Renown® HEALTH PLAN
Brought to you by Hometown Health

INDIVIDUAL AND FAMILY PLANS
2025 EVIDENCE OF COVERAGE

CONTACT INFORMATION

HOMETOWN HEALTH
ATTN: CUSTOMER SERVICE
10315 PROFESSIONAL CIRCLE
RENO, NEVADA 89521

MAIN
(775) 982-3232
TOLL FREE
(800) 336-0123
FAX (ATTENTION: CUSTOMER SERVICE)
(775) 982-3741
TTY (SPECIAL EQUIPMENT REQUIRED)
711
ESPAÑOL
(775) 982-3232

CUSTOMER_SERVICE@HOMETOWNHEALTH.COM
HometownHealth.com

This Evidence of Coverage (EOC) describes health insurance policies provided by Hometown Health Plan, Inc., and Hometown Health Providers Insurance Company, Inc.

Both Hometown Health Plan, Inc. and Hometown Health Providers Insurance Company, Inc. are licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members, and Renown Health.

Health Maintenance Organizations (HMO) and Exclusive Provider Organizations (EPO) health plans are issued by Hometown Health Plan, Inc.. Additionally, Preferred Provider Organization (PPO) health plans are issued by Hometown Health Providers Insurance Company, Inc.; both organizations are referred to as Hometown Health (HTH) throughout this document.

This document includes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures for HMO, EPO, and PPO health insurance policies. Refer to Your respective Schedule of Benefits (SOB) for Policy-specific Cost Sharing information not described within this EOC. In case of conflicts between this EOC and SOB, this EOC shall be the document that determines the benefits or interpretation of those documents.

Network.

HMO network

- HTH's HMO Network provides access to Renown Health for Primary and Specialty Care in addition to Community Specialty Care providers. There is no coverage for services outside the Network unless services are rendered as part of an Emergency room visit or the member has previously been approved by HTH to be paid at the HMO Benefit Level. *You must select a Primary Care Physician (PCP) from the Renown Medical Group (RMG) or an otherwise approved in-network Pediatrician or Geriatric Care Services provider. Additionally, You must receive a referral from Your PCP prior to receiving services for specialty care.*
- ***EPO network*** HTH's Nevada EPO Network provides access to providers throughout the state of Nevada for Primary and Specialty Care. There is no coverage for services outside the Network unless the services are rendered as part of an Emergency room visit or have been previously approved by HTH to be paid at the EPO Benefit Level. *You may select any PCP within the network and are not required by Hometown Health to receive a referral prior to receiving services for specialty care.*

PPO network

- HTH's PPO Network provides access to a large Network of In-Network Providers both in the state of Nevada as well as close surrounding areas who have contracts with Hometown Health. Services from In-Network Providers will be paid at the In-Network benefit level. Members may also seek services from Out-of-Network Providers at a reduced benefit level (higher cost to the Member). *You may select any PCP within the network and are not required by Hometown Health to receive a referral prior to receiving services for specialty care.*

Out-of-Network Services. If you have out of network benefits, when you do not use an In-Network Provider or get care as part of an Authorized Referral, Covered Services are covered at the Out-of-Network level.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount, except for Emergency Care received in the United States, and certain non-Emergency Covered Services that you receive from an Out-of-Network Provider while you are receiving services from an In-Network Facility;
2. You may have higher cost sharing amounts (i.e. deductibles, coinsurance, and/or copayments)

unless your claim involves a Surprise Billing Claim;

3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims;

Non-Network Liability and Balance Billing. If you receive services from a non-network provider, you may have to pay more for services you receive. Non-network providers may be permitted to bill you for the difference between what we agreed to pay, and the full amount charged for a service. This is known as balance billing. This amount is likely more than network costs for the same service and might not count toward your annual maximum out-of-pocket amount limit. However, you will not be balance billed when balance billing protections apply to covered services.

A directory of providers is available on Our website at www.hometownhealth.com/provider-directories or by calling Hometown Health, Customer Service at (775) 982-3232 or (800) 336-0123.

Obtaining Care. If you need care urgently outside of Hometown Health's office hours, please go to your nearest urgent care provider (see page 33 for coverage details). If you have an emergency, please call 911 or go to your nearest emergency room or hospital (see page 32 for coverage details). To find an Urgent Care or Emergency Room provider, please refer to your Provider Directory or the most recent list of providers is available on our website www.hometownhealth.com/provider-directories.

Prescription Drug Coverage. Members must utilize the Hometown Health Pharmacy Network. *This Policy does not cover drugs which are purchased from pharmacies that are not part of the Hometown Health Pharmacy Network*. Members must work with their doctors to select drugs that are included in the Hometown Health

Direct Member Reimbursement. Member reimbursement forms are available for direct reimbursement for services rendered at an office for Urgent or Emergent services. Urgent or Emergent care services are reimbursable at the current usual and customary rate incurred inside the United States. Emergencies or Urgent Care inside of the United States must have the applicable Member Reimbursement form filled out with the member information, CPT and diagnosis codes and evidence of payment to the Provider. Claims incurred outside the United States for Emergency treatment of a Member must have medical records or itemized superbill. Bills that are not itemized for services rendered will not be reimbursed. This needs to be submitted with the Member Reimbursement form filled out with member information. If requested documents are not signed and returned to us or our representative within 90 days of the request, we will no longer have any obligation to pay any covered expense incurred by the member. The Member Reimbursement form can be found at hometownhealth.com/customer-service-support/member-forms (Medical Claim Form). Once the form is completed you can fax it to our Reimbursement Services Department at 775-982-3751, email it to customer_service@hometownhealth.com or mail it to our office located at:

Hometown Health

10315 Professional Circle

Reno, NV 89521

Standard Drug Formulary. *This Policy does not cover drugs which are not included in the Hometown Health Standard Drug Formulary*.

Pediatric Coverage. This Policy provides pediatric vision coverage for those members under the age of 19, with a corresponding vision Network of In-Network Providers. A list of In-Network Providers for this Network and the medical and pharmacy networks are available at hometownhealth.com.

Geographic Service Area. This Policy is available only to those individuals and families who live in

- Carson City
- Douglas County
- Lyon County
- Storey County
- Washoe County

Additional eligibility requirements are detailed later in this EOC.

Minimum Essential Coverage. This Benefit Plan is considered Minimum Essential Coverage as defined by the ACA, 26 U.S.C. § 5000A(f) and its implementing regulations. Subscribers enrolled in this plan will receive an IRS Form 1095-B from Hometown Health. Form 1095-B is used to report certain information to the IRS and to taxpayers about individuals who are covered by Minimum Essential Coverage and therefore are not liable for the individual shared responsibility payment for the months during which they are enrolled in this plan.

Ongoing Regulation. This EOC complies with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act of 2008 and all other applicable state and federal insurance laws (including Nevada's Telehealth law), regulations and guidance effective on the date of publication of this Schedule of Benefits and the EOC it supports. These laws, regulations and supporting guidance may change. We will provide coverage under this Policy in accordance with these laws, regulations and guidance as they are issued.

Guaranteed Renewable Coverage under this Certificate is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable State and Federal law. The member may renew this Certificate by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage;
3. Membership has not been terminated by Us under the terms of this Certificate.

Your Documents. Copies of Your EOC, Schedule of Benefits, attachments, In-Network Provider lists and other associated documents are available online at hometownhealth.com. We will provide You with paper copies of these documents without charge upon Your request to Our customer services department.

HMO

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- 2025 Renown Gold HMO Plus
- 2025 Renown Gold HMO
- 2025 Silver HMO Plus
- 2025 Renown Silver HMO $20 PCP
- 2025 Renown Silver HMO $10 PCP
- 2025 Renown Silver HMO $5 PCP
- 2025 Renown Silver 70 HMO HSA
- 2025 Renown Silver 68 HMO HSA
- 2025 Renown Silver 70 HMO
- 2025 Renown Silver 68 HMO
- 2025 Renown Bronze HMO Plus
- 2025 Renown Bronze HMO
- 2025 Renown Bronze HMO HSA
- 2025 Renown Catastrophic HMO

EPO

- 2025 Hometown Gold EPO Plus
- 2025 Hometown Gold EPO
- 2025 Hometown Silver EPO Plus
- 2025 Hometown Silver EPO HSA
- 2025 Hometown Silver EPO
- 2025 Hometown Bronze EPO Plus
- 2025 Hometown Bronze EPO HSA
- 2025 Hometown Bronze EPO

PPO

- 2025 Hometown Gold PPO Plus
- 2025 Hometown Silver PPO Plus
- 2025 Hometown Bronze PPO Plus

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I. NOTICE OF NONDISCRIMINATION

Discrimination is Against the Law

HTH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HTH does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HTH:

- Provides free aids and services to people with disabilities to communicate effectively with Us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If You need these services, contact the Compliance Officer.

If You believe that HTH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, You can file a grievance with: Compliance Officer, 10315 Professional Circle, Reno, NV, 89521, 800-611-5097, (TTY: 1- 800-833-5833). You can file a grievance in person or by mail, fax, or email. If You need help filing a grievance, the Compliance Officer is available to help You.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

II. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If You have any questions about this notice, please contact Renown Health Corporate Compliance/Privacy office at 775-982-8300.

