Summary of Benefits for Renown Employee Health Plan

All Essential Health Benefits			
Lifetime Maximum Benefits			**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.			
Deductible	**Renown/WCA**	**HTH In-Network**	**Out-of Network**
Individual	None	$750	$4,000
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	None	$1,500	$8,000
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			
Medical and Prescription Drug benefit expenses are subject to the same Maximum Out-of-Pocket maximum. **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).			
Individual	$5,000		Unlimited
Except as noted, in any calendar year a covered person will not be required to pay more than the Individual Out-of-Pocket Maximum toward their deductible, copay and/or coinsurance obligations. Once the individual has paid the out-of-pocket maximum, their covered charges will be paid at 100% benefit level for the balance of the calendar year.			
Family Unit	$10,000		Unlimited
Except as noted, in any calendar year a covered family (employee and dependents) will not be required to pay more than the Family Out-of-Pocket Maximum 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.			
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?**
The following table identifies what does and does not apply toward the Network and Non-Network Out-of-Pocket Maximums:			
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 Expense	**Renown/WCA**	**HTH In-Network**	**Out-of-Network**
Alternative Care (acupuncture, homeopathies), per visit	$40	$50	50% after deductible
Limited to 20 visits per calendar year.			
Ambulance (ground/water/air), per trip	See Preferred	$100	50% after deductible
See referral and prior authorization requirements.			
Ambulatory Surgical Center, per admit	10%	30%	50% after deductible
Bariatric Surgery	Benefits based on types of services provided		
Limited to one medically necessary gastric restrictive surgery at Bariatrics Center of Excellence per lifetime. Limits include complications directly resulting from gastric restrictive services.			
Cataract Lenses (one set)	$25	30%	50% after deductible
Chiropractic Care, per visit	See Preferred	$65	50% after deductible
Limited to 20 visits per calendar year and 100 lifetime visits.			
Chemotherapy (in office), per visit	$25	$50	50% after deductible
Durable Medical Equipment (DME)	See Preferred	$50	50% after deductible
Limited to one purchase of a specific item of DME, including repair and replacement every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The rental of warning or monitoring decives for infants (defined as a child 24 months old or less) suffering from recurrent apnea is limited to 90 days.			
Food Products, Special (as definied by Nevada Statute)	$0	$0	50% after deductible
Limited to a maxmum benefit of 4, 30 days of therapeutic supplies per member per calendar year.			
Gender Assignment/Reassignment	Benefits based on types of services provided		
Genetic Counseling, per visit	$40	30%	50%
Genetic Testing	$0	$0	50% after deductible
If medically necessary as determined by the plan. If mandated by PPACA for high risk BRCA testing and counseling.			
Home Health Care, per visit	$40	30%	50% after deductible

Covered Medical Expense	Renown/WCA	HTH In-Network	Out-of-Network
Home Hospice Care (inluding family bereavement counseling)	$0	30%	50% after deductible
Limited to 185 day period of patient care beginning on the first day of services. Benefits for outpatient counseling services for the patient and their immediate family are limited to 6 visists for all family memebers combined, if they are not otherwise eleigbile for mental health benefits under another policy. Respite care providing nursing care is limited to a maximum of 8 inpatient respite care days per calendar year and 37 hours per calendar year for outpatient respite care services.			
Hospital, Inpatient, per admit	10%	30%	$500 and 50% after deductible
Hospital, Observation	10%	30%	50% after deductible
Hospital, Rehabilitation Facility, per admit	10%	30%	50% after deductible
Inpatient accommodation is limited to a semi-private room except when confinement in an Intensive Care Unit is medically necessary. Requires prior authorization. See Utilization Management Program.			
Imaging (CT, MRI, nuclear medicine, PET scans), per visit	$250	30%	50% after deductible
Infertility	Benefits based on types of services provided		
Limited to medically necessary services to diagnose problems of infertility for a covered individual. One diagnostic evaluation for infertility every year up to 3 per lifetime and 6 artificial inseminations per lifetime. Exclusions apply and are detailed in Medical Plan Component.			
Kidney Dialysis Services, per visit	See Preferred	$80	50% after deductible
Mental Health and Substance Abuse Residential Treatment Facility, per admit	10%	30%	$500 and 50% after deductible
Mental Health and Substance Abuse Outpatient Services, per visit	$20	$40	50% after deductible
Benefits for inpatient alcohol and substance abuse care are subject to review for medical necessity and level of care determination. Requires prior authorization. See Utilization Management Program.			
Office Visit, Primary Care Physician, per visit	$20	$40	50% after deductible
Office Visit, Specialist, per visit	$40	$80	50% after deductible
OB/GYN, per visit	$20	$40	50% after deductible
Orthopedic/Prosthetic Devices	$25	$25	50% after deductible
Ostomy Care Supplies	$0	$0	50% after deductible
Limited to 30 days of theraputic supplies per month.			
Outpatient Diagnostic X-ray or ultrasound, per visit	$0	30%	50% after deductible
Outpatient Emergency Room Services, per visit	$250	$250	$250
Copay waived if admitted to hospital from ER.			
Outpatient Infusion/Chemotherapy	$25	$50	50% after deductible
Outpatient Lab Services, per visit	$0	30%	50% after deductible
Outpatient Surgery, per admit	10%	30%	50% after deductible
Pharmaceuticals, special	$75	30%	50% after deductible
Requires prior authorization. See Utilzation Management Programs.			
Pharmaceuticals, other medical	$40	30%	50% after deductible
Requires prior authorization. See Utilzation Management Programs.			
Pregnancy, Birth (vaginal or cesearean), per admit	10%	30%	$500 and 50% after deductible
Pregnancy, Physician Services during Birth, per admit	10%	30%	50% after deductible
Prenatal Screening, as defined under Women's Preventative Services in ACA	$0	$0	50% after deductible
Preventative Care, per visit	$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. The latest covered preventive care services can be found by visiting https://www.healthcare.gov/coverage/preventive-care-benefits. 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.			

