Schedule of Benefits

24 LG PPO 15-90 CINS P D0500X2;RX$10$30$60;30%

HIOS Plan ID:

Benefit period: From 01/01/2026 through 12/31/2026 Calendar Year.

About your Schedule of Benefits

This Schedule of Benefits describes your Preferred Provider Organization (PPO) health insurance policy provided by Hometown Health Providers Insurance Company, 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

This Policy is an open access Preferred Provider Organization (PPO) plan that provides access to a large, state-wide 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 Providers (Out-of-Network), generally at a reduced benefit level (higher cost to the Member).

Prescription Drug Coverage

Members must utilize the HometownRx Pharmacy Network. This Policy does not cover drugs which are purchased from pharmacies that are not part of the HometownRx Pharmacy Network. Members must work with their doctors to select drugs that are included in members plan specific HometownRx Drug Formulary. This Policy does not cover drugs which are not included in the HometownRx 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 Approval / Prior Authorization

Approval 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. HMO members require a Referral from their Primary Care Physician (PCP) for higher level care and may require a Prior Authorization. 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.

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 only - Some services do not apply to the deductible, as indicated below.	$500/Individual $1,000/Family	$2,000/Individual $4,000/Family
Out-of-Pocket Maximum: - Per Calendar Year - Medical and Drug Combined	$2,000/Individual $4,000/Family	$4,000/Individual $8,000/Family

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.

Benefit Details

The following table provides information about your benefits.

Benefit	In Network	Out of Network
Primary & Specialist Office Visits		
Primary Care Visit to Treat an Injury or Illness with a Renown Medical Group (RMG) Provider	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Primary Care Visit to Treat an Injury or Illness	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Specialist Visit	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Other Practitioner Office Visit (Nurse, Physician Assistant)	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Physician to Physician eConsult	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance

Benefit	In Network	Out of Network
Surgical Services performed in a Physician's Office	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Preventive Care		
Prenatal and Postnatal Care	No Cost	Subject to deductible, then 30% Coinsurance
Preventive Care/Screening/Immunization	No Cost	Subject to deductible, then 30% Coinsurance
Well Baby Visits and Care	No Cost	Subject to deductible, then 30% Coinsurance
Therapy		
Habilitation Services *120 visit(s) per year*	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Outpatient Rehabilitation Services *120 visit(s) per year*	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Rehabilitative Occupational and Rehabilitative Physical Therapy *120 visit(s) per year*	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Rehabilitative Speech Therapy *120 visit(s) per year*	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Infusion Therapy *Does not include the cost of special pharmaceuticals used in infusion therapy.*	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Chemotherapy	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Radiation	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Cardiac and Pulmonary Rehabilitation	$10/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Diagnostic & Imaging		
Advanced Imaging (CT/PET Scans, MRIs, Angiograms, Myelograms, Nuclear Medicine)	$50/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Laboratory Outpatient and Professional Services	$0/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
X-rays and Diagnostic Imaging	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Outpatient Care		
Mental/Behavioral Health Outpatient Services	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	$250/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Outpatient Surgery Physician/Surgical Services	$250/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Substance Abuse Disorder Outpatient Services	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance

Benefit	In Network	Out of Network
Inpatient Care		
Childbirth/Delivery Facility Services	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Childbirth/Delivery Professional Services	$250/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Inpatient Hospital Services (e.g., Hospital Stay)	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Inpatient Physician and Surgical Services	$250/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Mental/Behavioral Health Inpatient Services	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Skilled Nursing Facility *100 days per year*	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Substance Abuse Disorder Inpatient Services	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Hospice Care		
Hospice Services *5 days per episode*	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Home Health Care		
Home Health Care Services	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Long-Term/Custodial Nursing Home Care	Not Covered	Not Covered
Private-Duty Nursing	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Urgent Care		
Urgent Care Centers or Facilities	$15/Visit, Deductible does not apply	
Emergency Care/Ambulance		
Emergency Room Services	$100/VisitWaived if Admitted, Deductible does not apply	
Emergency Transportation/Ambulance *(Ground, Air, Water)*	$100/Visit, Deductible does not apply	
Durable Medical Equipment		
Durable Medical Equipment *1 item(s) per 3 years*	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Prosthetic Devices *1 item(s) per 3 years*	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Hearing Aids *1 item(s) per 3 years*	Not Covered	Not Covered
Dental Care		
Accidental Dental	$60/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance

Benefit	In Network	Out of Network
Basic Dental Care – Child	Not Covered	Not Covered
Basic Dental Care – Adult	Not Covered	Not Covered
Vision Care		
Eye Glasses for Children *1 item(s) per year*	Not Covered	Not Covered
Routine Eye Exam for Children *1 exam(s) per year*	No Cost	Subject to deductible, then 30% Coinsurance
Routine Eye Exam (Adult)	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*	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Allergy Testing	$0/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Bariatric Surgery *1 Procedure(s) per lifetime*	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Cosmetic Surgery	Not Covered	Not Covered
Diabetes Education	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Dialysis	$15/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Reconstructive Surgery	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Transplant	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Treatment for Temporomandibular Joint Disorders	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Weight Loss Programs	Not Covered	Not Covered
Remote Monitoring *Copay paid once per 30-day period.*	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Special Food Products *4 item(s) per year*	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance
Applied Behavioral Therapy for the treatment of Autism	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Nutritional Counseling *1 visit(s) per episode*	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Chiropractic Care *20 visit(s) per year*	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance
Infertility Treatment *6 Procedure(s) per lifetime*	$30/Visit, Deductible does not apply	Subject to deductible, then 30% Coinsurance

Benefit	In Network	Out of Network
Routine Foot Care	Not Covered	Not Covered
Any other covered medical service not listed in this Schedule of Benefits	Subject to deductible , then 10% Coinsurance	Subject to deductible, then 30% Coinsurance

Prescription Drugs

Rx Deductible and Out of Pocket Maximum (OOPM)

Rx Cost Share & Features	In Network	Out of Network
Deductible	$0/Individual $0/Family	Not Covered
Maximum Out of Pocket (Integrated with Medical Maximum Out of Pocket)	$2,000/Individual $4,000/Family	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)	$10 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$30 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	$60 Copayment	Not Covered
Specialty Drugs (Tier 4)	30% Coinsurance	Not Covered

Mail Order – 90 day supply (2*copay)		
Tier	**In Network**	**Out of Network**
Generic Drugs (Tier 1)	$20 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$60 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	$120 Copayment	Not Covered
Specialty Drugs (Tier 4)	30% 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)	$10 Copayment	Not Covered
Preferred Brand Drugs (Tier 2)	$30 Copayment	Not Covered
Non-Preferred Drugs (Tier 3)	$60 Copayment	Not Covered
Specialty Drugs (Tier 4)	30% Coinsurance	Not Covered