Schedule of Benefits

SENSIBLE Silver D5000 HMO IFP LCS

HIOS Plan ID: 41094NV0030075

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 SENSIBLE HMO plan, adult Members must choose a Renown PCP on the Renown SENSIBLE HMO Network at the time of enrollment or HTH will choose one based on your geographic location. If you have a child enrolled in coverage, you will need to designate a Renown pediatrician as the child's PCP. There is no coverage for services outside the Renown SENSIBLE HMO Network unless the services are rendered as part of an Emergency Room or Urgent Care Center visit, or they have been previously approved by Hometown Health to be paid at the In-Network Benefit Level. To find an In-Network provider please visit the provider directory at www.hometownhealth.com. 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.

Limited 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.
- You **do need a referral** from an Indian health care provider when getting essential health benefits through a Marketplace plan to **avoid paying** copayments, deductibles, or coinsurance.
- The amounts listed as cost share will be charged if you **do not** receive a referral from an Indian health care provider in obtaining 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
Deductible: - Per Calendar Year - Medical and Drug Combined - Some services do not apply to the deductible, as indicated below.	$5,000/Individual $10,000/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	Indian Health Care Provider (IHCP)	In Network	Out of Network
Primary Care Visit to Treat an Injury or Illness	$0	Subject to deductible , then $5/Visit	Not Covered
Specialist Visit	$0	Subject to deductible , then $80/Visit	Not Covered
Physician to Physician eConsult	$0	Subject to deductible , then $80/Visit	Not Covered
Surgical Services performed in a Physician's Office	$0	Subject to deductible , then $160/Visit	Not Covered

Benefit	Indian Health Care Provider (IHCP)	In Network	Out of Network
Mental/Behavioral Health Office Visit	$0	Subject to deductible , then $5/Visit	Not Covered
Substance Abuse Disorder Office Visit	$0	Subject to deductible , then $5/Visit	Not Covered
Preventive Care			
Prenatal and Postnatal Care	$0	No Cost	Not Covered
Preventive Care/Screening/Immunization	$0	No Cost	Not Covered
Well Baby Visits and Care	$0	No Cost	Not Covered
Therapy			
Habilitation Services *120 visit(s) per year*	$0	Subject to deductible , then $80/Visit	Not Covered
Outpatient Rehabilitation Services *120 visit(s) per year*	$0	Subject to deductible , then $80/Visit	Not Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy *120 visit(s) per year*	$0	Subject to deductible , then $80/Visit	Not Covered
Rehabilitative Speech Therapy	$0	Subject to deductible , then $80/Visit	Not Covered
Infusion Therapy *Does not include the cost of special pharmaceuticals used in infusion therapy.*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Chemotherapy	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Radiation	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Cardiac and Pulmonary Rehabilitation	$0	Subject to deductible , then $80/Visit	Not Covered
Diagnostic & Imaging			
Imaging (CT/PET Scans, MRIs)	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Laboratory Outpatient and Professional Services	$0	Subject to deductible , then 50% Coinsurance	Not Covered
X-rays and Diagnostic Imaging	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Outpatient Care			
Mental/Behavioral Health Outpatient Services *Including intensive outpatient treatment programs, partial hospitalization, and residential treatment programs.*	$0	Subject to deductible , then 50% Coinsurance	Not Covered