Covered Medical Expense	Renown/WCA	HTH In-Network	Out-of-Network
Physician Services, Inpatient, per admit	10%	30%	50% after deductible
Physician Services, Same Day Surgery, per admit	10%	30%	50% after deductible
Port Wine Stain Removal	$20	$50	50% after deductible
Radiation Therapy	$0	$0	50% after deductible
Second Surgical Opinions	$40	$80	50% after deductible
Skilled Nursing Facility, per admit	10%	30%	$600 and 50% after deductible
Limited to 100 days per calendar year. Requires prior authorization. See Utilization Management Services.			
Telahealth, Mental Health Services, per visit	$20	$40	50% after deductible
Telahealth, Primary Care Physician, per visit	$20	$40	50% after deductible
Telahealth, Specialist, per visit	$40	$80	50% after deductible
Teladoc, per visit	$0	30%	50% after deductible
Temporomandibular Joint Discorder (TMJ)	depends of type of services	30%	50% after deductible
Annual maximum of 1 surgery and lifetime maximum of 2 surgeries.			
Tertiary Care	Benefits based on types of services provided		
Tertiary Care: Highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Examples of tertiary care services are specialist cancer care, neurosurgery (brain surgery), burn care and plastic surgery. A Travel Benefit is established to offset the cost of travel for patients and/or their support person or family members when Hometown Health Utilization Management provides the physician and/or covered person, as an option for Tertiary Care (evaluation and/or treatment), authorization to receive treatment at an in-network benefit level. Referral and authorization for all levels of care are required prior to the approved service. Tertiary Care will be considered but not a guarantee of benefit when no available in the Hometown Health service area. To qualify for the Travel Benefit, the following must apply: 1. Covered Person and/or their treating physician has requested a referral to a specific facility/provider for Tertiary Care. Service may or may not be in the primary PPO network and will require travel to Utah or in some cases to southern Nevada. 2. Utilization Management has determined that the requested services are medically necessary and Tertiary Care cannot be provided in the primary PPO network. 3. Utilization Management has provided the physician and/or Covered Person, as an option, to receive Tertiary Care at an approved provider or facility. Utilization Management may indicate an alternate care provider for requested services and the care must be authorized at an in-network benefit level. 4. Covered Person has agreed to be in Case Management and followed by Case Manager while in Tertiary Care. 5. Prior to travel for Tertiary Care, the covered person must advise the RN Case Manager of travel to receive the benefit and the travel benefit must be approved. Travel Benefit Travel Expenses Per Day, Per Trip: $250* per patient, support person/caregiver or parent as defined below. Travel Expenses Maximum, Per Trip: $10,000* Per calendar year * Per diem rates. No exclusions, no receipts necessary.			
Therapy Services, Autism Spectrum Disorder Treatment, per visit	$20	$40	50% after deductible
Therapy Services, Cardiac Rehabilitation, per visit	$10	30%	50% after deductible
Therapy Services, Occupational, per visit	$25	30%	50% after deductible
Therapy Services, Physical, per visit	$25	30%	50% after deductible
Therapy Services, Pulmonary Rehabilitation, per visit	$25	30%	50% after deductible
Therapy Services, Speech, per visit	$25	30%	50% after deductible
Speech, occupational and physical therapy coverage is limited to 60 visits/sessions for all modalities combined per calendar year. Cardiac and pulmonary rehabilitation is limited to 60 visits/sessions for all modalities combined per calendar year. Coverage for these therapies are provided for rehabilitative and habilitative separaretely, as per the medical necessity of these services. Habilitative therapy does not require that an injury or illness preceded the need for service.			
Transplants, Recipient and donor expenses	Benefits based on types of services provided		
Requires prior authorization. See Utilzation Management Programs.			
Urgent Care Facility, per visit	$30	30%	50% after deductible
Varicose Veins	$40	$80	50% after deductible
Requires prior authorization. See Utilzation Management Programs.			
Wigs	See Preferred	$50	50% after deductible
Wound Care	$40	30%	50% after deductible

REFERRAL AND PRIOR AUTHORIZATION REQUIREMENTS

- All inpatient stays and services in any type of facility, including acute and skilled care, mental health care, and drug or alcohol detoxification, rehabilitation.
- Inpatient, same day, or in-office surgical services with a cost greater than $750.00 (total billed charges) (excluding diagnosti c and screening colonoscopies)
- Air ambulance transportation
- Anesthesiology and physiatrist, including pain management
- Cardiac and pulmonary rehabilitation
- Certain infertility laboratory and diagnostic tests
- Chemotherapy
- Dialysis
- Gastric restrictive services
- Genetic counseling services
- 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
- 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.

See Utilization Management Program in the Summary Plan Description for more information.