AT A GLANCE

Who can HTH disclose Your information to?	
Without Your consent	• Doctors, nurses, and others involved in treating You. This includes providers at other hospitals, clinics, and offices who have a treatment relationship with You. • To insurance companies unless You pay for Your visit in its entirety out of pocket up front and request Your insurance not be billed. • For healthcare operations such as quality reviews, safety and privacy investigations, or any other business need. • As required by law. Nevada and Federal regulations require reporting of certain conditions, infections, illnesses, acts of violence, and other situations.
Situations where You have the opportunity to object or opt-out	• With Your consent, Our staff may discuss limited information with Your family and friends about Your condition or treatment. If You are unable to consent, staff will use Professional judgment on whether the disclosure is in Your best interest. • Hometown Health may disclose information about You to the Renown Health Foundation for fundraising purposes. You may opt out of this by calling 775-982-8300 or by writing to the address below.

Who Will Follow This Notice

This notice describes the practices of HTH. HTH includes it employees, physician staff, trainees, volunteer groups, students, interns anyone authorized to enter information into Your medical record, contracted employees, business associates and their employees, and other health care personnel. For the purposes of this notice, the entities, will be referred to in this notice as "HTH."

Our Pledge Regarding Your Health Information

We understand that medical information about You and Your health is personal. We are committed to protecting Your health information, including personal financial information related to Your healthcare. We create a record of Your benefits and eligibility status and claims history. We need this record to provide You with quality healthcare benefits and to comply with certain legal requirements. Hospitals, physicians and other healthcare providers providing healthcare services to HTH members may have different policies or notices regarding their uses and disclosures of Your medical information.

This notice will tell You how We use and disclose health information about You. We also tell You about Your rights and obligations We have about the use of Your medical information.

We are required by law to:

- Make sure Your health information that identifies You is kept private;
- Give You this notice of Our legal duties and privacy practices with respect to health information about You; and,
- Follow the terms of the notice that is current in effect.

How We May Use and Disclose Health Information about You

The following categories describe different ways that We use and disclose health information. For each category of use or disclosures, We will provide examples of the types of ways Your information may be used. Not every use or disclosure in each category will be listed.

- **For Treatment.** We may use and disclose Your health information during the provision, coordination, or management of healthcare and related services among healthcare providers, consultation between healthcare providers regarding Your care, or the referral of care from one healthcare Provider to another. For example, a clinician providing a vaccination to You may need to know if You are sick so that You do not receive a vaccine. The clinician may refer You to a doctor and may also need to tell the doctor that You are sick in order to arrange for appropriate medical services, to receive the vaccine at a later date.

- **For Payment.** We may use and disclose Your health information in order to pay for Your medical benefits under Our health plan. These activities may include determining benefit eligibility, billing and collection activities, coordinating the payment for benefits with other health plans or third-parties, reviewing healthcare services for Medical Necessity, and performing utilization review. For example, to make payment for a healthcare claim, We may review medical information to make sure that the services provided to You were necessary.

- **For Healthcare Operations.** We may use and disclose Your health information for health plan operations. These uses and disclosures are necessary to run the health plan and make sure that all of Our members receive quality benefits and customer service. For example:
    - We may use and disclose general health information but not reveal Your identity in the publication of newsletters that offer members information on various healthcare issues such as asthma, diabetes, and breast cancer.
    - We may use and disclose Your health information for claims management, utilization review and management, data and information systems management, Medical Necessity review, coordination of care, benefits and services, responding to Member inquiries or requests for services, processing of grievances, appeals and external reviews, benefits and program analysis and reporting, risk management, detection and investigation of fraud and other unlawful conduct, auditing, underwriting, and ratemaking.
    - We may use and disclose Your health information for the operation of disease and case management programs, through which We or Our contractors perform risk and health assessments, identify and contact members who may benefit from participation in disease or case management programs, and send relevant information to those members who enroll in the programs and their providers.
    - We may use and disclose Your health information for quality assessment and improvement activities, such as peer review and credentialing of In-Network providers, program development, and accreditation by independent organizations.
    - We may use and disclose Your health information to the sponsor of the plan if We are providing health benefits to You as a beneficiary of an employer-sponsored group health plan.

  - We may use and disclose Your health information for the transition of policies or contracts from and to other health plans.

- **To Your Family and Friends**. We may use and disclose Your health information to a family Member, friend or other person to the extent necessary to help with Your healthcare or payment for Your healthcare. Before We disclose Your medical information to a person involved in Your healthcare or payment for Your healthcare, We will provide You with an opportunity to object to such uses and disclosures. If You are not present, or in the event of Your incapacity or an Emergency, We will use and disclose Your health information based on Our Professional judgment of whether the use or disclosure would be in Your best interest.

- **As Required By Law**. We will disclose medical information about You when required to do so by federal, state or local law. We must also share Your medical information with authorities that monitor Our compliance with privacy laws.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about You when necessary to prevent a serious threat to Your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat.

Special Situations

- **Military and Veterans.** If You are a Member of the armed forces, We may disclose health information about You as required by military command authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

- **Public Health Risks.** As required by law, We may disclose health information about You for public health activities. These activities may include the following:
  - To prevent or control disease, Injury, or disability;
  - To report birth and deaths;
  - To report the abuse or neglect of children, elders, and dependent adults;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To notify the appropriate government authority if We believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make the disclosure if You agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. For example: audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights laws.

- **Lawsuits and Disputes.** If You are involved in a lawsuit or a dispute, We may disclose health information about You in response to a court or administrative order. We may also disclose health information about You in response to a subpoena, discovery request, or other lawful process.

- **Law Enforcement.** We may disclose health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, We are unable to obtain the person's agreement;
- About a death We believe may be the result of criminal conduct;
- About criminal conduct at the Hospital; or
- In Emergency circumstances to report a crime; the location of the crime victims; or the identity, description, or location of the person who committed the crime.

- **Nevada Attorney General and Grand Jury Investigations.** We may disclose health information if asked to do so by an investigator for the Nevada Attorney General, or a grand jury, investigating an alleged violation of Nevada laws prohibiting patient neglect, elder abuse, or submission of false claims to the Medicaid program. We may also disclose health information to an investigator for the Nevada Attorney General investigating an alleged violation of Nevada workers' compensation laws.

- **National Security.** We may disclose health information about You to authorized federal officials for purposes of national security.

- **Inmates.** An inmate does not have the right to this notice. If You are an inmate of a correctional facility or are under the custody of a law enforcement official, We may release health information about You to the correctional institution or law enforcement official. This release would be necessary to provide You with health care or to protect Your health and safety or health and safety of others, including the correctional institution.

Former Members of Hometown Health

HTH does not destroy the health information of individuals who terminate their coverage with Us. The information is necessary and is used for many purposes described above, even after an individual leaves a plan, and in many cases is subject to legal retention requirements. The procedures that protect that information against inappropriate use or disclosure apply regardless of the status of any individual Member.

Your Rights Regarding Health Information About You

You have the following rights regarding health information We maintain about You:

- **Right to Inspect and Copy.** You have the right to inspect and copy health information that may be used to make decisions about Your benefits. Usually, this includes benefits, eligibility and claims records, but may not include some mental health information.

  To inspect and copy health information that may be used to make decisions about You, You must submit Your request in writing. We may charge You a fee for the cost of copying, mailing or other supplies associated with Your request.

  We may deny Your request to inspect and copy in very limited circumstances. You may request that a denial be reviewed.

- **Right to Amend.** If You feel that health information We have about You is incorrect or incomplete,You may ask Us to amend the information. You have the right to request an amendment for as long as the

information is kept by or for HTH. To request an amendment to Your record, You must send a written request providing a reason that supports Your request.

We may deny Your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny Your request if You ask Us to amend information that:

- Was not created by Us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the records used to make decisions about You;
- Is not part of the information which You would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to receive a list of disclosures We made with Your health information. This list will not include all disclosures made. This list will not include disclosures made for treatment, payment, or health care operations, disclosures made more than six years prior, or disclosures You specifically authorized. To request this list or an "accounting of disclosures" You must submit Your request in writing.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information We use or disclose about You to someone who is involved in Your care or in the payment for Your care, such as a family Member or friend. We are not required to agree with Your request, unless the request seeks a restriction on the disclosure of information to a health plan, the disclosure is for the purpose of carrying out payment or health care operations, and is not otherwise required by law, and the information relates to an item or service which You, or someone acting for You other than the health plan, has paid Us in full. If We do agree with Your restriction, We will comply with Your request unless the information is needed to provide You Emergency treatment. To request restrictions, You must make Your request in writing.

  Your request must tell Us: (1) what information You want to limit; (2) whether You want to limit Our use, disclosure, or both; and (3) to whom You want the limits to apply (for example, disclosures to Your spouse)

- **Right to Request Confidential Communications.** You have the right to request that We communicate with You about health matters in a certain way or at a certain locations. For example, You can ask that We only contact You by mail or at work. We will accommodate all reasonable requests. You must make Your request in writing.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask Us to give You a copy of this notice at any time. Even if You have agreed to receive this notice electronically, You are still entitled to a paper copy of this notice. You may obtain a current copy of this notice at www.HometownHealth.com.