Benefit	Indian Health Care Provider (IHCP)	In Network	Out of Network
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Outpatient Surgery Physician/Surgical Services	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Substance Abuse Disorder Outpatient Services *Including intensive outpatient treatment programs, partial hospitalization, and residential treatment programs.*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Inpatient Care			
Childbirth/Delivery Facility Services	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Inpatient Hospital Services (e.g., Hospital Stay)	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Mental/Behavioral Health Inpatient Services	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Skilled Nursing Facility *100 days per year*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Substance Abuse Disorder Inpatient Services	$0	Subject to deductible , then 50% 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*	$0	Subject to deductible , then $0/Visit	Not Covered
Home Health Care			
Home Health Care Services	$0	Subject to deductible , then $80/Visit	Not Covered
Long-Term/Custodial Nursing Home Care	$0	Not Covered	Not Covered
Private-Duty Nursing	$0	Subject to deductible , then $80/Visit	Not Covered
Urgent Care			
Urgent Care Centers or Facilities	$0	Subject to deductible , then $50/Visit	Not Covered
Mobile Urgent Care	$0	Subject to deductible , then $50/Visit	Not Covered
Emergency Care/Ambulance			
Emergency Room Services	$0	Subject to deductible , then 50% Coinsurance	
Emergency Transportation/Ambulance *(Ground, Air, Water)*	$0	Subject to deductible , then 50% Coinsurance	
Durable Medical Equipment			

Benefit	Indian Health Care Provider (IHCP)	In Network	Out of Network
Durable Medical Equipment *1 item(s) per 3 years*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Prosthetic Devices *1 item(s) per 3 years*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Hearing Aids *1 item(s) per 3 years*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Dental Care			
Accidental Dental	$0	Subject to deductible , then $160/Visit	Not Covered
Basic Dental Care – Child	$0	Not Covered	Not Covered
Basic Dental Care – Adult	$0	Not Covered	Not Covered
Vision Care			
Eye Glasses for Children *1 item(s) per year*	$0	No Cost	Not Covered
Routine Eye Exam for Children *1 exam(s) per year*	$0	No Cost	Not Covered
Routine Eye Exam (Adult)	$0	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*	$0	Not Covered	Not Covered
Acupuncture	$0	Not Covered	Not Covered
Allergy Testing	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Bariatric Surgery *1 Procedure(s) per lifetime*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Cosmetic Surgery	$0	Not Covered	Not Covered
Diabetes Education	$0	Subject to deductible , then $80/Visit	Not Covered
Dialysis	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Reconstructive Surgery	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Transplant	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Treatment for Temporomandibular Joint Disorders	$0	Subject to deductible , then $80/Visit	Not Covered
Weight Loss Programs	$0	Not Covered	Not Covered

Benefit	Indian Health Care Provider (IHCP)	In Network	Out of Network
Remote Monitoring *Copay paid once per 30-day period.*	$0	Subject to deductible , then $80/Visit	Not Covered
Special Food Products *4 item(s) per year*	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Applied Behavioral Therapy for the treatment of Autism	$0	Subject to deductible , then $5/Visit	Not Covered
Nutritional Counseling *1 visit(s) per episode*	$0	Subject to deductible , then $80/Visit	Not Covered
Chiropractic Care *20 visit(s) per year*	$0	Subject to deductible , then $80/Visit	Not Covered
Infertility Treatment *6 Procedure(s) per lifetime*	$0	Subject to deductible , then $80/Visit	Not Covered
Routine Foot Care	$0	Not Covered	Not Covered
Wound Care	$0	Subject to deductible , then $80/Visit	Not Covered
Specialty Pharmaceuticals	$0	Subject to deductible , then 50% Coinsurance	Not Covered
All Other Medical Benefit Drugs	$0	Subject to deductible , then 50% Coinsurance	Not Covered
Any other covered medical service not listed in this Schedule of Benefits	$0	Subject to deductible , then 50% Coinsurance	Not Covered
General Med Urgent Care by Teladoc	$0	Subject to deductible , then $0/Visit	Not Covered
Mental/Behavioral Health by Teladoc	$0	Subject to deductible , then $20/Visit	Not Covered
Dermatology by Teladoc	$0	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 $13 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $55 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 $26 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $110 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then 50% Coinsurance	Not Covered

Mail Order – 90 day supply (2*copay)		
Tier	**In Network**	**Out of Network**
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 $13 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	Deductible then $55 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	Deductible then 50% Coinsurance	Not Covered
Specialty Drugs (Tier 4)	Deductible then 50% Coinsurance	Not Covered