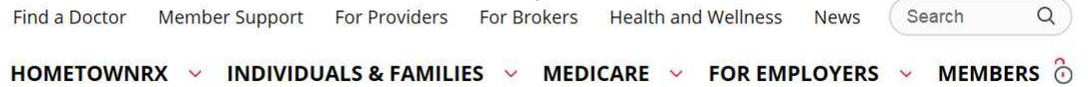


QUOTING AND ENROLLING

BROKER QUOTING FOR CLIENT

Log in to www.hometownhealth.com

Click



Sign in

Forgot your Password? [Click here.](#)

Don't have an account yet?
Create one now!

Welcome to Hometown Health - eQuote

The online Producer quoting tool.

[Click here for secure documents.](#)

[My Info](#)
[Click here to go to VUE Site](#)



Employer Groups

Prospects (19)

Review, edit, and select plans for your existing prospects and/or add a new prospect.

[My Existing Prospects Groups >>](#)
[Add New Prospect Group >>](#)

Renewals (0)

Review and select plans for your existing Renewal groups.

[My Renewal Groups >>](#)



Individuals

Individual and Family (0)

Review, edit, and select plans for your existing prospects and/or add a new prospect.

[My Individual Prospects >>](#)

Medicare Supplemental (Medigap) (0)

Add, review, edit, and select plans for Medicare Supplemental (Medigap) prospects.

[My Medigap Prospects >>](#)

Referrals (0)



My Individual and Family Prospects

Exclude Closed/Not Sold

Search

+ Add New



ID	Name	Status	Status Date
No data available!			

Your personal Hometown Health Individual and Family link!

Use the below link on your website and in any other marketing campaigns that you may have. Anyone who clicks this link will automatically be tied to your account!
(Note: please be sure to copy the entire link.)

<http://cyndev01/IndividualAndFamily/Default.aspx?b=c3loMWdMTIN0d3oyZTd5V3FqRlhsZz09>

Prospect

Required

First Name:

Last Name:

Email:

Optional

Phone #: • • Ext

Contact Between: and (Mon-Fri)

Prospect

Required

First Name:

Last Name:

Email:

Optional

Phone #: • • Ext

Contact Between: and (Mon-Fri)

Jane Doe

-
-
-
-

Prospect Detail

✓ 1. Added	2. Quoted	3. Registered	4. Application	5. Agreement	6. Payment	Enrolled
------------	-----------	---------------	----------------	--------------	------------	----------

Jane Doe
 ID: 15135
 Status: Added/Pending Action
 Email: janedoe@test123.com
 Phone: (775) 982-3101
 Contact: Between 8:00 AM and 5:00 PM

Application Detail

The application has not been started yet.

Billing History

Zip Code (Residential)

Your Info

Date of Birth (MM/DD/YYYY)

Effective Date [\[have a life qualifying event?\]](#)

Zip Code (Residential)

Your Info

Date of Birth (MM/DD/YYYY)

If a dependent is to be enrolled add here

Effective Date [\[have a life qualifying event?\]](#)

Please acknowledge:

I acknowledge that I have a valid Qualifying Life Event and would like to change my effective date to the date above. I understand that Hometown Health will withhold all claim payments until I provide the necessary documentation and that if I fail to provide the required documentation I will be responsible for paying all claims, if any, incurred during that period.

Cancel

Qualifying Life Event (QLE)

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby). (Source: HealthCare.gov)

Qualifying Life Event and Requested Effective Date

- QLE: Please select -

9/1/2017

The application must be submitted either before or within 60 days after the date of the Qualifying Life Event. If the current and/or application submission date is past the 60-day window you do not qualify for the special enrollment period. Hometown Health will request documentation of the event after the application is submitted along with instructions on how and where to send this information.

Zip Code (Residential)

89523

Your Info

Date of Birth (MM/DD/YYYY)

02/26/1972

+ Add Spouse

+ Add Child

Effective Date [\[have a life qualifying event?\]](#)

12/1/2017

See Plans!

You can narrow down the search for plans here.

<< Back to eQuote

Save

Please remember to save your changes before leaving this page. Saving the quote will save any selected plans and filter(s).

