Hometown Health Providers Insurance Company, Inc.
Schedule of Benefits
Benefit Plan: 20 LG PPO 25-80 CINS S D3000X2 A9;RX $10/$35/$55/20%

This Schedule of Benefits describes your health insurance Policy provided by Hometown Health Providers Insurance Company, Inc. (Hometown Health), an insurance company 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 an open access Preferred Provider Organization (PPO) that provides access to a network of Preferred Providers who have contracts with Hometown Health. Services from Preferred Providers will generally be paid at the In-Network benefit level. Members may also seek services from Non-Preferred or Out-of-Network Providers generally at a reduced benefit level (higher cost to the Member). Out-of-Network services may be paid at the In-Network coinsurance and copayment level if the services are rendered as part of an Emergency room visit or they have been previously approved by Hometown Health. *Generally, those Members who live or work in the State of Nevada will only have access to the Hometown Health Nevada network of providers at the In-Network benefit level; they will not have access to our national network at the In-Network benefit level.* Those Members who live and work outside the State of Nevada will have access to both the Hometown Health Nevada network and our national network of providers and will be able to receive services from those providers at the In-Network benefit level.

Prescription Drug Coverage. The Enhanced formulary is a list of covered prescription drugs for HometownRx members. The formulary is a valuable resource for members and health care professionals to determine the most effective drug for your condition at the lowest out-of-pocket cost to you. This Policy covers some drugs which are not included in the HometownRx Enhanced Prescription Drug List but at a non-preferred tier 3 copay.

Pharmacy Network. Members must utilize the HometownRx Standard Pharmacy Network. This Policy does not cover drugs which are purchased from pharmacies that are not part of the HometownRx Standard Pharmacy Network.

Geographic Service Area. This Policy is available only to employees of employers who have a physical business location in Nevada. Additional eligibility requirements are detailed in the Hometown Health Large Group PPO Evidence of Coverage (EOC).

Minimum Essential Coverage. This Benefit Plan is considered Minimum Essential Coverage as defined by 26 U.S.C. § 5000A(f) and its implementing regulations.

Additional Requirements. This Schedule of Benefits describes what Hometown Health covers and what you pay. This document is 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. In case of conflicts between the EOC and this Schedule of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents.

Nondiscrimination. Hometown Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Definitions. Specific capitalized terms used throughout this Schedule of Benefits are defined in the EOC that governs this Schedule of Benefits and the Drug Formulary.

Benefit Summary Table. The following Benefit Summary Table lists the Member's responsibility. This table may not include all eligible benefits. Items marked with "CYD" are subject to the Calendar Year Deductible which resets each January 1.

Benefit Summary Table		
Benefit Category / **Benefit Tier Level**	***Member Responsibility*** **PPO Network**	**Out-of- Network**
Calendar Year Deductibles		
Individual Medical Deductible	$3,000	$6,000
Family Medical Deductible	$6,000	$12,000
Individual Pharmacy Deductible	$0	$0
Family Pharmacy Deductible	$0	$0
This plan has an Embedded Deductible. Hometown Health will begin to pay for non-preventive covered services for a Member once that Member has met the individual Deductible or when the family meets the family Deductible, whichever comes first.		
Calendar Year Out-of-Pocket Maximums		
Individual Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	$6,600	$13,200
Family Combined Out-of-Pocket Maximum (Medical and Pharmacy services combined)	$13,200	$26,400
The Out-of-Pocket Maximum includes Deductibles, Copayments and Coinsurance. The Out-of-Pocket Maximum does not include Premiums, cost-sharing for non-covered services, expenses associated with denied claims, Ancillary Charges and amounts that Non-Participating Providers bill and are payable that are greater than the Allowed Amount.		
Physician Office Visits		
Primary Care (PCP) Office Visits *(Does not include imaging, surgery and other services.)*	$25	CYD then 40%
Convenient Care Facility services provided for Medically Necessary, non-urgent Illness or Injury	$25	CYD then 40%
Primary care ACA wellness visit *(All necessary wellness visits are covered for children less than two years of age. One wellness visit per Calendar Year is covered for members older than two years or as frequently as mandated by the ACA.)*	$0	CYD then 40%
Obstetrics and gynecology ACA services	$0	CYD then 40%
Prenatal and postnatal office visits	$0	CYD then 40%
Specialist Office Visit including covered maternity care	$50	CYD then 40%
PCP and specialist visits include telemedicine only available through select in-network providers. Imaging, surgery and other services provided in an office setting may have a higher copayment or coinsurance.		
Preventive Screenings		
Mammography screening	$0	CYD then 40%
Papanicolaou (Pap) test	$0	CYD then 40%
Prostate Specific Antigen (PSA) screen	$0	CYD then 40%
Colorectal screening	$0	CYD then 40%
Counseling for sexually transmitted infections (STI) HIV counseling and testing	$0	CYD then 40%
Breastfeeding support, supplies and counseling	$0	CYD then 40%
Screening for interpersonal and domestic violence	$0	CYD then 40%
Contraceptives and in office counseling for FDA approved injections, implants, and contraceptive devices not covered under pharmacy benefits	$0	CYD then 40%
Screening for Gestational Diabetes	$0	CYD then 40%
High-risk human papillomavirus (HPV) testing	$0	CYD then 40%

