Summary of Benefits for Renown Employee Health Plan

All Essential Health Benefits

LIFETIME MAXIMUM BENEFIT	**Unlimited**

Total Plan benefits for each covered person are not limited. However, utilization limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are included in this summary.

NOTE: Any use of the term "lifetime" refers to all periods an individual is covered under the Plan. It does not mean a covered person's entire lifetime.

	Renown Network	**IN-Network**	**Out-of Network**
Deductible			
Individual	None	None	$4,000
Family Unit	None	None	$8,000

Individual Deductibles – The individual Deductible is an amount a covered person must contribute toward payment of covered charges. The deductible is due and payable by the covered person upon receipt of certain covered services. Where applicable, the deductible must be met before benefits are paid by the Plan. See "†" notations in the columns for instances where the Calendar Year Deductible does not apply.

Family Maximum Deductible – If covered charges equal to the Family Maximum Deductible are incurred collectively by family members during a calendar year and are applied toward Individual Deductible, the Family Maximum Deductible is satisfied. A "family" includes a covered employee and his covered dependents.

NOTE: The preferred and non-preferred deductibles are separate. Expenses applied toward the preferred provider deductibles will not apply toward the non-preferred deductibles or vice versa.

Maximum Out-of-Pocket ***(NOTE: Medical and Prescription Drug benefit expenses are subject to the same Maximum Out-of-Pocket)***		
Individual	$8,150	Unlimited
Family Unit	$16,300	

Individual Out-of-Pocket Maximum – Except as noted, in any calendar year a covered person will not be required to pay more than his Individual Out-of-Pocket Maximum toward his deductible, copay and/or coinsurance obligations. Once he has paid his out-of-pocket maximum, his covered charges will be paid at 100% benefit level for the balance of the calendar year.

Family Out-of-Pocket Maximum – Except as noted, a covered family (employee and his dependents) will not be required to pay more than the Family Out-of-Pocket Maximum in any calendar year toward their deductibles, copay and/or coinsurance obligations. Once the family has paid their out-of-pocket maximum, their covered charges will be paid at 100% benefit level for the balance of the calendar year.

NOTE: The non-preferred provider out-of-pocket maximums do not apply to or include expenses which become the covered person's responsibility for failure to comply with the requirements of the Utilization Management Program (see Part 4 of the Summary Plan Description).

The following table identifies what does and does not apply toward the Network and Non-Network Out-of-Pocket Maximums:

Plan Features	**Applies to the Renown & Affiliate providers Out-of-Pocket Maximum?**	**Applies to the In Network Out-of-Pocket Maximum?**	**Applies to the Out Network Out-of-Pocket Maximum?**
Payments toward the annual Deductible	Yes	Yes	Yes
Coinsurance payments, including those for covered services available in the Prescription Drug Benefits section.	Yes	Yes	Yes
Copayments	Yes	Yes	Yes
Charges for non-covered services	No	No	No
The amounts of any Pre-Certification penalties "You are subject to a 50% reduction in benefits if you do not obtain a required Prior Authorization for the service even if the service is Medically Necessary."	No	No	No
Charges that exceed Allowable Expenses	No	No	No
Covered Medical Expenses	**Renown Network**	**In-Network**	**Out-Network**
Acupuncture, Homeopathies, Alternative Care, per visit	$40	$50	50% after deductible

