



## **Schedule of Benefits**

IFP Renown Silver HMO \$20PCP ZCS

*HIOS Plan ID: 41094NV0030063*

Benefit period: From 01/01/2025 through 12/31/2025 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. Additionally, You must receive a referral from Your PCP 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.

### Zero Cost Sharing Options for American Indian and Alaska Natives (AIAN) Plan Variants

- You **do not have to pay** copayments, deductibles, or coinsurance when getting care from an Indian health care provider or when getting essential health benefits through a Marketplace plan.
- You **do not** need a referral from an Indian health care provider when getting essential health benefits through a Marketplace plan.

# 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 |
|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------|
| <b>Deductible:</b><br>- Per Calendar Year<br>- Medical and Drug Combined<br>- Some services do not apply to the deductible, as indicated below. | \$0/Individual<br>\$0/Family | Not Applicable |
| <b>Out-of-Pocket Maximum:</b><br>- Per Calendar Year<br>- Medical and Drug Combined                                                             | \$0/Individual<br>\$0/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    | No Cost    | Not Covered    |
| Specialist Visit                                    | No Cost    | Not Covered    |
| Physician to Physician eConsult                     | No Cost    | Not Covered    |
| Surgical Services performed in a Physician's Office | No Cost    | Not Covered    |

| Benefit                                                                                                                                                                                                                           | In Network | Out of Network |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------|
| Mental/Behavioral Health Office Visit                                                                                                                                                                                             | No Cost    | Not Covered    |
| Substance Abuse Disorder Office Visit                                                                                                                                                                                             | No Cost    | Not Covered    |
| <b>Preventive Care</b>                                                                                                                                                                                                            |            |                |
| 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    |
| <b>Therapy</b>                                                                                                                                                                                                                    |            |                |
| Habilitation Services<br><i>120 visit(s) per year</i>                                                                                                                                                                             | No Cost    | Not Covered    |
| Outpatient Rehabilitation Services<br><i>120 visit(s) per year</i>                                                                                                                                                                | No Cost    | Not Covered    |
| Rehabilitative Occupational and<br>Rehabilitative Physical Therapy<br><i>120 visit(s) per year</i>                                                                                                                                | No Cost    | Not Covered    |
| Rehabilitative Speech Therapy<br><i>120 visit(s) per year</i>                                                                                                                                                                     | No Cost    | Not Covered    |
| Infusion Therapy<br><i>Does not include the cost of special<br/>pharmaceuticals used in infusion therapy.</i>                                                                                                                     | No Cost    | Not Covered    |
| Chemotherapy                                                                                                                                                                                                                      | No Cost    | Not Covered    |
| Radiation                                                                                                                                                                                                                         | No Cost    | Not Covered    |
| Cardiac and Pulmonary Rehabilitation                                                                                                                                                                                              | No Cost    | Not Covered    |
| <b>Diagnostic &amp; Imaging</b>                                                                                                                                                                                                   |            |                |
| Imaging (CT/PET Scans, MRIs)                                                                                                                                                                                                      | No Cost    | Not Covered    |
| Laboratory Outpatient and Professional<br>Services                                                                                                                                                                                | No Cost    | Not Covered    |
| X-rays and Diagnostic Imaging                                                                                                                                                                                                     | No Cost    | Not Covered    |
| <b>Outpatient Care</b>                                                                                                                                                                                                            |            |                |
| Mental/Behavioral Health Outpatient<br>Services<br><i>Including intensive outpatient treatment<br/>programs, partial hospitalization, and<br/>residential treatment programs.</i>                                                 | No Cost    | Not Covered    |
| Outpatient Facility Fee (e.g., Ambulatory<br>Surgery Center)                                                                                                                                                                      | No Cost    | Not Covered    |
| Outpatient Surgery Physician/Surgical<br>Services                                                                                                                                                                                 | No Cost    | Not Covered    |
| Substance Abuse Disorder Outpatient<br>Services Mental/Behavioral Health<br>Outpatient Services<br><i>Including intensive outpatient treatment<br/>programs, partial hospitalization, and<br/>residential treatment programs.</i> | No Cost    | Not Covered    |
| <b>Inpatient Care</b>                                                                                                                                                                                                             |            |                |

