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, call Hometown Health at 775-982-5883. 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 775-982-5883 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0 for Renown/Western Clinical Alliance (WCA) providers $750 individual/$1,500 family for Hometown Health in-network $4,000 individual/$8,000 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 and primary care services 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?	Yes. $250 for name brand prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers, $5,000 individual / $10,000 family; for out-of-network providers, unlimited	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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hometownhealth.com or call 775-982-5883 for a list of network 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.	This plan will pay some or all of the costs to see a specialist for covered services.

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
		Renown/WCA Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	$40 copay/visit	50% coinsurance	None.
	Specialist visit	$40 copay/visit	$80 copay/visit	50% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No charge	No charge	50% coinsurance	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)	No charge	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	$250 copay/visit	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hometownhealth.com	Generic drugs (Tier 1)	$10 copay/prescription (retail); $20 copay/prescription (mail order)	$15 copay/prescription	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$25 copay/prescription (retail); $70 copay/prescription (mail order)	$45 copay/prescription; $250 deductible applies	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at www.hometownhealth.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Renown/WCA Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Tier 3)	$50 copay/prescription (retail); $100 copay/prescription (mail order)	$75 copay/prescription or 50% coinsurance (whichever is greater)	Not covered	
	Specialty drugs (Tier 4)	20% coinsurance	20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	$10% coinsurance	30% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$300 copay/visit	$300 copay/visit	$300 copay/visit	Copay is waived if patient is admitted to hospital.
	Emergency medical transportation	N/A	$250 copay	50% coinsurance	None.
	Urgent care	$30 copay/visit	30% coinsurance	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	$500 copay/admit and 50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	$40 copay/visit	50% coinsurance	None.
	Inpatient services	10% coinsurance	30% coinsurance	$500 copay/admit and 50% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	$20 copay/visit	$40 copay/visit	50% coinsurance	Cost sharing does not apply for preventive

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Renown/WCA Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	50% coinsurance	services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	$500 copay/admit and 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$40 copay/visit	30% coinsurance	50% coinsurance	50 visits/year. Preauthorization is required.
	Rehabilitation services	$25 copay/visit	30% coinsurance	50% coinsurance	60 visits/year. Includes physical, speech and occupational therapy.
	Habilitation services	$25 copay/visit	30% coinsurance	50% coinsurance	60 visits/year. Includes physical, speech and occupational therapy.
	Skilled nursing care	$1,250 copay/admit	30% coinsurance	50% coinsurance	100 days/calendar year. Preauthorization is required.
	Durable medical equipment	N/A	$50	50% coinsurance	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
	Hospice services	No charge	30% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	N/A	$25 copay/visit	$25 copay/visit	You may receive a lesser benefit at out of network providers and pay more
	Children's glasses	N/A	$150		

[* For more information about limitations and exceptions, see the plan or policy document at www.hometownhealth.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Renown/WCA Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
			allowance/frames; Single vision, polycarbonate lenses included with copay		out of pocket. Frames covered every 24 months; lenses every 12 months.
	Children's dental check-up	No charge	No charge		

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.)

- Abortion
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care (limited to 20 visits/year)

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: Hometown Health, visit www.hometownhealth.com or call 775-982-5883.

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:

[* For more information about limitations and exceptions, see the plan or policy document at www.hometownhealth.com.]

[Spanish (Español): Para obtener asistencia en Español, llame al 775-982-3232.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 775-982-3232.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 775-982-3232.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 775-982-3232.]

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)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other copayment	**$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)*

Total Example Cost	**$13,600**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,760**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other copayment	**$10**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$480**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**10%**
Other copayment	**$300**

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	**$35,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$460
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$460**

The plan would be responsible for the other costs of these EXAMPLE covered services.