Filter your results

Price Range

\$316  \$569

Product Type

- HMO
- PPO

Pediatric Dental

- Without
- With

Tier

- Bronze
- Silver
- Gold

Deductible

\$500  \$7150

17 IF HMO 00-NA 0000 P D7150X2

Select / [Compare](#)

Select Plan

Tier Bronze

Individual Deductible \$7,150

Individual Out-of-Pocket \$7150

Pediatric Dental No

\$316.71

/ Month

 [Summary of Benefits](#) | [Premier Provider Directory](#)

Showing 18 plans (out of a total of 36) | [Update Quote](#)

Compare

Confirm Selected Plan

17 IF HMO 00-NA 0000 P D7150X2

\$316.71 / Month

Confirm and Enroll Now!

[Continue Shopping](#) >>

Confirm

Please acknowledge...

By selecting the box below, I confirm that I will be required to select a Hometown Premier Primary Care Physician (PCP) from the attached list (below; PDF). I must see the selected Hometown Premier PCP and receive a referral prior to receiving any specialist care. Visits to PCPs not included in this list will not be covered. Visits to specialists without a referral from a Hometown Premier PCP will not be covered. Furthermore, I must utilize the Hometown Premier Preferred Pharmacy Network. Prescription drugs purchased at Pharmacies not included in this network will not be covered.

 [Hometown Premier PCP Directory](#)

I understand and I am willing to accept these conditions.

Continue

[Never mind - I'd like to purchase a PPO plan](#)

Only required when
member enrolls in an HMO

Member will be required to create a login. If it's a returning member they will need to use the sign on they had previously.

Let's Enroll Our New Member!

The first step in the enrollment process is to create an account in My Benefits Coverage. The mybenefitscoverage.com website is a secure online tool that allows members to access and manage their health insurance benefit information. It only takes a minute to sign up and it will allow us to email you your member confirmation. Click the "Register" button below and remember to write down your login and password to use with mybenefitcoverage.com in the future.

If the user already has a My Benefits Coverage account from previous coverage and they want to retain that account, please just login using that account below.

Member Sign in

Forgot your Password? [Click here.](#)

Member Register

Email

Password [\[requirements\]](#) Confirm Password

Security Question

Answer

Please note: by default, all correspondence, including your monthly invoice/receipt will be sent to you electronically (via email) if your application is approved. In the event that your application is approved, if you would like to receive certain types of correspondence, such as your evidence of benefits (EOB) for all claims, etc, in paper format, you may change your My Benefits Coverage™ account settings at any time. However, please note that your monthly invoice/receipt will continue to be electronic.

Welcome!

You have successfully registered for My Benefits Coverage, Hometown Health's online member portal! Click the button below to continue with your application.

To access the site in future, go to either www.MyBenefitsCoverage.com, or www.HometownHealth.com under Members.

Resume Application



Current Status: Questions

Application Checklist:

- Application Started Complete
- Application / Demographics **In Progress**
- Confirm Plan / Benefits --
- Sign (Terms and Conditions) --
- Checkout and Pay --

Back Cancel

Next



Some quick questions...

Please answer the question(s) below and provide details if requested.

Do you currently have, or have you ever had other health insurance (including Hometown Health)?

Yes No

Hometown Health - Official use only

This section should only be completed if a Hometown Health representative is assisting you with this application. Otherwise, please leave blank.

Identification No.



If a Hometown Health Employee is assisting with the sale of the plan then the Employee number should be included here.

Applicant Information

Name

First Name	MI	Last Name
<input type="text" value="Jane"/>	<input type="text"/>	<input type="text" value="Doe"/>

Primary Care Physician (PCP)

Primary Care Physician

You must select a Hometown Premier Primary Care Physician (PCP). HMO Members may only utilize services from providers and pharmacies in the Hometown Premier Network and must receive a referral from their PCP for specialty care.