- To make a request for: inspection of Your health record, amendment to Your health record, accounting of disclosures, restrictions on information We may release, or confidential communications, please submit Your request in writing to:

  Hometown Health Compliance Officer
  10315 Professional Circle Mail Stop T-9
  Reno, NV 89521

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective immediately for health information We already have about You as well as any information We receive in the future. We will post a copy of the current notice in Our facilities and at www.HometownHealth.com. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time You enroll in a HTH plan, We will offer You a copy of the current notice in effect.

Complaints

If You believe Your privacy rights have been violated, You may file a complaint with Us by contacting 775-982-8300. You may also file a complaint with the Office for Civil Rights at www.hhs.gov/ocr or You may file a complaint in writing to:

Renown Health Chief Compliance/Privacy Officer
1155 Mill St, Mail Stop N-14
Reno, NV 89502

You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to Us will be made only with Your written authorization. If You provide Us permission to use or disclose health information about You by signing an authorization, You may revoke that permission, in writing, at any time. If You revoke Your permission, We will no longer use or disclose health information about You for the reasons covered by Your written authorization. You understand that We are unable to take back any disclosures We have already made with Your permission, and that We are required to retain Our records of the care that We provided to You.

Notice to Patients Regarding the Destruction of Health Care Records

In accordance with NRS 629.051, Your regularly maintained health records will be retained for five years after receipt or production, unless otherwise provided for by federal law. If You are less than 23 years old on the date of destruction Your records will not be destroyed; after You have reached 23 years of age, Your records will be destroyed after a five year retention, unless otherwise provided by federal law.

In accordance with 42 CFR 422.504(d) and (e); 423.505(d) and (e), HTH as a Medicare Advantage organization, will retain health records for Medicare Advantage beneficiaries for 10 years, unless otherwise provided for by federal law.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to Us will be made only with Your written authorization. If You provide Us permission to use or disclose health information about You by signing an authorization, You may revoke that permission, in writing, at any time. If You revoke Your permission, We will no longer use or disclose health information about You for the reasons covered by Your written authorization. You understand that We are unable to take back any disclosures We have already made with Your permission and that We are required to retain Our records of the care that We provided to You.

III. SCHEDULE OF BENEFITS

If You incur expenses for Covered Services, We will pay that Expense less the applicable Deductible, Copayments, and/or Coinsurance, except as otherwise provided in this EOC. The specific Deductible, Copayments, and Coinsurance amounts are shown in Your Schedule of Benefits. We will pay up to the maximum benefit specified for Covered Services.

When We determine that two or more courses of treatment are substantially equivalent, We have the right to substitute less costly services or benefits for those that We would otherwise cover under this Policy. This applies regardless of whether We otherwise would cover such less costly benefits.

Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, We could limit coverage to the inpatient care. We could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in this EOC.

The fact that an In-Network Provider prescribed, ordered, recommended, or approved a service, treatment, or supply does not necessarily make it a Covered Service or Medically Necessary.

The following is a description of Covered Services. All Covered Services must be Medically Necessary and are subject to exclusions and limitations as described herein. Prior Authorization is required for many services. Limitations may apply. All services must be provided by Providers licensed or certified to provide the service unless otherwise indicated. The fact that a In-Network Provider prescribed, ordered, recommended, orapproved a service, treatment, or supply does not necessarily make it a Covered Service or Medically Necessary.

This chapter should be read in conjunction with Chapter IV – Exclusions and Limitations and Your Schedule of Benefits. Your Schedule of Benefits lists specific Cost Sharing information not listed within this EOC.

A. PROFESSIONAL SERVICES

The following services are Covered Services when provided by a Professional.

1) Alcohol and Substance Abuse Services (Inpatient andOutpatient).

Medically Necessary inpatient and outpatient alcohol and substance abuse services will be provided under the terms as noted in the Schedule of Benefits. Substance abuse care benefits are for Acute medical detoxification and for substance abuse rehabilitation and counseling. The main purpose of medical detoxification is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed.

Certain inpatient and require Prior Authorization, subject to the Utilization Management Program rules applicable to all medical and mental health services (see Section V. Utilization Management Program). A full listing of services subject to Prior Authorization can be found at hometownhealth.com or by referring to your Schedule of Benefits. Alcohol and substance abuse Office Visits do not require a referral or a Prior Authorization. Services subject to Prior Authorization are assessed and monitored on an ongoing basis to ensure compliance with the Mental Health Parity and Addiction Equity Act.

This Benefit Plan provides all mental health and substance abuse benefits in accordance with the *Mental Health Parity and Addition Equity Act of 2008.*

2) Allergy Testing and Treatment.

Coverage is provided for Medically Necessary allergy testing, preparation of serum, serum, and administration of injections.

3) Alternative Medicine

Alternative medicine is a Covered Service for therapeutic procedures and approaches to medical diagnosis and therapy that currently may not be considered part of conventional medical practice. These generally include acupressure, holistic medicine homeopathy, hypnosis, herbal, vitamin or supplement therapies, naturopathy, biofeedback, and neurofeedback.

Office visits, procedures, and therapies for alternative medicine and related medications are only covered if prescribed or provided by a licensed Provider (limited to $1,000 maximum benefit per Calendar Year).

4) Autism Spectrum Disorders

Coverage is provided for Medically Necessary screening for and diagnosis of Autism Spectrum Disorders (ASD) and for the Medically Necessary treatment of ASD. Treatment may be provided by a licensed provider as defined in NRS.

"Autism Spectrum Disorder" means a condition that meets the diagnostic criteria for Autism Spectrum Disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association or the edition thereof that was in effect at the time the condition was diagnosed or determined.

Treatment of Autism Spectrum Disorders must be identified in a treatment plan and may include Medically Necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy, or therapeutic care that is:

- Prescribed for a person diagnosed with an Autism Spectrum Disorder by a licensed Physician or licensed psychologist; and
- Provided to a person diagnosed with an Autism Spectrum Disorder by a licensed Physician, licensed psychologist, state certified behavior analyst or other Provider that is supervised by the licensed Physician, psychologist, or behavior analyst.

We may request and review a copy of the treatment plan.

Coverage is subject to Copayment, Deductible, and Coinsurance provisions and any other general exclusion or limitation of this Policy to the same extent as other medical services or Prescription Drugs covered by Us. Services for applied behavioral analysis treatment for ASD require Prior Authorization. Coverage is not provided for reimbursements to a school for services delivered through school services.

5) Blood Services for Surgery

Medically Necessary blood and related supplies provided during a surgical or other procedure that requires blood replacement are Covered Services.

6) Chemotherapy

Chemotherapy and other drug therapies that are Medically Necessary to treat cancers and other diseases and conditions in an outpatient hospital, outpatient facility or Physician's office are Covered Services.

7) Clinical Trials

The routine medical treatment costs, including reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial, may be covered. Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Approved clinical trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and meets the requirements under Criteria for Approved Clinical Trials.

Criteria for Approved Clinical Trials

The Clinical Trial must be described in one of the main bullets below:

- National Institutes of Health (NIH) [includes National Cancer Institute (NCI)]
- Centers for Disease Control and Prevention (CDC)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Medicare and Medicaid Services (CMS)
- A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA)
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health;
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;

OR

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- There is no medical treatment available that is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

- You have signed, before Your participation in the clinical trial or study, a statement of consent indicating that You have been informed of, without limitation:

    i. The procedure to be undertaken;
    ii. Alternative methods of treatment; and
    iii. The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks; and

- The medical treatment is limited to:

    i. Coverage for any drug or device that is FDA-Approved for sale without regard to whether the approved drug or device has been approved for use in Your medical treatment;
    ii. The cost of any reasonable necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III, or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase

II, Phase III, or Phase IV clinical trial or study, to the extent that such health care services would otherwise be Covered Services;

iii. The cost of any routine health care services that would otherwise be Covered Services for Your participation in a Phase I clinical trial;

iv. The initial consultation to determine whether You are eligible to participate in theclinical trial or study; or

v. Health care services required for the clinically appropriate monitoring of You during a Phase II, Phase III, or Phase IV clinical trial or study.

Services for the following clinical trial services are excluded:

- Any portion of the clinical trial or study that is customarily paid for by a government ora biotechnical, pharmaceutical, or medical industry;
- Coverage for a drug or device described above that is paid for by the manufacturer, distributor, or Provider of the drug or device;
- Health care services that are specifically excluded from coverage in this EOC, regardlessof whether such services are provided under the clinical trial or study;
- Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to participants in the trial or study;
- Extraneous expenses related to You in the clinical trial or study including but not limited to travel, housing, and other expenses that You may incur;
- Any expenses incurred by a person who accompanies You during the clinical trial or study;
- Any item or service that is provided solely to satisfy a need or desire for data collectionor analysis that is not directly related to the clinical management of You; and
- Any costs for the management of research relating to the clinical trial or study.

8) Diabetic Services for Type 1, Type 2, and Gestational Diabetes

Coverage is provided for the Medically Necessary management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies, and appliances for the treatment of diabetes.

Coverage is provided for the Medically Necessary self-management of diabetes for training and education provided after You are diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

9) Family Planning

Coverage is provided for vasectomies and tubal ligations. Reversals of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals are excluded.

10) Gastric Restrictive Services (Bariatric)

Covered Services include Medically Necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese with associated illnesses. These services will not be covered unless You receive Prior Authorization.

