Schedule of Benefits

Renown Bronze HMO HSA

HIOS Plan ID: 41094NV0020064

Benefit period: From 01/01/2026 through 12/31/2026 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

Following the terms of your HMO plan, adult Members must choose a Renown, Geriatric Specialty Care, Alpine Family Medicine, Virginia Family Care Center or Reno Family Physician PCP on the Renown HMO Network at the time of enrollment or HTH will choose one based on Your geographic location. In addition, if you have a child enrolled in coverage, HTH will permit you to designate any pediatrician, Renown or Community, as the child's PCP if such pediatrician is an In-Network provider. HTH will permit your child to see an In-Network primary care provider as their pediatrician if pre-notified prior to services received of the primary care provider your child will be seeing. 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. You 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.	$6,000/Individual $12,000/Family	Not Applicable
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$8,500/Individual $17,000/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.

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, only in the event that a generic drug is available. 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	Subject to deductible , then $65/Visit	Not Covered
Specialist Visit	Subject to deductible , then $100/Visit	Not Covered
Physician to Physician eConsult	Subject to deductible , then $65/Visit	Not Covered
Surgical Services performed in a Physician's Office	Subject to deductible , then $200/Visit	Not Covered
Mental/Behavioral Health Office Visit	Subject to deductible , then $65/Visit	Not Covered

Benefit	In Network	Out of Network
Substance Abuse Disorder Office Visit	Subject to deductible , then $65/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*	Subject to deductible , then $100/Visit	Not Covered
Outpatient Rehabilitation Services *120 visit(s) per year*	Subject to deductible , then $100/Visit	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy *120 visit(s) per year*	Subject to deductible , then $100/Visit	Not Covered
Rehabilitative Speech Therapy	Subject to deductible , then $100/Visit	Not Covered
Infusion Therapy *Does not include the cost of special pharmaceuticals used in infusion therapy.*	Subject to deductible , then $200/Visit	Not Covered
Chemotherapy	Subject to deductible , then $200/Visit	Not Covered
Radiation	Subject to deductible , then $200/Visit	Not Covered
Cardiac and Pulmonary Rehabilitation	Subject to deductible , then $100/Visit	Not Covered
Diagnostic & Imaging		
Imaging (CT/PET Scans, MRIs)	Subject to deductible , then $500/Visit	Not Covered
Laboratory Outpatient and Professional Services	Subject to deductible , then $100/Visit	Not Covered
X-rays and Diagnostic Imaging	Subject to deductible , then $100/Visit	Not Covered
Outpatient Care		
Mental/Behavioral Health Outpatient Services *Including intensive outpatient treatment programs, partial hospitalization, and residential treatment programs.*	Subject to deductible , then $100/Visit	Not Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Subject to deductible , then $600/Visit	Not Covered
Outpatient Surgery Physician/Surgical Services	Subject to deductible , then $0/Visit	Not Covered
Substance Abuse Disorder Outpatient Services *Including intensive outpatient treatment programs, partial hospitalization, and residential treatment programs.*	Subject to deductible , then $100/Visit	Not Covered
Inpatient Care		
Childbirth/Delivery Facility Services	Subject to deductible , then 40% Coinsurance	Not Covered

Benefit	In Network	Out of Network
Inpatient Hospital Services (e.g., Hospital Stay)	Subject to deductible , then 40% Coinsurance	Not Covered
Mental/Behavioral Health Inpatient Services	Subject to deductible , then 40% Coinsurance	Not Covered
Skilled Nursing Facility *100 days per year*	Subject to deductible , then 40% Coinsurance	Not Covered
Substance Abuse Disorder Inpatient Services	Subject to deductible , then 40% Coinsurance	Not Covered
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*	Subject to deductible , then $0/Visit	Not Covered
Home Health Care		
Home Health Care Services	Subject to deductible , then $100/Visit	Not Covered
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing	Subject to deductible , then $100/Visit	Not Covered
Urgent Care		
Urgent Care Centers or Facilities	Subject to deductible , then $50/Visit	Not Covered
Mobile Urgent Care	Subject to deductible , then $50/Visit	Not Covered
Emergency Care/Ambulance		
Emergency Room Services	Subject to deductible , then 40% Coinsurance	
Emergency Transportation/Ambulance *(Ground, Air, Water)*	Subject to deductible , then 40% Coinsurance	
Durable Medical Equipment		
Durable Medical Equipment *1 item(s) per 3 years*	Subject to deductible , then 40% Coinsurance	Not Covered
Prosthetic Devices *1 item(s) per 3 years*	Subject to deductible , then 40% Coinsurance	Not Covered
Hearing Aids *1 item(s) per 3 years*	Subject to deductible , then 40% Coinsurance	Not Covered
Dental Care		
Accidental Dental	Subject to deductible , then $200/Visit	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

Benefit	In Network	Out of Network
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
Acupuncture	Not Covered	Not Covered
Allergy Testing	Subject to deductible , then $100/Visit	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	Subject to deductible , then $65/Visit	Not Covered
Dialysis	Subject to deductible , then $200/Visit	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	Subject to deductible , then $100/Visit	Not Covered
Weight Loss Programs	Not Covered	Not Covered
Remote Monitoring *Copay paid once per 30-day period.*	Subject to deductible , then $65/Visit	Not Covered
Special Food Products *4 item(s) per year*	Subject to deductible , then 40% Coinsurance	Not Covered
Applied Behavioral Therapy for the treatment of Autism	Subject to deductible , then $65/Visit	Not Covered
Nutritional Counseling *1 visit(s) per episode*	Subject to deductible , then $100/Visit	Not Covered
Chiropractic Care *20 visit(s) per year*	Subject to deductible , then $100/Visit	Not Covered
Infertility Treatment *6 Procedure(s) per lifetime*	Subject to deductible , then $100/Visit	Not Covered
Routine Foot Care	Not Covered	Not Covered
Wound Care	Subject to deductible , then $100/Visit	Not Covered
Specialty Pharmaceuticals	Subject to deductible , then 40% Coinsurance	Not Covered
All Other Medical Benefit Drugs	Subject to deductible , then 40% Coinsurance	Not Covered
Any other covered medical service not listed in this Schedule of Benefits	Subject to deductible , then 40% Coinsurance	Not Covered

Benefit	In Network	Out of Network
General Med Urgent Care by Teladoc	Subject to deductible , then $0/Visit	Not Covered
Mental/Behavioral Health by Teladoc	Subject to deductible , then $20/Visit	Not Covered
Dermatology by Teladoc	Subject to deductible , then $20/Visit	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)	Deductible then $30 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $250 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then 50% Coinsurance	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 $60 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $500 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then 50% Coinsurance	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 $30 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $250 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then 50% Coinsurance	Not Covered
Specialty Drugs (Tier 4)	Deductible then 50% Coinsurance	Not Covered