Physical Address

Address Line 1	Address Line 2	
<input type="text"/>	<input type="text"/>	
City	State	Zip Code
<input type="text"/>	<input type="text" value="NV"/>	<input type="text"/>

Mailing Address

Same as physical address (uncheck if not)

Demographics

Primary Phone #	Social Security No. [why?]
<input type="text"/>	<input type="text"/>
Date of Birth (MM/DD/YYYY)	Gender
<input type="text"/>	<input type="text"/>



Confirm Plan / Benefits

Below is the plan you selected during the quote process. Please confirm that this is the plan/benefits you want. If so, simply click "Next". If not, please feel free to review our other plans ("Change plan").

Bronze

17 IF HMO 00-NA 0000 P
D7150X2

Premium

\$316.71*/mo

\$7150 Out-of-pocket Max
\$7,150 Deductible
CYD, \$0 PCP Copay
\$0 Preventive Care

[Summary of Benefits \(SOB\)](#)
[Evidence of Coverage \(EOC\)](#)

[Change plan](#)

[Back](#)

[Next](#)

Terms and Conditions

IMPORTANT: It is important that you carefully read and understand the following. All applicants age 18 and over must personally read and agree to the following.

Terms and Conditions

1. Contract. If this application is accepted, this application, the Evidence of Coverage and Schedule of Benefits will become part of my contract with Hometown Health I am responsible for reading and accurately completing this application. I am responsible for reading the Evidence of Coverage and Schedule of Benefits.
2. Current Health Coverage. If you currently have health coverage, we strongly recommend that you maintain your coverage until the effective date of your Hometown Health Policy.
3. Out-of-Network Providers. If I use an out-of-network hospital or physician I will have to pay more than if I use an in-network hospital or physician.

I, **Jane Doe**, have personally read and completed this application and I understand and agree to the terms and conditions outlined above.

The person completing this application must click the Complete button to fully accept terms and conditions.

[Back](#)

[Next](#)

Please review your Application

Please review your application thoroughly and make sure that everything is accurate. Once you submit the application all of this information will be locked and any changes will have to be requested from Customer Services. Once you are satisfied with everything, click the "Continue" button.

My Plan

17 IF HMO 00-NA 0000 P D7150X2

[Change Plans](#)

\$316.71 * / Month

* Total monthly premium for all members listed below.

[Summary of Benefits](#)

Members

[+ Add Spouse](#)

[+ Add Child](#)

Changes can be cancelled below.

Subscriber **new!**

[Edit](#)

Jane Doe

10315 Professional Circle
Reno, NV 89502
Phone: (775) 982-3101

Additional Questions

Current/Previous Carrier: No

[Back](#)

[Next](#)

Please note, to bind (purchase) your health insurance policy, payment for the first month of coverage is required now. Your next payment will not be due until the first of the month following your effective date. For example, if you are purchasing a policy with a 1/1 effective date, your second payment will be due 2/1.

First Payment - 12/1/2017

17 IF HMO 00-NA 0000 P D7150X2

Payment Due

\$316.71

Total: **\$316.71**

Payment Card Info

Card-holder Information

(Should match card holder information. Please change if different.)

First Name	Last Name
<input type="text" value="Jane"/>	<input type="text" value="Doe"/>

Address

City	State	Zip Code
<input type="text" value="Reno"/>	<input type="text" value="NV"/>	<input type="text" value="89502"/>

Primary Phone	Email
<input type="text" value="(775) 982-3101"/>	<input type="text"/>

Card



Card No.	CVV [what is this?]
<input type="text"/>	<input type="text"/>
Expire Month	Expire Year
<input type="text"/>	<input type="text"/>

Payment Schedule

- I want to make my payments manually every month when I am billed.
- I would like to set up automatic, recurring payments.

Make Payment

Welcome!

You have successfully completed your application!

Thank you for choosing Hometown Health - Individual and Family coverage to meet your medical and pharmacy insurance needs!



Member ID Cards

Your Hometown Health eCard, the region's first electronic member ID card, will be available from your smartphone or through My Benefits Coverage™ within 72 hours (business days). You will receive a physical member ID card in the mail within 7 - 10 business days.

My Benefits Coverage™

My Benefits Coverage™ allows you to securely check the status of your claims, download and print member ID cards, and much more.