In order to receive Prior Authorization You must:

a) Have a body mass index (BMI) of more than 40kg/m2, or;

b) Have a BMI greater than 35kg/m2 with significant co-morbidities; and
c) Provide documented evidence that weight-loss attempts are ineffective; and
d) Provide documentation of a recommendation for Gastric Restrictive Services from a psychologist or psychiatrist; and
e) Are at least 18 years old.

HTH will also require proof of attendance at a medically supervised weight-loss program for at least three (3) months within the last twenty-four (24) and documentation of weight-loss failure within the program. HTH will require clinical evidence that Your weight is affecting Your overall health and is a threat to Your life. HTH may also require participation in a post-operative therapy program.

Benefits for gastric restrictive services are limited to one (1) surgery per lifetime.

Surgical or invasive treatments for obesity or morbid obesity including but not limited to gastric restrictive services, reversals, and treatments to resolve complications are generally excluded, unless Medically Necessary and are covered as described above.

Medically Necessary treatment for complications resulting from Gastric Restrictive Surgical Services will be covered the same as any other illness.

11) Genetic Counseling/Testing

Covered Services include Medically Necessary genetic disease testing. Genetic disease testing is the analysis of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition. Coverage is not available for tests solely for research, or for the benefit of individuals not covered under the Policy.

Covered services also include the explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk and review testing options, where available.

Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, in Our discretion, as approved by a Physician that We may designate to review the utilization, Medical Necessity, clinical appropriateness, and quality of such genetic testing.

Medically Necessary genetic counseling will be covered in connection with pregnancy management with respect to the following individuals:

- Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality;
- Parents of a child with developmental disability, autism, down syndrome, trisomy conditions, or fragile X syndrome;
- Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein test, test for sickle cell anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects; or
- Parents affected with an autosomal dominant disorder who are contemplating pregnancy; or Women who are known to be, or who are likely to be, carriers of an X-linked recessive disorder.

Covered services include genetic testing of heritable disorders as Medically Necessary when the following conditions are met:

- The results will directly impact clinical decision-making and/or clinical outcome forthe individual;
- The testing method is considered scientifically valid for identification of agenetically-linked heritable disease; and
- One of the following conditions is met:
    i. The Member demonstrates signs/symptoms of a genetically-linked heritable disease; or
    ii. The Member or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically-linked heritable disease.

Additional genetic testing will be covered as required by Federal or state mandates.

In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime of the Member.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology, or mandated by federal or state law.

12) Home Health Care

Medically Necessary home health care is covered if such care is provided by an organization or Professional licensed by the state to render home health services. Such care will not be available if it is substantially or primarily for the Member's convenience or the convenience of a caregiver. Home care is covered in the home only on a part-time and temporary basis and to the extent that such care is performed by a licensed or registered nurse or appropriate therapist. See the section entitled "Other Services and Supplies" for coverage for other home health care services.

13) Infertility Services

Medically Necessary services to diagnose problems of infertility are covered for one workup per year up to three (3) evaluations per lifetime. Up to six (6) cycles of artificial insemination are covered per lifetime for covered members. For the covered female, services include the preparation of the sperm and the insemination, provided that the sperm has not been purchased or the donor compensated for his biological material or services, and that the donor is covered under a HTH individual or small group plan. Costs related to the actual insemination of a non-covered person, are not covered under the terms of this Benefit Plan.

The following services are not covered:

- All other costs incurred for reproduction by artificial means or assisted reproductivetechnology (such as in-vitro fertilization or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy;
- The promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization;

the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are excluded;

- In the case of a surrogate, any services related to determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the Member's ability to become pregnant are excluded; and
- Any payment made by or on behalf of a Member who is contemplating or has entered into a contract for surrogacy to a Provider or individual related to any services potentially included in the scope of surrogacy services described above is excluded.

14) Mastectomy Reconstructive Surgery

Breast reconstructive surgery and the internal or external prosthetic devices are covered for Members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the Physician and the Member.

Subject to all the terms and conditions of this EOC, if a covered mastectomy or other breast cancer treatment is performed, We will also provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical structure;
- Prostheses; and
- Physical complications for all stages of mastectomy, including lymphedemas.

If reconstructive surgery occurs within three years after a mastectomy, the amount of the benefits for that surgery will equal the amounts provided for in the Policy at the time of the mastectomy. If the surgery occurs more than three years after the mastectomy, the benefits provided are subject to all the terms, conditions, and exclusions contained in the Policy at the time of reconstructive surgery.

15) Medical Care

Medically Necessary medical care and services, performed by a Physician or other Professional on an inpatient and outpatient basis, are covered, including:

- Office visits and consultations;
- Hospital and skilled nursing facility services;
- Ambulatory surgical center services;
- Home health care services;
- Surgery; and
- Other Professional services.

16) Medical Pharmacy

Cost Sharing resulting from receipt of Medical Pharmacy benefits described in this section apply to the medical or combined Deductible, as applicable. These benefits do not apply to any separate pharmacy Deductible if the pharmacy Deductible is separate from the medical Deductible.

This benefit includes the distribution, administration, and/or supply of pharmaceuticals and immunizations, frequently in conjunction with other services provided at a Medical Pharmacy. This

benefit does not include other types of pharmaceuticals, which may be covered as described elsewhere in this EOC.

Medically Necessary immunizations, biologics, Injectables, or other Specialty Pharmaceuticals, implantable rods (birth control rods), copper-based and progesterone-based intrauterine devices (IUDs) and contraceptive diaphragms (one device per a 12-month period, unless otherwise prescribed by an In-Network Physician) distributed, administered, or supplied by a Medical Pharmacy (except as described below) are covered. Additionally, if a patient giving birth at a hospital requests the insertion or injection of long-acting reversible contraception (as mentioned above), the hospital shall provide for the insertion or injection of the long-acting reversible contraception immediately after birth, in accordance with NRS.

Specialty Pharmaceuticals, which include Injectables, and medications given by other routes of delivery, may be delivered in any setting. Specialty Pharmaceuticals are pharmaceuticals that typically have:

- Limited access;
- Complicated treatment regimens;
- Compliance issues;
- Special storage requirements; or
- Manufacturer reporting requirements.

We maintain and update a list of Specialty Pharmaceuticals at hometownhealth.com.

17) Mental Health Services

Medically Necessary mental health services, including screenings for depression, provided by a doctor, clinical psychologist, clinical social worker, clinical nurse Specialist, nurse practitioner, Physician assistant, or other qualified mental health care Professional are covered according to the limits provided in the Schedule of Benefits. Direct payment to Out-of-Network mental health and substance abuse providers can be made with a written assignment of benefits.[1]

Inpatient services are subject to Prior Authorization, whether for medical or mental health services. A full listing of services subject to Prior Authorization can be found at hometownhealth.com or by referring to your Schedule of Benefits. Mental Health Office Visits do not require a referral or a Prior Authorization.

This Benefit Plan provides all mental health and substance abuse benefits in accordance with the *Mental Health Parity and Addition Equity Act of 2008.*

18) Newborns and Maternity Care

Medically Necessary maternity services for pregnant Members are covered, including prenatal and postpartum care, related delivery room and ancillary services and newborn care. Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition. Newborn care is subject to the eligibility requirements as defined in this EOC. Newborn care and treatment may be subject to the Newborn's policy coverage and applicable deductibles, copays and/or coinsurance.

HTH covers newborn and maternity care in a Hospital for no less than 48 hours for a normal vaginal delivery and no less than 96 hours for a cesarean section or as otherwise provided in the guidelines

[1] NRS 689A.046; NRS 689B.0397; NRS 689C.167; NRS 695C.1789

established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

Notwithstanding anything in this EOC to the contrary, a Member does not need Prior Authorization to obtain access to gynecological care from a Professional in Our Network who specializes in obstetrics or gynecology. The Professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of In-Network Professionals who specialize in obstetrics or gynecology, go to hometownhealth.com.

Notwithstanding anything in this EOC to the contrary, in the case of a person who has a child enrolled in coverage, We will permit such person to designate any pediatrician as a PCP if such pediatrician is an In-Network Provider.

Services that are not covered include:

- Amniocentesis to the extent that it is performed to determine the sex of the child.
- Non-newborn circumcisions after eight weeks of age unless Medically Necessary and We provide a Prior Authorization.

19) Oral Surgery, Dental Services, and Temporomandibular Joint Disorder

Although dental services are not Covered Services, except as otherwise provide in Part III – Schedule of Benefits, the following Oral Surgical Services are Covered Services:

- For Members up to age 19, services include the Medically Necessary treatment of:

  a) Oral cancer;
  b) Dental Fractures; and
  c) Dental Biopsies

- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth;
- Treatment required to stabilize sound natural teeth, the jawbones, or surrounding tissues after an Injury (not to include injuries caused by chewing) when the treatment starts within the first ten (10) days after the Injury and ends within sixty (60) days.

No benefits are provided for removable dental prosthetics, dentures (partial or complete) or subsequent restoration of teeth, including permanent crowns.

- Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate;
- Repair and restoration of sound and natural teeth from injuries that arise from non-gustatory trauma;
- Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant);
- Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures; and
- Dental general anesthesia for a dependent child when services are rendered in a Hospital or outpatient surgical facility, when enrolled dependent child is being referred because, in the opinion of the dentist, the child:

  i. Is under 18 and has a physical, mental, or medically compromising condition;

ii. Is under 18 and has dental needs for which local anesthesia is ineffective because of an Acute infection, an anatomic anomaly or an allergy; or

iii. Is under age five (5).

Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Member Cost Sharing for covered TMJ services follows the same benefit allowance as other Medically Necessary services, subject to applicable deductibles, copayments and Coinsurance. TMJ surgeries are covered under the medical benefits based on Medical Necessity and are limited to an annual maximum of one (1) surgery and a lifetime maximum of two (2) surgeries.

Prior Authorization is required for dental general anesthesia in a Hospital or outpatient surgical facility. Dental anesthesiology services are covered only for procedures performed by a qualified Specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which Hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate Hospital training to be granted Hospital privileges.

Only the services and supplies described above are covered, even if the condition is due to a genetic, congenital, or acquired characteristic. Exclusions include:

- Under the medical benefits, except as described above as an inclusion, services involving treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of Injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; and repairs and restorations except for appliances that are Medically Necessary to stabilize or repair sound and natural teeth after an Injury as set forth above;
- Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as set forth above;
- Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings; and
- Other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

20) Orthopedic Devices and Prosthetic Devices

Coverage for orthopedic devices is limited to Medically Necessary braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post and pre-operative devices.

One (1) Medically Necessary prosthetic device, approved by the Centers for Medicare & Medicaid (CMS), is covered for each missing or non-functioning body part or organ every three (3) years. Coverage is limited to:

- Devices that are required to substitute for the missing or non-functioning body part or organ;
- Devices provided in connection to an illness or Injury that occurred subsequent to Your effective date of coverage;

- Adjustment of initial prosthetic device; and
- The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.
- Replacement in limited situations involving mastectomy reconstructive surgery

21) Ostomy Care Supplies

Coverage is provided for Medically Necessary care and supplies after colon, ileum, or bladder surgery to assist in carrying on normal activities with a minimum of inconvenience.

22) Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the Schedule of Benefits that accompanies this EOC. The same services covered for inpatient services are also covered for Partial Hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than three and no more than 12 hours of therapy per day. Partial day treatment is covered only when the Member receives care through a day treatment program. Every two partial-day treatments count as one full inpatient day.

23) Physician to Physician eConsult

Coverage is provided for eConsults initiated by Your Primary Care Physician (PCP) to a Specialist in order to receive advice or treatment recommendation for Your care.

24) Plan Approved Medical Necessity Travel Benefit

The Plan Travel Benefit is meant to offset the cost of travel for members and/or their support person or family members when the Utilization Management Department approves services at a Tertiary Care facility (evaluation and/or treatment) in either southern Nevada or in the state of Utah. The specific tertiary care facility must be approved by the Utilization Management Department and agreed upon by the member's referring physician.

Any care administered while following the HTH Utilization Management Care Plan will be subject to in-network cost sharing by the member.

A tertiary care facility provides highly specialized medical care that involves advanced and complex procedures and treatments performed by medical specialists. Examples of tertiary care are specialized cancer care, neurosurgery, cardiovascular and burn care.

- To qualify for Medical Necessity Travel Benefit, the following must apply:
  1. The member and/or their treating physician has requested a referral for a service that is not available within the primary network and will require travel outside of the geographic service area to either southern Nevada or Utah.
  2. Utilization Management has determined that the requested services are medically necessary and tertiary care cannot be provided in the primary network.
  3. Utilization Management has approved the tertiary care at a medical facility capable of providing the medically necessary level of care.
  4. Covered Person has agreed to be in Case Management, and followed by Case Manager while in tertiary care.

5. Prior to travel for tertiary care, the member must advise the RN Case Manager of travel to receive the benefit.

- Covered Travel Expenses:
  1. For a member under the age of 19, travel expenses will be reimbursed at $250 per person for the member and two parents or two legal guardians.
  2. For an adult member age 19 or older, travel expenses will be reimbursed at $250 for the member and one additional person/caregiver.
  3. Coverage will include the day prior to a scheduled service and the day following the scheduled service not to exceed $2,500 per episode of care.
  4. The maximum travel reimbursement per calendar year is $10,000.
  5. After approved travel, complete a Medical Necessity Travel Reimbursement Benefit form, attach all receipts and submit to the Utilization Management Department at HTH.

25) Podiatry Services

Podiatry services are covered for the Medically Necessary treatment of Acute conditions of the foot such as infections, inflammation, or Injury and other foot care that is disease related.

The following services are not covered:

- Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and Chronic foot strain; and
- Routine foot care.

26) Preventive Services

Notwithstanding anything to the contrary in this EOC, the following preventive services will be covered without any Member Cost Sharing if such services are provided by an In-Network Provider:

- One wellness physical examination per calendar year is covered for members older than two or as frequently as mandated by ACA and routine immunizations;
- Coverage for smoking cessation programs for an enrollee who is 18 years of age or older;
- Prostate Specific Antigen (PSA) screen;
- Counseling for sexually transmitted infections (STI);
- HIV counseling, testing and prescription drugs without the need for a prescription;
- Breastfeeding support, supplies and counseling;
- Screening for interpersonal and domestic violence;
- Screening for depression;
- Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a Provider of healthcare;
- High-risk human papillomavirus (HPV) testing;
- Annual well-woman preventive visits as recommended by the Health Resources and Services Administration for women 14 years of age or older.
- Routine gynecologic examination (one per calendar year), including annual cytologic screening test (Pap smear) for women 21 to 65 years of age, pelvic examination, urinalysis, and breast examination;

- Screening mammograms annually for insureds 40 years of age or older;
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics;
- Colorectal cancer screening starting at age 45 years and continuing until age 75 years in accordance with:
    i. The guidelines concerning such screening that are published by the American Cancer Society; or
    ii. Other guidelines or reports concerning such screening that are published by nationally recognized Professional organizations and that include current or prevailing supporting scientific data;
- Lung Cancer screening with low dose computed tomography (LDCT) for qualified individual every 12 month
    i. Eligible members are people aged 50 years or older and
    ii. have no signs or symptoms of lung cancer
    iii. history of tobacco smoking of at least 20 pack-years and
    iv. who currently smokes or has quit smoking within the last 15 years and
    v. receives an order for lung cancer screening with LDCT.
    vi. Before the beneficiary's first lung cancer LDCT screening, the beneficiary must receive a counseling and shared decision-making visit that meets all of the following criteria, and is appropriately documented in the beneficiary's medical records:
    vii. Determination of beneficiary eligibility;
    viii. Shared decision-making, including the use of one or more decision aids;
    ix. Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment; and
    x. Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions.
- Immunizations, including influenza, pneumococcal, haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, measles, diphtheria, human papillomavirus (HPV), pertussis (whooping cough), poliovirus, rotavirus, varicella (chickenpox), shingles (herpes zoster) and tetanus, if such immunizations have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction;
- Evidence-based items or services that have an "A" or "B" Recommendation of the United States Preventive Services Task Force, provided that the recommendation does not conflict with a more recent "A" or "B" Recommendation of the United States Preventive Services Task Force;

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services; and
- With respect to women, such additional preventive care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- With respect to women, contraceptives are covered as preventive services. The following services are covered under Your medical benefit, subject to Prior Authorization as is required for any surgical procedure:
    i. Voluntary sterilization for women (once per lifetime); and
    ii. Surgical sterilization implants for women (once per lifetime);

  See Part H – Covered Services under the Pharmacy Benefit, Section 7) – Contraceptive Products below for contraceptive methods covered under the HTH Prescription Drug benefit.

For more information see: http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/

27) Radiation Therapy

Medically Necessary Professional services related to radiation therapy in an outpatient hospital, outpatient facility or Physician's office, are covered.

28) Rehabilitative and Habilitative Therapy

Coverage is provided for Medically Necessary physical, speech, occupational, cardiac, and pulmonary therapy habilitative and rehabilitation services. Such services must be performed by a Physician or by a therapy Provider licensed in accordance with state regulations for that therapy discipline.

Rehabilitative and habilitative services may require Prior Authorization depending on the setting in which the services are provided.

Coverage for these services is available for Acute conditions arising from illness or Injury, as well as Chronic or developmental conditions up to the benefit limits as defined in the Benefit Plan.

29) Remote Monitoring

Coverage is provided for Medically Necessary remote patient monitoring, including the collection, storage, and evaluation of health information through live monitoring via devices that transmit information from the home or care facility to Your provider.

30) Skin Lesions

Coverage is provided for Medically Necessary removal of skin lesions and related pathological analysis of such lesions.

31) Spinal Manipulation (Non-Surgical)

Coverage is provided for up to 20 visits per year for Medically Necessary spinal manipulations and adjustments, except for treatment for Chronic or recurring conditions.

Spinal manipulation and adjustment means the detection, treatment, and correction of structural imbalance, subluxation, or misalignment of the vertebral column in the human body, for the purpose of alleviating pressure on the spinal nerves and its associated effects related to such structural imbalance, misalignment, or distortion, by physical or mechanical means.

32) Transplant Services

Medically Necessary organ transplants at a HTH approved Centers of Excellence are covered when You are the organ recipient in the following cases:

- Bone marrow;
- Cornea;
- Heart;
- Heart and lung;
- Intestinal and liver;
- Kidney;
- Liver;
- Lung;
- Pancreas;
- Pancreas and kidney; or
- Stem cell.

