The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.hometownhealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-775-982-3034 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1000.00 individual / $2000.00 family for In-Network $2000.00 individual / $4000.00 family for Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care. Primary care visit, and Specialist visit for In-Network providers. are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6850.00 individual / $13700.00 family for In-Network $13700.00 individual / $27400.00 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, Premiums, amounts applied or paid to satisfy any Prescription Drug co-pays, or expenses which are not covered by the plan; charges that exceed the Maximum Allowable, expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	Non network transplant services., and health care this plan does not cover.	
Will you pay less if you use a network provider?	Yes. See www.hometownhealth.com or call 1-775-982-3232 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35/visit	50% coinsurance	None
	Specialist visit	$70/visit	50% coinsurance	None
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine lab work is covered as preventive, no member cost sharing. for In-Network. Routine lab work is covered as preventive, no member cost sharing. for .
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Routine lab work is covered as preventive, no member cost sharing. for In-Network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
				Routine lab work is covered as preventive, no member cost sharing. for .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Optumrx.com	Generic Drugs	Retail: $10/prescription Mail Order: $25/prescription	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Out-of-pocket limit is combined with medical. See Summary Plan Document for more information. for Tier 1
	Preferred Brand Drugs	Retail: $35/prescription Mail Order: 87.50% coinsurance	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Out-of-pocket limit is combined with medical. See Summary Plan Document for more information. for In-Network
	Non Preferred Brand Drugs	Retail: $50/prescription Mail Order: $125/prescription	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Out-of-pocket limit is combined with medical. See Summary Plan Document for more information. for In-Network
	Specialty drugs	Retail: $100/prescription	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Out-of-pocket limit is combined with medical. See Summary Plan Document for more information. for In-Network
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization may be required. for In-Network Preauthorization may be required. for

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$300/visit	$300/visit	ER copayment is waived if the patient is admitted. for In-Network ER copayment is waived if the patient is admitted. for
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50/visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required. for In-Network Preauthorization is required. for
	Physician/surgeon fee	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35/visit	50% coinsurance	——————none——————
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required for inpatient services. for In-Network Preauthorization is required for inpatient services. for
If you are pregnant	Office visits	$35/visit	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). for In-Network for
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	for In-Network for
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None
	Home health care	20% coinsurance	50% coinsurance	Maximum benefit: limited to 130 visits per member per calendar

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs				year, preauthorization is required. for In-Network Maximum benefit: limited to 130 visits per member per calendar year, preauthorization is equired. for
	Rehabilitation services	$70/visit	50% coinsurance	60 visit calendar year maximum combined between Physical Therapy, Occupational Therapy and Speech Therapy. See Therapy Services section. for In-Network 60 visit calendar year maximum combined between Physical Therapy, Occupational Therapy and Speech Therapy. See Therapy Services section. for
	Habilitation services	$70/visit	50% coinsurance	60 visit calendar year maximum combined between Physical Therapy, Occupational Therapy and Speech Therapy. See Therapy Services section. for In-Network 60 visit calendar year maximum combined between Physical Therapy, Occupational Therapy and Speech Therapy. See Therapy Services section. for
	Skilled nursing care	20% coinsurance	50% coinsurance	100 days per calendar year, preauthorization is required. for In-Network 100 days per calendar year, preauthorization is required. for
	Durable medical equipment	20% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, exercise and bathroom equipment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
				Preauthorization may be required. Coverage is limited to least expensive item that will fit the patient's needs. for In-Network Excludes vehicle modifications, home modifications, exercise and bathroom equipment. Preauthorization may be required. Coverage is limited to least expensive item that will fit the patient's needs. for
	Hospice services	20% coinsurance	50% coinsurance	See Summary Plan Document for more information. for In-Network See Summary Plan Document for more information. for
If your child needs dental or eye care	Children's eye exam	20% coinsurance	50% coinsurance	See Summary Plan Document for more information. for In-Network See Summary Plan Document for more information. for
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Private Duty Nursing
- Hearing aids
- Routine eye care (Adult)
- Routine Foot Care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (40 visits/benefit period)
- Chiropractic Care (20 visits/benefit period)
- Diabetes Education Programs
- Orthotics Devices
- Transplants

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage

options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-775-982-3034. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
▪ The plan's overall deductible	$7,200	▪ The plan's overall deductible	$7,200	▪ The plan's overall deductible	$7,200
▪ Specialist *copay*	$0	▪ Specialist *copay*	$0	▪ Specialist *copay*	$0
▪ Hospital (facility) *cost sharing*	0%	▪ Hospital (facility) *cost sharing*	0%	▪ Hospital (facility) *cost sharing*	0%
▪ Other *cost sharing*	0%	▪ Other *cost sharing*	0%	▪ Other *cost sharing*	0%
This EXAMPLE event includes services like: Specialist office visits (*prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work)* Specialist visit *(anesthesia)*		This EXAMPLE event includes services like: Primary care physician office visits (*including disease education)* Diagnostic tests *(blood work)* Prescription drugs Durable medical equipment *(glucose meter)*		This EXAMPLE event includes services like: Emergency room care *(including medical supplies)* Diagnostic test *(x-ray)* Durable medical equipment *(crutches)* Rehabilitation services *(physical therapy)*	
Total Example Cost	$12,700	Total Example Cost	$5600	Total Example Cost	$2800
In this example, Peg would pay: This condition is not covered, so patient pays 100 percent.		In this example, Joe would pay: This condition is not covered, so patient pays 100 percent.		In this example, Mia would pay: This condition is not covered, so patient pays 100 percent.	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$1,000	Deductibles	$1,000	Deductibles	$1,000
Copayments	$20	Copayments	$649	Copayments	$655
Coinsurance	$2,323	Coinsurance	$129	Coinsurance	$71
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$45	Limits or exclusions	$22	Limits or exclusions	$0
The total Peg would pay is	$3,389	The total Joe would pay is	$1,800	The total Mia would pay is	$1,727

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-775-982-3034. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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