You will also receive a welcome email once you are completely enrolled in our system (this may take several business days). If you do not receive this email, please check your spam folder. If you find it there, please mark it as not spam to ensure you receive important email updates from Hometown Health.

Again, thank you for choosing Hometown Health. If you have any questions please contact our Customer Service department via email at customer_service@hometownhealth.com or by phone at 775-982-3232, Monday through Friday, 8:00 a.m. - 5:00 p.m.

Email confirmation is sent to the client:

Sent: Friday, August 18, 2017 3:55 PM
To: josejunathl@gmail.com
Cc: patricia@totalhealthandlife.com
Subject: Hometown Health - Individual & Family - Thank you!



THANK YOU!

Hello Jose de Jesus,

Thank you for choosing Hometown Health Individual and Family coverage to meet your medical and pharmacy insurance needs. Please note that you will still be receiving an official Welcome email once you are fully enrolled with Hometown Health. Below are a few things to know as a member.

Your Application ID: 17263

Member ID Cards

Your Hometown Health eCard, the region's first electronic member ID card, will be available from your smartphone or through My Benefits Coverage™ within 48 hours of this email. You will receive a physical member ID card in the mail within 7 – 10 business days.

My Benefits Coverage™

[My Benefits Coverage™](#) allows you to securely check the status of your claims, download and print member ID cards, and much more.

Please be aware that this email was sent from a unattended mailbox. Please do not reply.

Email confirmation is sent to the broker:

From: donotreply@hometownhealth.com [<mailto:donotreply@hometownhealth.com>]
Sent: Friday, August 18, 2017 3:55 PM
To: patricia@totalhealthandlife.com
Subject: Hometown Health - Individual & Family - New Enrollment!



NEW ENROLLMENT!

Hello Patricia,

This is just to let you know that your Individual and Family prospect, Jose de Jesus Luna Nevarez, has just successfully enrolled in Hometown Health Individual and Family coverage!

Application ID: 17263

The details for this application are available in eQuote. Click [here](#) to review.

Please be aware that this email was sent from a unattended mailbox. Please do not reply.

CHANGING STATUS ON MEMBER

Colton Hogsett



 Add Note  Send Email +/- Status Change Payment Info Primary Care Physician

Status Change

Plan Changes - You may change your plan selection before commencement of coverage (i.e. before your initial effective date) and/or during Open Enrollment (OE). Plan changes are not allowed mid-contract. If selecting a higher premium plan the subscriber will be required to pay the difference before the plan change goes into effect. If selecting a lower premium plan the difference will be applied forward to the following month's premium.

Adding Dependents - Dependents must have a Qualifying Life Event (QLE) in order to enroll mid-contract (common examples: involuntary loss of coverage, birth/adoption, etc). The subscriber will be responsible for all prorated premium payments up to the next billing date, if applicable. **Please note, this policy is not eligible to have any dependents.**

Term coverage - Term coverage for yourself and/or any applicable dependents. Please note that you must notify us on or before the 20th of the month to terminate coverage at the end of that month. If you notify us after the 20th of a month, your coverage will terminate at the end of the following month.

Please select an action below.

[Change Plan](#)

[+ Add Spouse/Partner](#)

[+ Add Child/Dependent](#)

[Term Coverage](#)

This member is a child so you will notice the verbiage indicates this policy is not eligible to have any dependents.

PAYMENT INFORMATION

The member can indicate if they would like to have a recurring payment (automatically debited from credit card on the 1st of the month) OR Manual payment (Member logs in and makes payment).

Payment is due on the 1st of each month with a 30 day grace period (Due no later than the 30th of the month by **5pm**)

You do not have any outstanding invoices at this time.

Total: **\$0.00**

My Cards



Card ending: *****0561

Default card

+ Add Card

Payment Schedule

Current setting

Manual pay each month

I will login and make my payments manually each month when I am billed.

Change

[Refund Policy](#) | [Privacy Policy](#) | [Information about your premium](#)



ABOUT SSL CERTIFICATES

[More info about how this site is protected.](#)

Additional Info/Help

Need Assistance?
Please contact your broker.