Centers of Excellence are facilities that meet HTH's vigorous credentialing requirements for the specific type of organ transplant. A facility that is designated as a Center of Excellence for one type of organ transplant may not be designated as a Center of Excellence for another type of organ transplant. Designation as a Center of Excellence is at HTH's sole discretion.

Organ transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable.

Coverage for related transplant services is limited to:

- Tests necessary to identify an organ donor;
- The reasonable Expense of acquiring the donor organ;
- One (1) procurement per transplant benefit period. The transplant benefit period begins on the date the Member first receives services directly related to evaluation as candidate for a covered transplant procedure, and ends on the earlier of the date 12 months after the Covered Transplant is performed, or the date the Member ceases to be a Member, subject to Nevada's Essential Health Benefits.
- Transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ;
- Storage costs of an organ, but only as part of an authorized treatment protocol; and
- Follow-up care.

Services excluded from coverage include, but are not limited to:

- Services provided at a facility that has not been designated as a HTH Center of Excellence are excluded.
- Services provided in connection with purchasing or selling organs are excluded.
- Transplants utilizing any animal organs are excluded.

- Any transportation of the donor (as opposed to transportation of the donor organ only) is excluded.
- Any expenses associated with an organ transplant where an alternative remedy is available are excluded.
- Artificial heart implantation is excluded.
- Services for which government funding or other insurance coverage is available are excluded.
- Any expenses for transportation, lodging, and meals for services associated with the transplant including evaluations and the transplant and post-transplant periods for the donor, donor's family, recipient, or recipient's family are excluded.
- Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement are excluded, except as described above.

33) Sickle Cell Disease and It's Variants

Benefits for treatment of Sickle Cell Disease and Its Variants, including Medically Necessary Prescription Drugs and necessary care management services through Hometown Health's Utilization Management Program to assist patients in managing complex patient care.

B. HOSPITAL, SKILLED NURSING CARE, AND SERVICES IN AN OUTPATIENT SURGICAL CENTER

1) Inpatient Care

Medically Necessary inpatient Hospital care is covered. Services include, but are not limited to:

- Services for medical conditions treated in an Acute care Hospital inpatient environment;
- Semi-private room and board (private room when Medically Necessary);
- General nursing care facilities, services, and supplies on an inpatient basis;
- Diagnostic services that are provided in a facility, whether such facility is a Hospital or a freestanding facility (see "Other Services and Supplies for related Covered Services);
- Surgical and obstetrical procedures, including the services of a surgeon or Specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care;
- Maternity and newborn care for up to 48 hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to 96 hours of inpatient care for a mother and her newborn child following a Cesarean delivery. The time-periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time-periods will be made by the attending Physician after conferring with the mother;
- Inpatient, short-term rehabilitative services, limited to treatment of conditions that are subject to significant clinical improvement over a continuous 30-day period from the date inpatient therapy commences in a distinct rehabilitation unit of a Hospital, or other facility approved by Us (limited to 120 days per calendar year);
- Inpatient alcohol and substance abuse rehabilitation services in a Hospital, residential treatment facility, or day treatment program; and

- Inpatient mental health services.

Inpatient services to treat mental health conditions are subject to medical Policy and Medical Necessity. Provider visits received during a covered admission are also covered. Benefits are provided for Medically Necessary inpatient care, outpatient care, Partial Hospitalization, and Provider office services for the diagnosis, crisis intervention and treatment of severe mental illness conditions and substance abuse conditions as noted in the Schedule of Benefits. *Inpatient services must be provided by a licensed Hospital, psychiatric Hospital, alcoholism treatment center, or residential treatment center.*

The Member should contact HTH to determine Medical Necessity, appropriate treatment level and appropriate setting. Inpatient services are subject to Prior Authorization notification guidelines to avoid potential penalties related to non-notification of services.

HTH must be notified for all Emergency admissions by the next business day unless the Member is unable to do so.

2) Skilled Nursing Care

Medically Necessary care at a skilled nursing facility for non-Custodial Care is covered (limited to 100 days per calendar year). A skilled nursing facility is a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services, or other related health services that are not custodial or convenience in nature. Skilled nursing care includes Medically Necessary services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse. HTH does not cover skilled nursing care that is not covered by CMS. Prior care in a Hospital is not required before being eligible for coverage for care in a skilled nursing facility.

3) Outpatient Care

Medically Necessary outpatient Hospital or outpatient surgical center care is covered. Services furnished in a Hospital's or outpatient surgical center premises are covered, including use of a bed and periodic monitoring by a Hospital's nursing or other staff that are Medically Necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital. If a Hospital intends to keep a patient in observation status for more than 48 hours, observation status will become an inpatient admission for administration of benefits.

All coverage for the following benefits are dependent upon the coverage described in the Schedule of Benefits for each plan.

Outpatient services include, but are not limited to:

- Services for medical conditions treated in an Acute care Hospital outpatient environment;
- Semi-private room and board (private room when Medically Necessary) if patient is in observation status;
- General nursing care facilities, services, and supplies on an outpatient basis;
- Diagnostic services that are provided in a facility, whether such facility is a Hospital or a freestanding facility;
- Surgical procedures, including the services of a surgeon or Specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care;
- Outpatient, short-term rehabilitative services;

- Outpatient alcohol and substance abuse rehabilitation services in a Hospital, Hospital residential treatment facility, or day treatment program; and
- Outpatient mental health services.

Medically Necessary short-term outpatient habilitative and rehabilitative services are covered for:

- Short-term speech, physical, and occupational habilitative and rehabilitative therapy for Acute conditions that are subject to significant clinical improvement over a 90-day period from the date outpatient therapy commences to maintain function in an individual (see Schedule of Benefits for visit limits); and
- Services for cardiac rehabilitation and pulmonary.

Medically Necessary services such as radiation therapy and chemotherapy (including chemotherapy drugs), are covered to the extent that such services are delivered in the most appropriate clinical manner and setting as part of a treatment plan.

Services that are not covered under this benefit include:

- Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution;
- Private duty nursing and private rooms in an inpatient setting;
- Personal, beautification, or comfort items for use while in a Hospital or skilled nursing facility; and
- Services related to psychosocial rehabilitation or care received as a custodial inpatient.

C. EMERGENCY SERVICES

1) General

Medically Necessary medical and Hospital services are covered in the case of an Emergency. Emergency care is available through In-Network Providers 24 hours per day, seven days per week. If You have an Emergency:

- **Get help as soon as possible**. Call 911 for help or go to the nearest Emergency room, Hospital, or other Emergency facility. Call an ambulance if necessary.
- **Notify HTH about Your Emergency no later than 24 hours, the next business day, or as soon as reasonably possible.**. We need to follow up on Your Emergency care.

Emergency medical and Hospital services are limited to situations that require immediate and unexpected treatment. You should notify Your PCP and Our customer service department as soon as possible following receiving Emergency services.

Notwithstanding anything in this EOC to the contrary, coverage for Emergency services will be provided:

- Without the need for any Prior Authorization;
- Without regard to whether the Provider furnishing the Emergency services is a In-Network Provider with respect to the services;

- If the Emergency services are provided Out-of-Network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency services received from In-Network Providers and at the Cost Sharing level described in the Schedule of Benefits; and
- Without regard to any other terms or condition of such coverage other than exclusion, coordination of benefits or applicable cost-sharing.

2) Medical care and notification.

Out-of-Network Medically Necessary Emergency services are covered only if We are notified no more than 24 hours after onset of the Emergency or the next business day, except as provided in this section.

3) Extended Notification

If You are unable to contact Us before You receive Emergency medical services or within 24 hours of the Emergency due to shock, unconsciousness, or otherwise, You must, at the earliest time reasonably possible, contact HTH Customer Service at (775)982-3232 or (800)336-0123 to provide Us with information about the event and relevant circumstances.

4) Follow-Up Care (outside Our Geographic Service Area/non-contracted facility)

Continuing or follow-up treatment for an Emergency service outside of Our Geographic Service Area or from an Out-of-Network Provider is limited to care required before You can, without harmful or injurious consequences, return to Our Geographic Service Area and receive care from In-Network Providers as determined by Us. Benefits for continuing or follow-up treatment(s) are otherwise covered only in Our Geographic Service Area from In-Network Providers, subject to all provisions of this EOC. *Routine or non-Emergency follow-up care at an Out-of-Network Provider Emergency room facility is not covered*.

5) Emergencies or Urgent Care Outside of the United States

Claims incurred outside the United States for Emergency or Urgent Care and Treatment of a member must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper proof of loss and evidence of payment to the Provider.

D. URGENT CARE SERVICES

1) Medical Care and Notification

Urgent Care is available through In-Network Providers. Please review the Hometown Health Provider Directory for In-Network urgent care centers.

2) Follow-up Care if Temporarily Outside Our Geographic Service Area

Continuing or follow-up care for Urgent Care is limited to care required before You can, without medically harmful or injurious consequences, return to Our Geographic Service Area to receive services from In-Network Providers as determined by Us. Routine follow-up care is not a covered Urgent Care service. You should notify HTH Customer Service at (775)982-3232 or (800)336-0123 upon Your return to Our Geographic Service Area to avoid a denial of Your claim.

3) Limitations

Urgent Care services obtained at a Hospital Emergency facility may cost You more. Please refer to Your Schedule of Benefits.