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Hospital Facility Services		
Acute care hospital admission	CYD then 20%	CYD then 40%
Inpatient delivery, postpartum care and newborn care services	CYD then 20%	CYD then 40%
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	CYD then 20%	CYD then 40%
Skilled nursing facility (limited to 100 days per Calendar Year)	CYD then 20%	CYD then 40%
Rehabilitation facility (limited to 60 days per Calendar Year)	CYD then 20%	CYD then 40%
All Hospital Facility Services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network inpatient hospital and facility admissions. In emergencies in which a member is admitted to a hospital for an inpatient stay, to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so.		
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services. Maternity care is covered except as noted in the Infertility section of covered services in the Evidence of Coverage.		
Urgent Care and Emergency Services		
Virtual Visits for Urgent Care Services *(available only through Hometown Health's preferred virtual visit provider)*	$0	Not Available Out-of-Network
Urgent Care Services *(includes Out-of-Area Out-of-Network Urgent Care Center Services; Out-of-Network Providers may balance bill you for the amount charged in excess of the Allowed Amount)*	$50	$50
Emergency Room Services *(Copayment is waived if admitted; Out-of-Network Providers may charge for amounts greater than the Allowed Amount)*	CYD then 20%	CYD then 20%
Ambulance (ground)	CYD then 20%	CYD then 40%
Ambulance (air and water)	CYD then 20%	CYD then 40%
Specialty Imaging and Diagnostic Testing		
Computer Tomography (CT, CTA) scan	CYD then 20%	CYD then 40%
Positron Emission Tomography (PET) scan	CYD then 20%	CYD then 40%
Magnetic Resonance Imaging (MRI/MRA)	CYD then 20%	CYD then 40%
Nuclear Medicine	CYD then 20%	CYD then 40%
Angiograms and Myelograms	CYD then 20%	CYD then 40%