| Benefit                                                                                                                                                    | In Network  | Out of Network |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------|
| Childbirth/Delivery Facility Services                                                                                                                      | No Cost     | Not Covered    |
| Inpatient Hospital Services (e.g., Hospital Stay)                                                                                                          | No Cost     | Not Covered    |
| Mental/Behavioral Health Inpatient Services                                                                                                                | No Cost     | Not Covered    |
| Skilled Nursing Facility<br><i>100 days per year</i>                                                                                                       | No Cost     | Not Covered    |
| Substance Abuse Disorder Inpatient Services                                                                                                                | No Cost     | Not Covered    |
| <u>Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services</u> |             |                |
| <b>Hospice Care</b>                                                                                                                                        |             |                |
| Hospice Respite Services<br><i>5 days per 90 days</i>                                                                                                      | No Cost     | Not Covered    |
| <b>Home Health Care</b>                                                                                                                                    |             |                |
| Home Health Care Services                                                                                                                                  | No Cost     | Not Covered    |
| Long-Term/Custodial Nursing Home Care                                                                                                                      | Not Covered | Not Covered    |
| Private-Duty Nursing                                                                                                                                       | No Cost     | Not Covered    |
| <b>Urgent Care</b>                                                                                                                                         |             |                |
| Urgent Care Centers or Facilities                                                                                                                          | No Cost     | Not Covered    |
| Mobile Urgent Care                                                                                                                                         | No Cost     | Not Covered    |
| <b>Emergency Care/Ambulance</b>                                                                                                                            |             |                |
| Emergency Room Services                                                                                                                                    | No Cost     | No Cost        |
| Emergency Transportation/Ambulance<br>(Ground, Air, Water)                                                                                                 | No Cost     | No Cost        |
| <b>Durable Medical Equipment</b>                                                                                                                           |             |                |
| Durable Medical Equipment<br><i>1 item(s) per 3 years</i>                                                                                                  | No Cost     | Not Covered    |
| Prosthetic Devices<br><i>1 item(s) per 3 years</i>                                                                                                         | No Cost     | Not Covered    |
| Hearing Aids<br><i>1 item(s) per 3 years</i>                                                                                                               | No Cost     | Not Covered    |
| <b>Dental Care</b>                                                                                                                                         |             |                |
| Accidental Dental                                                                                                                                          | No Cost     | Not Covered    |
| Basic Dental Care – Child                                                                                                                                  | Not Covered | Not Covered    |
| Basic Dental Care – Adult                                                                                                                                  | Not Covered | Not Covered    |
| <b>Vision Care</b>                                                                                                                                         |             |                |
| Eye Glasses for Children<br><i>1 item(s) per year</i>                                                                                                      | No Cost     | Not Covered    |
| Routine Eye Exam for Children<br><i>1 exam(s) per year</i>                                                                                                 | No Cost     | Not Covered    |

| Benefit                                                                                                                                            | In Network  | Out of Network |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------|----------------|
| Routine Eye Exam (Adult)                                                                                                                           | Not Covered | Not Covered    |
| <b>Additional Services</b>                                                                                                                         |             |                |
| Abortion<br><i>Except in the case of rape, incest, or for a pregnancy which, as certified by a doctor, places the woman in grave danger</i>        | Not Covered | Not Covered    |
| Acupuncture                                                                                                                                        | Not Covered | Not Covered    |
| Allergy Testing                                                                                                                                    | No Cost     | Not Covered    |
| Bariatric Surgery<br><i>1 Procedure(s) per lifetime</i>                                                                                            | No Cost     | Not Covered    |
| Cosmetic Surgery                                                                                                                                   | Not Covered | Not Covered    |
| Diabetes Education                                                                                                                                 | No Cost     | Not Covered    |
| Dialysis                                                                                                                                           | No Cost     | Not Covered    |
| Reconstructive Surgery                                                                                                                             | No Cost     | Not Covered    |
| Transplant                                                                                                                                         | No Cost     | Not Covered    |
| Treatment for Temporomandibular Joint Disorders                                                                                                    | No Cost     | Not Covered    |
| Weight Loss Programs                                                                                                                               | Not Covered | Not Covered    |
| Remote Monitoring<br><i>Copay paid once per 30-day period.</i>                                                                                     | No Cost     | Not Covered    |
| Special Food Products<br><i>4 item(s) per year</i>                                                                                                 | No Cost     | Not Covered    |
| Applied Behavioral Therapy for the treatment of Autism                                                                                             | No Cost     | Not Covered    |
| Nutritional Counseling<br><i>1 visit(s) per episode</i>                                                                                            | No Cost     | Not Covered    |
| Chiropractic Care<br><i>20 visit(s) per year</i>                                                                                                   | No Cost     | Not Covered    |
| Infertility Treatment<br><i>6 Procedure(s) per lifetime</i>                                                                                        | No Cost     | Not Covered    |
| Routine Foot Care                                                                                                                                  | Not Covered | Not Covered    |
| Wound Care                                                                                                                                         | No Cost     | Not Covered    |
| Specialty Pharmaceuticals                                                                                                                          | No Cost     | Not Covered    |
| All Other Medical Benefit Drugs                                                                                                                    | No Cost     | Not Covered    |
| Any other covered medical service not listed in this Schedule of Benefits                                                                          | No Cost     | Not Covered    |
| <b>Telemedicine - For more information, please visit <a href="http://www.hometownhealth.com/telehealth">www.hometownhealth.com/telehealth</a>.</b> |             |                |
| General Med Urgent Care by Teladoc                                                                                                                 | No Cost     | Not Covered    |
| Mental/Behavioral Health by Teladoc                                                                                                                | No Cost     | Not Covered    |
| Dermatology by Teladoc                                                                                                                             | No Cost     | 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)                                                                      | No Charge  | Not Covered    |
| Preferred Brand Drugs (Tier 2)                                                              | No Charge  | Not Covered    |
| Non-Preferred Drugs (Tier 3)                                                                | No Charge  | Not Covered    |
| Specialty Drugs (Tier 4)                                                                    | No Charge  | Not Covered    |

| Mail Order – 90 day supply (2*copay) |            |                |
|--------------------------------------|------------|----------------|
| Tier                                 | In Network | Out of Network |
| Generic Drugs (Tier 1)               | No Charge  | Not Covered    |
| Preferred Brand Drugs (Tier 2)       | No Charge  | Not Covered    |
| Non-Preferred Drugs (Tier 3)         | No Charge  | Not Covered    |
| Specialty Drugs (Tier 4)             | No Charge  | 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)                                                                      | No Charge  | Not Covered    |
| Preferred Brand Drugs (Tier 2)                                                              | No Charge  | Not Covered    |
| Non-Preferred Drugs (Tier 3)                                                                | No Charge  | Not Covered    |
| Specialty Drugs (Tier 4)                                                                    | No Charge  | Not Covered    |