E. BALANCE BILLING

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact The Centers for Medicare & Medicare Services at 1-800-985-3059 or visit https://www.cms.gov/nosurprises, or The Nevada Department of Insurance - https://doi.nv.gov/Consumers/Health_and_Accident_Insurance/Balance_Billing_FAQs/

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

F. OTHER SERVICES AND SUPPLIES

1) Ambulance Services

Ambulance services are covered if the services are Medically Necessary and they are:

- Provided in an Emergency; or
- Provided in a non-Emergency setting when a Prior –Authorization is received from Us.

A non-contracted Provider of ambulance services or the insured may submit a claim for reimbursement if that Provider does not receive reimbursement from any other source.

Covered Services include Ambulance Services to the nearest appropriate Hospital. Hometown Health will make direct payment to a Provider of Ambulance Services if the Provider does not receive payment from any other source. Ambulance Services will be reviewed on a Retrospective basis to determine Medical Necessity, as defined by:

1) Use of ambulance transportation by homebound individuals for non-medical emergencies. These include:

a. Ambulance trips to the ER for purpose of filling controlled substance prescriptions (non-emergent pain)

b. Ambulance trips to the ER for common cold, sore throat etc.

c. Ambulance trips to the ER for reasons that any medical professional would consider blatant non-emergent utilization.

The Member will be fully liable for the cost of Ambulance Services that are not Medically Necessary.

2) Durable Medical Equipment (DME)

Coverage is provided for the purchase, rental, repair, or maintenance of durable medical equipment prescribed by a Provider for a Medically Necessary condition other than kidney dialysis.

Durable medical equipment is equipment that:

- Can withstand repeated use;
- Is not disposable;
- Is appropriate for use in the home;
- Is not useful in the absence of an illness or Injury;
- Is prescribed by a Physician;
- Meets CMS guidelines for coverage; and
- Is not primarily for convenience or comfort, but serves a medical purpose.

Durable medical equipment includes, but is not limited to:

- Oxygen equipment (all oxygen and oxygen related equipment, except for oxygen while traveling on an airline);
- Wheelchairs;
- Hospital beds;
- Glucose monitors (which may be covered under the pharmacy benefits); and
- Warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea.

Coverage will be based on an amount equal to the generally accepted cost of durable medical equipment that provides the Medically Necessary level of care at the lowest cost. In determining Our liability, We will be guided by nationally established standards of the rental or purchase of such equipment.

Items not covered under this benefit include, but are not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, hearing aids, and any other primarily non-medical equipment, except as otherwise covered and described within this EOC.

Also excluded are exercising equipment, vibratory or negative gravity equipment, swimming or therapy pools, spas, and whirlpools (even if recommended by a Professional to treat a medical condition).

3) Enteral Formulas and Special Food Products

Enteral formulas and special food products are covered if they are Medically Necessary for the treatment of an inherited metabolic disease. An inherited metabolic disease is a disease caused by an inherited abnormality of the body chemistry of a person characterized by congenital defects or defects arising shortly after birth resulting in deficient metabolism, or malabsorption originating from amino acid, organic acid, carbohydrate, or fat. Inherited metabolic diseases do not include obesity. Special food products do not include foods that are naturally low in protein.

Special food products are only covered if they are Medically Necessary and specially formulated to have less than one gram of protein per serving and are consumed under the direction of a Physician for the Medically Necessary dietary treatment of an inherited metabolic disease.

Special formulas, food supplements, or special diets including, but not limited to, total parenteral nutrition, except for Acute episodes, are not covered.

4) Hearing Aids

Coverage is provided for repair and replacement of Medically Necessary hearing aids once every three years for each ear that requires a hearing aid.

HTH does not cover hearing aids that have functionality that is not Medically Necessary such as Bluetooth and GPS technology.

Hearing Aids are only covered if obtained from approved Providers.

5) Home Health Care

Home health care covered under this section includes skilled nursing care, therapies, and other health related services provided in the home environment for other than convenience for patient or patient's family, personal assistance, or maintenance of activities of daily living or housekeeping. Covered home health care services under this part include home health care provided by a Professional as the nature of the illness dictates.

Excluded from coverage as home health care are:

- Personal care, Custodial Care, Domiciliary Care, or homemaker services;
- In-home services provided by certified nurse aides or home health aides;
- Over-the-counter medical equipment, over-the-counter supplies, or any Prescription Drugs, except to the extent that they are covered elsewhere in this EOC.

6) Hospice Services

The following hospice care services are covered for Members with a life expectancy of six (6) months or less as certified by his or her Provider (limited to a lifetime benefit maximum of 185 days):

- Part-time intermittent home health or respite care services totaling fewer than eight (8) hours per day and thirty-five (35) or fewer hours per week.
- Outpatient counseling of the Member and his or her immediate family. Counseling must be provided by a psychiatrist, psychologist, or social worker. Members who are eligible for mental health benefits under their specific Policy should refer to the applicable description of such benefits to determine coverage. Medically Necessary mental health services may be covered under this Policy in addition to the outpatient counseling benefits described above.
- Hospice respite care providing nursing care for a maximum of five (5) inpatient days or five (5) outpatient visits per ninety (90) days of home hospice care.
- Inpatient respite care will be authorized only when We determine that home respite care is not appropriate or practical.

7) Kidney Dialysis Services

Kidney dialysis services and related therapeutic services and supplies, (e.g., epogen) are not covered if a member is covered by Medicare or another federal or state program, other than Medicaid.

8) Lab and Diagnostic Services

Coverage is provided for Medically Necessary laboratory and diagnostic procedures, services, and materials, including:

- Diagnostic x-rays;
- Fluoroscopy;
- Ultrasounds;
- Electrocardiograms;
- Complex imaging and diagnostic services including Computer Tomography (CT, CTA), Positron Emission Tomography (PET), Magnetic Resonance Imaging (MRI, MRA), Nuclear Medicine, Angiograms and Myelograms; and
- Laboratory tests.

Coverage is provided for medically necessary biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidence.

Coverage for breast cancer screening is covered at no cost share to the member. Coverage for diagnostic breast cancer imaging is covered at no cost share to the member, unless the member is enrolled in a high deductible health plan, in which the member must satisfy the minimum deductible of the plan prior to the service being covered at no cost share.

Coverage is also provided for other laboratory and diagnostic screenings as well as Physician services related to interpreting such tests.

9) Telemedicine/Telehealth

Covered telehealth services are provided to facilitate the diagnosis, consultation and treatment, care management and self-management of a patient's physical and or/mental health. You may receive services while at an originating site and the provider for telehealth is at a distant site. Services can be provided through the use of information and audio-visual communication technology or any other method required by applicable law. Telemedicine does not include communication through facsimile or email.

HTH will not prevent the use of Telemedicine in a course of treatment or evaluation. HTH will not prevent the use of Telemedicine based on where the Provider is located.

A Provider who uses Telemedicine to provide services is responsible for ensuring he or she complies with all federal and state laws, including licensure, at the location in which the patient is located. HTH will not pay claims for services provided by Providers who are not licensed in the state where the patient is located.

Your Cost Sharing for services received through the use of Telemedicine are the same as if the service were received in person. However, HTH does not control the methods of treatment and business arrangements between third parties. Therefore, You may have to pay both the originating site and the Provider located at the distant site.

Additionally, it is Your responsibility to ensure the Providers You use are In-Network Providers. Failure to use In-Network Providers will result in a higher cost to You.

10) Gender Affirming Care

Transgender healthcare services cover treatment for gender dysphoria. Treatment includes both hormonal and surgical modalities, and psychotherapy based on medical necessity. Genital reconstruction surgery is covered for recipients who meet eligibility criteria under Nevada and federal laws.

11) Other Items

HTH will not deny a claim, refuse to issue or cancel a Policy of health insurance solely because the claim involves an act that constitutes domestic violence pursuant to NRS 33.018, or because the person applying for or covered by the health insurance Policy was the victim of such an act of domestic violence, regardless of whether the insured or applicant contributed to any loss or Injury.

HTH will not deny a claim, refuse to issue or cancel a Policy of health insurance solely because the claim involves an Injury sustained by an insured as a consequence of being intoxicated or under the influence of a controlled substance or because an insured has made a claim involving an Injury sustained by the insured as a consequence of being intoxicated or under the influence of a controlled substance, except in the case of a felony.

G. CONTINUED COVERAGE FOLLOWING TERMINATION OF A PROVIDER CONTRACT

If a Member is receiving treatment for a medical condition and the treatment is provided by a Provider whose contract with HTH is terminated (except for termination due to medical incompetence or Professional misconduct) during the course of medical treatment, the Member may continue to obtain that medical treatment from the Provider if:

- The treatment is a Medically Necessary Covered Service;
- The Provider and Member agree that the continuity of care is desirable;
- The Provider agrees to all prior terms of the contract between Hometown Health and the Provider; and
- The Provider agrees not to seek additional payment from the Member for any medical service provide by the Provider that the Provider could not have received from the Member were the Provider still under contract with HTH.

Such coverage will continue until the 120th day after the date the contract between the Provider and HTH is terminated or, if the medical condition is pregnancy, the 90th day after the end of the pregnancy. Such coverage will not continue if the treatment is no longer Medically Necessary. Such coverage will not continue beyond the termination date of this Benefit Plan.