Benefit Summary Table		
Benefit Category **Benefit Tier Level**	***Member Responsibility*** **PPO Network**	**Out-of- Network**
All Other (Non-Specialty) Imaging and Diagnostic Testing (including X-rays and ultrasounds)		
X-ray and all other diagnostic imaging services not performed in an office setting	$50	CYD then 40%
Diagnostic mammography	$50	CYD then 40%
Services provided in a Primary Care Physician office (*except Specialty Imaging and Diagnostic Testing*)	$25	CYD then 40%
Services provided in a Specialty Care Physician office *(except Specialty Imaging and Diagnostic Testing)*	$50	CYD then 40%
Laboratory Services		
General laboratory services *(unless covered under ACA preventive guidelines)*	$25	CYD then 40%
Outpatient Speech, Occupational and Physical Therapy		
Speech therapy	CYD then 20%	CYD then 40%
Occupational therapy	CYD then 20%	CYD then 40%
Physical therapy	CYD then 20%	CYD then 40%
Coverage for Medically Necessary speech therapy, occupational therapy and physical therapy is limited to 90 visits per Calendar Year for all three therapy types combined as per the medical necessity of these services.		
Other Outpatient Therapy and Rehabilitation Services		
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 60 visits per Calendar Year all modalities combined.)*	$10	CYD then 40%
Wound therapy in an outpatient hospital or outpatient facility setting *(For wound therapy in an office based setting, see the Physician Office Visit section of this Benefit Summary Table.)*	CYD then 20%	CYD then 40%
Chemotherapy in an outpatient hospital, outpatient facility or Physician's office	CYD then 20%	CYD then 40%
Radiation therapy in an outpatient hospital, outpatient facility or Physician's office	CYD then 20%	CYD then 40%
Infusion therapy *(Includes home infusion therapy. Does not include the cost of special pharmaceuticals used in infusion therapy. For cost of the special pharmaceuticals, used in infusion therapy, see the special pharmaceuticals benefits in the Medical Pharmacy and Immunizations section or your Pharmacy Benefits as appropriate.)*	CYD then 20%	CYD then 40%
Port Wine Stain Removal	CYD then 20%	CYD then 40%
Rehabilitation services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Surgical Services		
Performed in primary care physician's office	CYD then 20%	CYD then 40%
Performed in specialty care physician's office	CYD then 20%	CYD then 40%
Performed in outpatient facility or hospital *(if admitted, see the acute care hospital admission cost sharing in the Hospital Services section above.)*	CYD then 20%	CYD then 40%
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	CYD then 20%	CYD then 40%
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime.)*	CYD then 20%	CYD then 40%
Diagnostic and/or therapeutic endoscopy	CYD then 20%	CYD then 40%
All surgical services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		

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Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME) *(Limited to one purchase, repair or replacement of a specific item of DME every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME, including oxygen and oxygen related equipment, in excess of $150 require Prior Authorization.)*	CYD then 20%	CYD then 40%
Orthopedic and prosthetic devices *(Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years. Orthopedic and prosthetic devices in excess of $800 require Prior Authorization)*	CYD then 20%	CYD then 40%
Ostomy supplies *(Limited to 30 days of therapeutic supplies per month. Ostomy supplies require Prior Authorization.)*	CYD then 20%	CYD then 40%
Special Food Products *(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Calendar Year. Prior Authorization required.)*	CYD then 20%	CYD then 40%
If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary.		
Alcohol and Substance-Abuse Treatment		
Inpatient treatment	CYD then 20%	CYD then 40%
Outpatient treatment – specialist	$25	CYD then 40%
Withdrawal treatment – inpatient	CYD then 20%	CYD then 40%
Withdrawal treatment – outpatient	$25	CYD then 40%
Inpatient and outpatient programs for alcohol and substance abuse treatment require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require Prior Authorization.		
Mental Health		
Inpatient Medically Necessary services for mental health disorders	CYD then 20%	CYD then 40%
Mental health outpatient and office visits	$25	CYD then 40%
Applied Behavioral Therapy for the treatment of Autism *(Limited to 1,250 hours (approximately 260 visits) of therapy for habilitation and 1,250 hours (approximately 260 visits) of therapy for rehabilitation per Calendar Year.)*	$25	CYD then 40%
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. If you do not obtain the required Prior Authorization for the service, the service may not be covered, even if the service is Medically Necessary. Mental health office visits that are not part of a mental health treatment program do not require Prior Authorization.		