Limited to 20 visits per calendar year.			
Advanced Imaging (Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans,)	$250	30%	50% after deductible
Ambulance (Ground/Water)	See Preferred	$100	50% after deductible
Ambulance (Air)	See Preferred	$100	50% after deductible
See Referral and Prior Authorization Requirements			
Ambulatory Surgical Center	$250	30%	50% after deductible
Chiropractic Care (Spinal Manipulations and Adjustments)	See Preferred	$65	50% after deductible
Limited to twenty (20) visits per calendar year and 100 visits per lifetime.			
Chemotherapy "In Office"	$40	$50	50% after deductible
Durable Medical Equipment	See Preferred	$50	50% after deductible
Limited to one purchase of a specific item of DME, including repair and replacement every three (3) years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The rental of warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea is limited to 90 days.			
Cataract Lenses (one set)	$25	30%	50% after deductible
Home Health Care	$40	30%	50% after deductible
Limited to fifty (50) visits per calendar year. Home health care requires prior authorization.			
Prior authorization is required; see "Utilization Management Program."			
Hospice Care			
Home Hospice Care	0	30%	50% after deductible
Limited to a 185-day period of patient care beginning on the first day of home hospice care services. Benefits for outpatient counseling services for the patient and his/her immediate family are limited to six (6) visits for all family members combined if they are not otherwise eligible for mental health benefits under another policy. Respite care providing nursing care is limited to a maximum of eight (8) inpatient respite care days per calendar year and thirty-seven (37) hours per calendar year for outpatient respite care services.			
Family Bereavement Counseling	0	30%	50% after deductible
Benefits for outpatient counseling services for the patient and his/her immediate family are limited to six (6) visits for all family members combined if they are not otherwise eligible for mental health benefits under another policy.			
Hospital			
Inpatient	$1000/admit	30%	$500/admit and 50% after deductible
Observation	$250	30%	50% after Deductible
Rehabilitation Facility	$1,250	30%	50% after Deductible
Inpatient accommodation is limited to a semi-private room except when confinement in an Intensive Care Unit is Medically Necessary. Prior authorization is required; see "Utilization Management Program."			
Infertility	**(benefits are based on types of service provided)**		
Limited to medically necessary services to diagnose problems of infertility for a covered individual. One diagnostic evaluation for infertility every year up to three (3) per lifetime and up to six (6) artificial inseminations per lifetime. Exclusions apply and are detailed in the Medical Plan Component.			
Mental Health and Substance Abuse			
Residential Treatment Facility	$1000 copay	30%	$500/admit and 50% after deductible
Outpatient Services	$20	$40	50% after deductible
Prior authorization is required; see "Utilization Management Program." Benefits for inpatient alcohol and substance abuse care are subject to review for medical necessity and level of care determination			
Orthotics Devices	$25	30%	50% after deductible
Outpatient Diagnostic X-ray	$0	30%	50% after deductible
Outpatient Lab	$0	30%	50% after deductible
Outpatient Emergency Services - Emergency Room			

Emergency "Copay waived if admitted"	$200	$200	$200
Outpatient Emergency Services - Other Providers			
Physician Services			
Office Visit--Primary Care Physician (PCP) Including office Procedures	$20	$40	50% after deductible
Office Visit--Specialist including office Procedures	$40	$80	50% after deductible
OB/GYN per visit	$20	$40	50% after deductible
Ultra-Sounds	$0	30%	50% after deductible
X-Rays	$0	30%	50% after deductible
Lab	$0	30%	50% after deductible
Pregnancy Expenses			
Physician Routine Prenatal Services Cesarean/Vaginal birth	$0	30%	50% after deductible
Pre-natal screening as defined under Women's Preventive Services of the Patient Protection and Affordable Care Act of 2010	$0	30%	50% after deductible
Preventive Care			
Well Adult Care	$0	$0	50% after deductible
Routine Physical Exam	$0	$0	50% after deductible
Mammograms (Screening) - must be over age 40	$0	$0	50% after deductible
Pap Smears	$0	$0	50% after deductible
Routine Immunizations	$0	$0	50% after deductible
Well Child Care	$0	$0	50% after deductible
Exam	$0	$0	50% after deductible
Immunizations	$0	$0	50% after deductible
Prostate Exam	$0	$0	50% after deductible

Preventive Care includes, but is not limited to:
• One (1) physical exam each calendar year and immunizations in accordance with medical practice guidelines, including influenza immunizations;
• One (1) routine GYN exam each calendar year including a Pap smear, pelvic exam, urinalysis and breast exam
• Mammogram screening;
• Colorectal cancer screening;
• Prostate screening (PSA);
• well-baby care during the first 2 years of life, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies;
• Hearing and vision screening for children through age 17 to determine the need for hearing or vision correction
Plan will cover the following services without any Member cost-sharing requirements if a Participating Provider provides such services:
• Evidence –based items or services that have in effect a rating of "A" or "B" in the current recommendation of the United States Preventive Services Task Force, provided that, with regard to breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Services Task Force will be the most current other than those issued in or around November 2009;
• Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention with respect to the individual involved

Prosthetics, Orthotics, Supplies	$25	$25	50% after deductible
Radiation Therapy	$0	$0	50% after deductible
Second Surgical Opinions	$40	$80	50% after deductible
Gender Assignment/Gender Reassignment	**(benefits are based on types of service provided)**		
Skilled Nursing Facility	$1,250	30%	50% after deductible; additional $600 deductible per admit

This is limited to one hundred (100) days per calendar year.

