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 775-982-5885. 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 775-982-5885 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,400 individual/$6,400 family for Carson Tahoe Health $4,100 individual/$8,200 family for Hometown Health in-network $6,100 individual/$12,000 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?	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 / $13,700 family; for out-of-network providers, $12,000 individual/$24,000 family	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 775-982-5885 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.

Important Questions	Answers	Why This Matters:
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
		CTH Provider (You will pay the least)	Hometown Health 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% coinsurance	30% coinsurance	50% coinsurance	None.
	Specialist visit	20% coinsurance	30% coinsurance	50% coinsurance	None.
	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 (blood work)	No charge	No charge	50% coinsurance	None.
	Imaging (x-ray, CT/PET scans, MRIs)	20% coinsurance	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	Preventive Drugs (Tier 0)	No charge	No charge		
	Generic drugs (Tier 1)	20% coinsurance	20% coinsurance	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail); $60 copay/prescription (mail order) $50 deductible applies	$30 copay/prescription (retail); $60 copay/prescription (mail order) $50 deductible applies	Not covered	
	Non-preferred brand drugs (Tier 3)	$60 copay/prescription (retail); Not covered (mail	$60 copay/prescription (retail); Not covered (mail	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CTH Provider (You will pay the least)	Hometown Health In-Network Provider	Out-of-Network Provider (You will pay the most)	
		order $50 deductible applies	order $50 deductible applies		
	Specialty drugs (Tier 4)	20% coinsurance (retail) Not covered (mail order) $50 deductible applies	20% coinsurance (retail) Not covered (mail order) $50 deductible applies	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	30% coinsurance	Copay is waived if patient is admitted to hospital.
	Emergency medical transportation	N/A	30% coinsurance	30% coinsurance	None.
	Urgent care	20% coinsurance	30% coinsurance	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	$500 copay/admit and 50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	50% coinsurance	None.
	Inpatient services	20% coinsurance	30% coinsurance	$500 copay/admit and 50% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	$0 copay/visit	$0 copay/visit	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	$500 copay/admit and 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		CTH Provider (You will pay the least)	Hometown Health In-Network Provider	Out-of-Network Provider (You will pay the most)	
					services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	Not Applicable	30% coinsurance	50% coinsurance	None.
	Rehabilitation services	20% coinsurance	30% coinsurance	50% coinsurance	90 visits/year. Includes physical, speech and occupational therapy.
	Habilitation services	20% coinsurance	30% coinsurance	50% coinsurance	90 visits/year. Includes physical, speech and occupational therapy.
	Skilled nursing care	30% coinsurance	30% coinsurance	50% coinsurance	120 days/calendar year. Preauthorization is required.
	Durable medical equipment	N/A	30% coinsurance	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	Not Applicable	30% coinsurance	50% coinsurance	None.

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Long-term Care
- Private-duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

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

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 15 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:

[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** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other copayment** **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	**$35,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$480
Coinsurance	$3,520
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,500**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other copayment** **$60**

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	$500
Copayments	$480
Coinsurance	$1386
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,366**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **20%**
- **Other copayment** **$200**

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	$500
Copayments	$680
Coinsurance	$2,580
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$3,760**

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