Benefit Summary Table		
Benefit Category **Benefit Tier Level**	***Member Responsibility*** **PPO Network**	 **Out-of- Network**
Other Medical Services		
Kidney dialysis received at home or in an outpatient or office setting (*for kidney dialysis received in an inpatient facility, see the inpatient facility benefit line.*)	$50	CYD then 40%
Spinal manipulations performed by a chiropractor or other physician (*Limited to 20 office visits per Calendar Year and 100 office visits per lifetime* .)	$50	CYD then 40%
Alternative Care including acupuncture services *(Limited to $1,000 maximum benefit per Calendar Year.)*	$50	CYD then 40%
Home health care *(Limited to 30 visits per Calendar Year; May provide for private duty nursing in the home; Prior Authorization required.)*	$50	CYD then 40%
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. *(Limited to one diagnostic evaluation for infertility every Calendar Year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the EOC. These limits and exclusions apply to both office based and non-office based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in this Benefit Summary Table)*	$50	CYD then 40%
Temporomandibular Joint (TMJ) Disorder Services *(TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to one (1) surgery per Calendar Year and two (2) surgeries in a lifetime.)* *Office based services (excluding surgical services)* *All other services (including surgical services)*	 $50 CYD then 20%	 CYD then 40% CYD then 40%
Hospice Services are covered for Members with a life expectancy of 6 months or 185 days or less as certified by his or her Provider *(Limited to a lifetime benefit maximum of 185 days)* : a. Part-time intermittent home health or respite care services totaling fewer than 8 hours per day and 35 or fewer hours per week. b. b. Outpatient counseling of the Member and his or her immediate family (limited to 5 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific Policy). Counseling must be provided by a psychiatrist, psychologist, or social worker. Members who are eligible for mental health benefits under their specific Policy should refer to the applicable description of such benefits to determine coverage. Medically Necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits describe above. c. Hospice care providing nursing care for a maximum of five (5) inpatient days or (5) outpatient visits per ninety (90) days of home hospice care. Inpatient respite care will be authorized only when we determine that home respite care is not appropriate or practical. *Office based services* *All other services (including surgical services)*	 $50 CYD then 20%	 CYD then 40% CYD then 40%
Any other covered medical service not listed in the Schedule of Benefit	CYD then 20%	CYD then 40%

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Medical Pharmacy Benefits (excludes Retail Pharmacy)		
Special Pharmaceutical: drugs eligible for coverage under the medical benefit; may require member cost-sharing in addition to the administration of the drug.	CYD then 20%	CYD then 40%
Preventive Immunizations (*as described in the Preventive Services section of the EOC* .)	$0	CYD then 40%
Medical Benefit Drugs: drugs eligible for coverage under the medical benefit; typically drugs that are not self-administered by the member.	CYD then 20%	CYD then 40%
Some injection and infusion drugs require Prior Authorization. If you do not obtain Prior Authorization for the administration of the drug, the service and drug may not be covered (even if the service and drug is Medically Necessary).		
Pharmacy Benefits - Enhanced		
Tier 1 – Generic Drugs *Member Responsibility reflects up to 30-day supply per fill.*	$10	N/A
Tier 2 – Preferred Brand Drugs – *may also include select Generic drugs. Refer to the EOC for ancillary charge.* *Member Responsibility reflects up to 30-day supply per fill.*	$35	N/A
Tier 2 – Preferred Brand Oral Oncological Drugs *(Preferred Brand Oral Oncological Drugs require Prior Authorization and must be purchased at a designated pharmacy; the cost to the Member for Orally Administered Chemotherapy will not to exceed $100 per prescription – excludes HSA plans.)* *Member Responsibility reflects up to 30-day supply per fill.*	$35	N/A
Tier 3 – Non-Preferred Brand or Generic Drugs *Member Responsibility reflects up to 30-day supply per fill.*	$55 plus the Ancillary Charge	N/A
Tier 4 – Specialty Pharmaceutical Drugs – *may also include non- preferred high cost Generic drugs. Specialty Pharmaceuticals require Prior Authorization.* *Most Specialty Pharmaceuticals must be obtained through a specialty Pharmacy designated by Hometown Health and are limited to a 30-day supply per fill.*	20%	N/A
Tier 5 – Preventive Drugs *(prescribed in accordance with the U.S. Preventive Task Force Recommendations A & B; excludes select Brand Drug formulations with an available Generic Drug alternative)* *Member Responsibility reflects up to 30-day supply per fill.*	$0	N/A
Cost sharing for diabetic supplies is based on the tier (Generic, Brand, etc.). Includes insulin, insulin syringes with needles, glucose blood-testing strips, lancets and lancet devices.		

For more information go to ***www.HometownHealth.com***