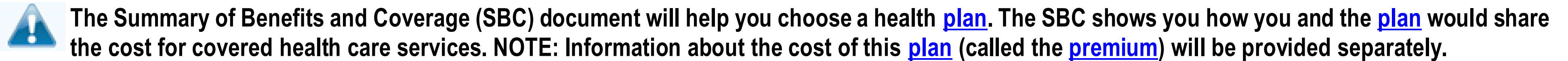

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.hometownhealth.com. 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 1-775-982-5880 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$350.00** individual / **$1,050.00** family for In-Network **$1,000.00** individual / **$3,000.00** 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 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. $100 per person for 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 $25,000 per individual up to $250,000 then individual pays 90% of remaining amount.	Plan has no maximum out-of-pocket limit; this is a grandfathered health plan.
What is not included in the out-of-pocket limit?	Deductibles, copays and services or supplies paid at a network benefit of less than 80%, premiums, balance-billing charges, penalties for not obtaining preauthorization, 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 **1-775-982-5880** for a list of participating 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. Out-of-network providers are subject to Maximum Allowable charge determinations. All out of network is subject to UCR.

Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan. Non-participating providers subject to Maximum Allowable.

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
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/office visit; deductible does not apply	70% coinsurance after deductible	See Summary Plan Document for more information.
	Specialist visit	$25 copay/office visit; deductible does not apply	70% coinsurance	See Summary Plan Document for more information.
	Preventive care/screening/immunization	No charge	Not Covered	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)	20% coinsurance after deductible	70% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	70% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Maxor.com	Generic Drugs	Retail: $10.00/prescription Mail Order: $20.00/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). If a brand drug is purchased when a generic is available, the Covered Person pays the brand copay plus the difference in cost between the brand drug and the generic equivalent. If this amount is larger than the total drug cost, then the Covered Person will pay the full cost of the drug.
	Preferred Brand Drugs	Retail: $25.00/prescription Mail Order: $50.00/prescription	Not covered	
	Non Preferred Brand Drugs	Retail: $50.00/prescription Mail Order: $100.00/prescription	Not covered	
	Specialty drugs	Retail: $50.00/prescription the Mail Order: $100.00/prescription	Not covered	Specialty drugs must be purchased through Maxor's specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 copay then 20% coinsurance Deductible does apply	Not covered	See Summary Plan Document for more information. Preauthorization may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
	Physician/surgeon fees	20% coinsurance	70% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay then 20% coinsurance	$1,000 copay then 70%	The copay will be waived if directly admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$25 copay/visit	70% after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay then 20% coinsurance	$1,000 copay then 70%	
	Physician/surgeon fee	20% coinsurance	70% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Not covered
	Inpatient services	Not covered	Not covered	Not covered
If you are pregnant	Office visits	$25 copay/office visit; deductible does not apply	70% coinsurance after deductible	See Summary Plan Document for more information.
	Childbirth/delivery professional services	$25 copay/office visit; deductible does not apply	70% coinsurance after deductible	See Summary Plan Document for more information.
	Childbirth/delivery facility services	$300 copay then 20% coinsurance	$1,000 copay then 70%	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	70% coinsurance	Limited to 60 visits per Calendar Year. Each visit by a nurse, therapist and/or each 4-hour period of home health aide services will count as 1 visit.
	Rehabilitation services	20% coinsurance	70% coinsurance	
	Habilitation services	20% coinsurance	70% coinsurance	
	Skilled nursing care	20% coinsurance	70% coinsurance	
	Durable medical equipment	20% coinsurance	70% coinsurance	
	Hospice services	20% coinsurance	70% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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.)		
• Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult) • Weight Loss Programs • Treatment of gender disorders	• Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing • Treatment of self-inflicted injuries	• Routine eye care (Adult) • Routine Foot Care • Hearing Aids • Abortion • Treatment of injuries sustained while pursuing a hazardous activity

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic Care		

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 the plan at 1-775-982-5880. You may also contact the

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:

Spanish (Español): Para obtener asistencia en Español, llame al 775-982-5880

*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** **$350.00**
- **Specialist copayment** **$25.00**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$12,700**
In this example, Peg would pay: .	
Cost Sharing	
Deductibles	$350
Copayments	$20
Coinsurance	$2,453
What isn't covered	
Limits or exclusions	$45
The total Peg would pay is	**$2,869**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$300.00**
- **Specialist copayment** **$25.00**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$5600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$350
Copayments	$584
Coinsurance	$182
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1,138**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$300.00**
- **Specialist copayment** **$25.00**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$2800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$350
Copayments	$305
Coinsurance	$397
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,052**

5