NOTE: All physician charges are paid in full after appropriate co-pays up to the contractual allowable while receiving treatment at a Renown Health facility, regardless if the physician is employed by Renown Health. These charges could include, but are not limited to outpatient surgery, anesthesia, emergency room, pathology and radiology. Preferred and Non-Preferred benefits only apply when a non-Renown business/service is used. For example, Outpatient Surgery performed at a non-Renown Outpatient Surgery Center.

Prior authorization is required; see "Utilization Management Program."

Outpatient Surgery Center	$250	30%	50% after deductible
Bariatric Surgery	**(benefits are based on types of service provided)**		
Limited to one medically necessary gastric restrictive surgery at a Bariatric Center of Excellence per lifetime. This designation is at the Plan Administrator's discretion. Limits include complications directly resulting from gastric restrictive services.			
Telahealth	$0	30%	50% after Deductible
Teladoc	$0	$0	$0
Temporomandibular Joint Disorder (TMJ)	**Depends on type of Service**	30%	50% after deductible
Annual maximum of (1) surgery and a lifetime maximum of two (2) surgeries			
Therapy Services			
Autism Spectrum Disorder Treatment	$25	30%	50% after deductible
Limited to one hundred and fifty (150) visits not to exceed five hundred and fifteen (515) total hours of therapy per calendar year.			
Cardiac Rehabilitation	$25	30%	50% after deductible
Outpatient cardiac rehabilitation and pulmonary rehabilitation therapy coverage is limited to 60 visits/sessions for all modalities combined per calendar year.			
Occupational Therapy	$25	30%	50% after deductible
Physical Therapy	$25	30%	50% after deductible
Pulmonary Rehab	$25	30%	50% after deductible
Speech Therapy	$25	30%	50% after deductible
Outpatient speech, occupational and physical therapy coverage is limited to 60 visits/sessions for all modalities combined per calendar year. Coverage for these therapies are provided for rehabilitative and habilitative separately, as per the medical necessity of these services. Habilitative therapy does not require that an injury or illness preceded the need for service. Outpatient cardiac rehabilitation and pulmonary rehabilitation therapy coverage is limited to 60 visits/sessions for all modalities combined per calendar year.			
Transplants			
Recipient Expenses	**(Benefits are based on types of services provided)**		
Donor Expenses	**(Benefits are based on types of services provided)**		
Prior authorization is required; see "Utilization Management Program."			
Urgent Care Facility	$30	30%	50% after deductible
Varicose Veins	$40	$80	50% after deductible
Prior authorization is required; see "Utilization Management Program."			
Kidney Dialysis Services, per visit	See preferred	$80	50% after deductible
Wigs	See preferred	$50	50% after deductible
All Other Covered Services	$0	30%	50% after deductible
Port Wine Stain Removal	$20	$50	50% after deductible
Wound Care	$40	30%	50% after deductible
Ostomy Care Supplies	$0	$0	50% after deductible
Limited to thirty (30) days of therapeutic supplies per month.			
Medical Pharmaceuticals			
Special Pharmaceuticals	$75	30%	50% after deductible
Other Medical Pharmaceuticals	$40	30%	50% after deductible
Prior authorization is required			
Food Products, Special as defined by Nevada Statute	$0	$0	50% after deductible
Special food products limited to a maximum benefit of four (4) thirty (30) days of therapeutic supplies per member per calendar year			
Genetic Counseling Genetic Counseling/Testing if medically necessary as determined by the plan, per visit If mandated by PPACA for high risk BRCA testing and counseling	$40 per visit, $0 testing and counseling	25% per visit, $0 testing and counseling	50% after deductible

REFERRAL AND PRIOR AUTHORIZATION REQUIREMENTS

Compliance Requirements - A referral from a covered person's Primary Care Physician (PCP) and prior authorization from Hometown Health Providers Insurance Company is required for the following:

- All inpatient stays and services in any type of facility, including acute and skilled care, mental health care, and drug or alcohol detoxification, rehabilitation (including partial or day hospitalization service stays).
- Inpatient, same day, or in-office surgical services with a cost greater than $750.00 (total billed charges) (excluding diagnostic and screening colonoscopies)

- Air ambulance transportation
- Anesthesiology and physiatrist, including pain management
- Autism services
- Cardiac and pulmonary rehabilitation
- Certain infertility laboratory and diagnostic tests
- Chemotherapy
- Dialysis
- Gastric restrictive services
- Genetic counseling services
- Home health care
- Hearing Aids (review plan document for coverage)
- Healthcare services and supplies including but not limited to oxygen, oxygen-related equipment and all durable medical equipment (DME) with the exception of Prosthetic and Orthopedic devices with a cost greater than $1000
- Prosthetic and Orthopedic devices (DME) with a cost greater than $850
- Hospice
- Infusion therapy
- Mental health office visits that are part of an alcohol or substance abuse program
- Ostomy Supplies
- Outpatient speech, occupational and physical therapy greater than 20 visits per calendar year
- Radiation Therapy
- Special food products
- Second-opinion services
- Specialist office visits for plastic surgery and genetic counseling services
- Transplant Services
- Wound therapy in an outpatient setting
- Certain medications specified by Hometown Health Specialty Drugs (see hometownhealth.com)
- Certain high cost pharmaceuticals and biological meds. A current list of these are available on the website; www.hometownhealth.com

Contracted providers are required to obtain certification/pre-certification from Hometown Health Providers. However, to avoid possible penalties, a covered person should verify that the referral and certification requirements have been met. Prior-Authorization by Hometown Health Providers does not guarantee that all charges are covered under the policy. Charges submitted for payment are subject to all of the terms of the policy.

Members may elect to seek services from non-preferred healthcare providers provided the member pays the additional deductible and coinsurance amounts and any additional charges over a usual and customary charge for the service provided. Members also may be required to obtain prior authorization before seeking services from

non-preferred providers. It is the member's responsibility to ensure that the appropriate prior authorizations are in place for both in-network and out of network non-emergency services.
For an emergency or urgent hospital admission or treatment (including all complications of pregnancy) where a non-contracted provider is used, the covered person is responsible for making sure his/her Primary Care Physician and Hometown Health Providers is notified within 24 hours or as soon as reasonably possible after admission or treatment. Non-contracted physicians and providers may not know or attempt to notify Hometown Health Providers to obtain pre-certification for such services. All emergency care not reported to the covered person's Primary Care Physician and certified by Hometown Health Providers will be reviewed retrospectively to determine coverage.

If the covered person or a family member is unable to contact his or her Primary Care Physician and Hometown Health Providers before receipt of emergency or urgent medical services or within 24 hours of onset of the condition due to shock, unconsciousness, or otherwise, the covered person must, at the earliest time reasonably possible, contact his/her Primary Care Physician and Hometown Health Providers.

Benefits will be provided only for certified services and supplies. No Plan benefits will be provided for care that is determined not a covered benefit or not meeting the Plan's criteria and protocols.

It is the obligation of the covered person to comply and cooperate with the referral and pre-certification requirements.

Pre-certification does not guarantee that all charges are covered. Benefits are subject to all of the terms of the Plan.

Summary of Benefits for Renown Health Plan

COVERED PRESCRIPTION DRUG EXPENSES	Renown Retail PHARMACY	In-Network PHARMACY
Pharmacy Option		
Copayment/Coinsurance, per prescription or refill, for generic	$10	$15
Copayment/Coinsurance, per prescription or refill, for name brands*	$35	$45 after Annual $250 deductible
Copayment/Coinsurance, per prescription or refill, for non-formulary name brands	$50 or 50% whatever is greater	$75 after Annual $250 deductible or 50% whatever is greater
Specialty	20% per 30 days only	20% per 30 days only
Mail Order Option		
Copayment/Coinsurance, per prescription or refill, for generic	$20	$20
Copayment/Coinsurance, per prescription or refill, for name brands*	$70	$70
Copayment/Coinsurance, per prescription or refill, for non-formulary name brands	100 or 50% if greater	100 or 50% if greater
Copayment/Coinsurance, per prescription or refill, for specialty drugs	20% per 30 days only	20% per 30 days only