Hometown Health **22 LG EPO 30-80 CINS P D0500X2;RX $20/$40/$60/20%** **Coverage for: Group | Plan Type: EPO**

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, visit us at hometownhealth.com or call 1-800-336-0123. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-336-0123 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In Network: $500 Person/ $1,000 Family Out of Network: Not covered Person / Not covered Family**	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?	No.	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?	**In Network: $3,000 Person/ $6,000 Family Out of Network: Not covered Person / Not covered 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?	Premiums, balance-billed charges, health care this plan doesn't cover, and services that require pre- authorization when no pre- authorization is given.	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 hometownhealth.com or call 1-800-336-0123 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.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	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	$30 copay/visit, Deductible does not apply	Not Covered	————————none————————
	Specialist visit	$50 copay/visit, Deductible does not apply	Not Covered	Prior Authorization required for plastic surgery and genetic counseling services.
	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)	X-Ray: $50 copay/visit, Deductible does not apply General Lab: No Charge	Not Covered	General laboratory services unless covered under ACA preventive guidelines.
	Imaging (CT/PET scans, MRIs)	$100 copay/visit, Deductible does not apply	Not Covered	————————none————————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hometownhealth.com	Generic drugs	$20 copay/Script, Deductible does not apply	Not Covered	————————none————————
	Preferred brand drugs	$40 copay/Script, Deductible does not apply	Not Covered	————————none————————
	Non-preferred brand drugs	$60 plus the Ancillary Charge copay/Script, Deductible does not apply	Not Covered	————————none————————
	Specialty drugs	20% co-insurance, Deductible does not apply	Not Covered	Prior Authorization required. Does not apply to specialty drugs obtained at the hospital or physician's office.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	CYD then $200 copay/visit	Not Covered	Prior Authorization required; Reduction in benefits if not obtained.
	Physician/surgeon fees	CYD then $200 copay/visit	Not Covered	Prior Authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 copay/visit, Deductible does not apply	$250 copay/visit, Deductible does not apply	————————none————————
	Emergency medical transportation	CYD then $100 copay/visit (Ground) CYD then $100 copay/visit (Air/Water)	CYD then $100 copay/visit (Ground) CYD then $100 copay/visit (Air/Water)	————————none————————
	Urgent care	$40 copay/visit, Deductible does not apply	$40 copay/visit, Deductible does not apply	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	CYD then 20%	Not Covered	Prior Authorization required.
	Physician/surgeon fees	CYD then 20%	Not Covered	Prior Authorization required.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral Outpatient services	$30 copay/visit, Deductible does not apply	Not Covered	Intensive outpatient, partial hospitalization and office visits that are part of a substance abuse treatment program require Prior Authorization.
	Mental/Behavioral Inpatient services	CYD then 20%	Not Covered	Prior Authorization required.
	Substance use disorder outpatient services	$30 copay/visit, Deductible does not apply	Not Covered	Intensive outpatient, partial hospitalization and office visits that are part of a substance abuse treatment program require Prior Authorization.
	Substance use disorder inpatient services	CYD then 20%	Not Covered	Prior Authorization required.
If you are pregnant	Office visits	No Charge	Not Covered	Depending on the type of services, a cost share may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prior approval required for coverage if inpatient stay exceeds federally established minimum time frames. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	CYD then 20%	Not Covered	————————none————————
	Childbirth/delivery facility services	CYD then 20%	Not Covered	————————none————————

If you need help recovering or have other special health needs	Home health care	$50 copay/visit, Deductible does not apply	Not Covered	Prior Authorization required, Limited to 30 visits per calendar year.
	Rehabilitation services	CYD then 20%	Not Covered	Refer to Therapy Services.
	Habilitation services	CYD then 20%	Not Covered	Refer to Therapy Services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	CYD then 20%	Not Covered	Prior Authorization required; Inpatient: Limited to 100 days per calendar year.
	Durable medical equipment	CYD then 20% Orthopedic and Prosthetic: CYD then 20%	Not Covered	Prior Authorization required. One purchase of specific item of DME every 3 years.
	Hospice services	$50 copay/visit, Deductible does not apply	Not Covered	Lifetime maximum of 185 days.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered
dental or eye care	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.)

- Complications of Non-Covered Treatment
- Cosmetic & Reconstructive surgery
- Dental care
- Exercise Equipment
- Hearing aids
- Most infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal Comfort of Convenience Items
- Private-duty nursing unless at home under home health benefit
- 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- covered up to $1,000 per calendar year
- Bariatric Surgery- Prior Authorization required, limited to 1 surgery per lifetime
- Chiropractic care- up to 20 visits per year, or 100 visits per lifetime for Medically Necessary spinal manipulations and adjustments, except for treatment for Chronic conditions

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: www.dol.gov/ebsa. 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 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: www.hometownhealth.com or call 1-800-336-0123.

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 1-800-336-0123.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-336-0123.] [Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-336-0123.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-336-0123.]

*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*	$50
Hospital (facility) *copayment*	CYD then 20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$190
Coinsurance	$1,792
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,542**

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*	$50
Hospital (facility) *copayment*	CYD then 20%
Other *copayment*	$0

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,480
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,381**

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

The plan's overall deductible	$500
Specialist *copayment*	$50
Hospital (facility) *copayment*	CYD then 20%
Other *copayment*	$0

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$760
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,267**

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

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