$50/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Specialist Visit	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Physician to Physician eConsult	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance

Benefit	In Network	Out of Network
Surgical Services performed in a Physician's Office	$110/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Mental/Behavioral Health Office Visit	$50/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Substance Abuse Disorder Office Visit	$50/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Preventive Care		
Prenatal and Postnatal Care	No Cost	Subject to deductible, then 50% Coinsurance
Preventive Care/Screening/Immunization	No Cost	Subject to deductible, then 50% Coinsurance
Well Baby Visits and Care	No Cost	Subject to deductible, then 50% Coinsurance
Therapy		
Habilitation Services *120 visit(s) per year*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Outpatient Rehabilitation Services *120 visit(s) per year*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Rehabilitative Occupational and Rehabilitative Physical Therapy *120 visit(s) per year*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Rehabilitative Speech Therapy *120 visit(s) per year*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Infusion Therapy *Does not include the cost of special pharmaceuticals used in infusion therapy.*	$110/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Chemotherapy	$110/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Radiation	$110/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Cardiac and Pulmonary Rehabilitation	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Diagnostic & Imaging		
Imaging (CT/PET Scans, MRIs)	$300/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Laboratory Outpatient and Professional Services	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
X-rays and Diagnostic Imaging	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Outpatient Care		
Mental/Behavioral Health Outpatient Services *Including intensive outpatient treatment programs, partial hospitalization, and residential treatment programs.*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance

Benefit	In Network	Out of Network
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$400/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Outpatient Surgery Physician/Surgical Services	$0/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Substance Abuse Disorder Outpatient Services Mental/Behavioral Health Outpatient Services *Including intensive outpatient treatment programs, partial hospitalization, and residential treatment programs.*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Inpatient Care		
Childbirth/Delivery Facility Services	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Inpatient Hospital Services (e.g., Hospital Stay)	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Mental/Behavioral Health Inpatient Services	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Skilled Nursing Facility *100 days per year*	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Substance Abuse Disorder Inpatient Services	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services		
Hospice Care		
Hospice Respite Services *5 days per 90 days*	$0/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Home Health Care		
Home Health Care Services	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Urgent Care		
Urgent Care Centers or Facilities	$50/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Mobile Urgent Care	$50/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Emergency Care/Ambulance		
Emergency Room Services	$675/VisitWaived if Admitted, Deductible does not apply	
Emergency Transportation/Ambulance *(Ground, Air, Water)*	20% Coinsurance, Deductible does not apply	
Durable Medical Equipment		

Benefit	In Network	Out of Network
Durable Medical Equipment *1 item(s) per 3 years*	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Prosthetic Devices *1 item(s) per 3 years*	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Hearing Aids *1 item(s) per 3 years*	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Dental Care		
Accidental Dental	$110/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
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	Subject to deductible, then 50% Coinsurance
Routine Eye Exam for Children *1 exam(s) per year*	No Cost	Subject to deductible, then 50% Coinsurance
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
Acupuncture	Not Covered	Not Covered
Allergy Testing	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Bariatric Surgery *1 Procedure(s) per lifetime*	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Education	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Dialysis	$110/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Reconstructive Surgery	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Transplant	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Treatment for Temporomandibular Joint Disorders	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Weight Loss Programs	Not Covered	Not Covered
Remote Monitoring *Copay paid once per 30-day period.*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance

Benefit	In Network	Out of Network
Special Food Products *4 item(s) per year*	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Applied Behavioral Therapy for the treatment of Autism	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Nutritional Counseling *1 visit(s) per episode*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Chiropractic Care *20 visit(s) per year*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Infertility Treatment *6 Procedure(s) per lifetime*	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Routine Foot Care	Not Covered	Not Covered
Wound Care	$55/Visit, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Specialty Pharmaceuticals	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
All Other Medical Benefit Drugs	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Any other covered medical service not listed in this Schedule of Benefits	20% Coinsurance, Deductible does not apply	Subject to deductible, then 50% Coinsurance
Telemedicine - For more information, please visit www.hometownhealth.com/telehealth.		
General Med Urgent Care by Teladoc	$0/Visit, Deductible does not apply	Not Covered
Mental/Behavioral Health by Teladoc	$20/Visit, Deductible does not apply	Not Covered
Dermatology by Teladoc	$20/Visit, Deductible does not apply	Not Covered

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)	$40 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)	$30 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$80 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)	$15 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$40 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	$200 Copayment	Not Covered
Specialty Drugs (Tier 4)	50% Coinsurance	Not Covered