H. COVERED SERVICES UNDER THE PHARMACY BENEFIT

Hometown HealthDrug Formulary – The Hometown Health Drug Formulary for this Benefit Plan has been selected to provide all of the therapeutic categories and classes of medications and the choice of medications within those classes to meet the Essential Health Benefits formulary requirements for the State of Nevada. This Drug Formulary may be substantially different from other Hometown Health formularies and may have different requirements for Prior Authorization and Step Therapy. If an exemption to step therapy is determined, an updated copy of the step therapy exemption form is available at HTH Step Therapy Exemption Form 2023 (optumrx.com). There is no coverage for medications that are not listed on this Drug Formulary. The costs of those medications will not be counted toward Your In-Network or Out-of-Network Deductible and Out-of-Pocket Maximum Costs.

The Hometown Health Pharmacy and Therapeutics Committee develops the Drug Formulary and is comprised of physicians and pharmacists with various medical specialties. The Committee reviews medications in all therapeutic categories and selects the agent(s) in each class that meet its criteria for safety, effectiveness, and cost. The Committee meets at least twice a year to review new and existing medications to ensure that the Drug Formulary remains responsive to the needs of Members and Providers. A copy of the Drug Formulary is available online at hometownhealth.com. Inclusion of a drug in the Drug Formulary does not guarantee that a Provider will prescribe that drug for a particular medical condition.

Nevada State law permits removal or tier movement of Prescription Drugs on January 1st (with some exceptions). If We remove a drug from the Drug Formulary We will continue to cover that drug if:

- We had previously approved Your utilization of that drug;
- Your Provider determines, after conducting a reasonable investigation, that none of the drugs which are currently approved for coverage are medically appropriate; and
- The drug is appropriately prescribed; and
- The drug is considered by the FDA to be safe and effective for treating Your medical condition.

Coverage is available for Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, Specialty Pharmaceuticals, and Diabetic Supplies. Specific benefit levels are detailed in the Schedule of Benefits that describes Your plan benefits.

Prior Authorization – For certain outpatient Prescription Drugs, a prescribing Physician must contact Hometown Health to request and obtain coverage for such drugs. Hometown Health will respond to the Physician once a decision has been made. An updated copy of the list of Prescription Drugs requiring Prior Authorization is available at hometownhealth.com.

If Prior Authorization is not obtained when necessary, the Member must pay the In-Network Retail Pharmacy in full for the cost of the Prescription Drug. To be eligible for reimbursement, the Member is responsible for submitting a request for reimbursement in writing to HTH. The request must include a copy of the receipt for the cost of the Prescription Drug and documentation from the prescribing Physician that the Prescription Drug is Medically Necessary. If the claim is approved, HTH will directly reimburse the Member the cost of HTH's contracted rate for the Prescription Drug, less the applicable Cost Sharing specified in Your Schedule of Benefits.

Member Responsibility – Benefits are provided for outpatient Prescription Drugs that meet the requirements specified in this EOC. Members are responsible for paying their Deductible, Copayments, Coinsurance and Ancillary Charge to the pharmacy at the time their prescriptions are filled. For Prescription Drug products covered under a Copayment benefit, the Member is responsible for paying the lesser of the Copayment or the actual retail price of the Prescription Drug product.

HTH is not responsible for the cost of any Prescription Drug for which the actual charge to the Member is less than the required Copayment or payment that applies to the Deductible or for any drug for which no charge is made to the Member. HTH retains the right to review all requests for reimbursement and, at its sole discretion make reimbursement determinations subject to the grievance procedure section of the certificate.

Members are required to present their HTH membership card when filling prescriptions at a pharmacy. A Member who fails to present the HTH ID card may not be entitled to direct reimbursement from HTH, and the Member may be responsible for the entire cost of the prescription. If a Member does not use this Policy (does not use their insurance card) to purchase a Prescription Drug and then requests reimbursement for the purchase of the Prescription Drug in a non-Emergency, non-Urgent Care situation, HTH will only reimburse the Member the amount that HTH would have paid if the Prescription Drug was purchased using the Policy. Because HTH has access to contract discounts, the amount that HTH pays could be considerably less than the amount the Member can get without using this Policy, resulting in a much higher cost to the Member compared to if the Member used this Policy to purchase the drug.

Amounts paid by a drug manufacturer which offer copayment offset programs (also called copay savings cards or coupons) do not count toward meeting the calendar year Deductible or Out-of-Pocket Maximum. You may continue to use these copay cards/coupons to help reduce Your out-of-pocket costs, however, the dollar value of the card/coupon does not apply toward Your Deductible or Out-of-Pocket Maximum under Your plan since You don't pay that amount. Only the dollars You actually pay out of pocket will count toward Your annual Deductible or out-of-pocket totals.

In-Network Pharmacies –Non-Emergency and non-Urgent Care prescriptions will be covered only when filled at an In-Network Retail Pharmacy or the In-Network Mail Order Pharmacy.

Out-of-Network Pharmacies – Out-of-Network Pharmacies may require payment in full for prescriptions, however reimbursements may be available if the use of an out-of-network pharmacy was due to an emergency or urgent care situation. Members may file a claim for reimbursement from HTH provided the claim is received by HTH within 120 days from the date the prescription was filled. Claim forms are available upon request from HTH. Charges in excess of the Maximum Allowed Amount for Prescription Drug products received from an Out-of-Network Pharmacy are the Member's responsibility.

1) **90-Day Supplies**

   Original and refill prescriptions are limited to a 90-day supply at a In-Network Retail Pharmacy unless otherwise limited by HTH or the drug manufacturer. A 30-day filled prescription is required prior to a 90-day filled prescription. Most medications to treat Chronic conditions are prescribed in 30 or 90-day supplies. You may request to receive Your prescriptions in smaller supplies.

2) **Less than a 30-Day Supply**

   If Your prescriber or pharmacist determines that filling or refilling a prescription for less than a 30-day supply of a Chronic medication is in Your best interest and You request less than a 30-day supply, such prescription will be covered at the standard Cost Sharing for a 30-day supply of that drug. This requirement does not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

3) **Mail Order**

   Some covered Prescription Drug products are available through an In-Network Mail Order Pharmacy and will be mailed to Your home. Mail order prescriptions are limited to a 90-day supply unless otherwise limited by HTH, the drug manufacturer or the FDA. A 30-day filled prescription is required prior to a 90-day filled prescription. You may be required to fill the prescription at a In-Network Retail Pharmacy before utilizing the mail order service.

   The Copayment for a 90-day supply of a Prescription Drug filled through a In-Network Mail Order Pharmacy is two times the Copayment of a 30-day supply.

4) **Maintenance Medications**

   After a Member receives (3) fills of a particular Maintenance Medication, not to exceed a 90-day supply at a retail pharmacy, all future prescription refills for that medication ***must be obtained*** through HTH's In-Network mail-service pharmacy. Your Plan allows for three (3) retail fills, not to exceed a 90-day supply at a retail pharmacy, to ensure that You can tolerate the medication with no side effects that would cause You to stop taking or change the medication. All future refills at a retail pharmacy will be denied and You ***must*** obtain Your medication through the In-Network mail-service pharmacy, unless HTH approves an exception this requirement.

5) **Specialty Pharmaceuticals**

   Many Specialty Pharmaceuticals are biotech medications, using DNA recombinant technology (genetic replication) as opposed to chemical processes. Specialty Pharmaceuticals may be delivered in any setting and may include Injectable Drugs or medications given by other routes of administration, or oral medications.

Most Specialty Pharmaceuticals must be obtained through a specific specialty pharmacy designated by HTH and are limited to a 30-day supply per script. A list of drugs classified as Specialty Pharmaceuticals is subject to change at the sole discretion of HTH.

6) Preventive Medications

There will be no cost to the Member for preventive medications prescribed by a Physician and purchased at an In-Network Retail Pharmacy or In-Network Mail Order Pharmacy. To be eligible for no Member Cost Sharing, the medication must be prescribed in accordance with Recommendations A or B issued by the U.S. Preventive Services Task Force. A list of preventive medications can be found at hometownhealth.com.

7) Contraceptive Products

FDA approved contraceptive products for women are covered as required by law. The Member must submit a request for reimbursement in writing to HTH. The request must include a copy of the receipt for the cost of the product. The following contraceptive products are covered under this Prescription Drug benefit and are covered as a preventive benefit with no Member Cost Sharing if it is included in the Prescription Drug Formulary[2]:

- Combined estrogen and progestin-based drugs (oral contraceptives);
- Progestin-based drugs (oral contraceptives);
- Extended or continuous regimen drugs;
- Vaginal contraceptive rings;
- Diaphragms with spermicide: One per 365 consecutive day period;
- Sponges with spermicide;
- Cervical caps with spermicide;
- Female condoms;
- Spermicide;
- Combined estrogen and progestin-based drugs for Emergency contraception or progestin-based drugs for Emergency contraception; and

Ulipristal acetate for Emergency contraception;The In-Network Physician will provide insertion and removal of the device. An Office Visit Copayment or Coinsurance may apply if services during that visit are for more than the contraceptive visit. There will be no Copayment or Coinsurance for the contraceptive devices as noted above if dispensed or inserted by an In-Network Provider. A pharmacist may dispense a self-administered hormonal contraceptive to a patient, regardless of whether the patient has obtained a prescription from a practitioner, and must provide a risk assessment questionnaire to a member that requests a self-administered hormonal contraceptive. Additional benefits also include education and counseling relating to the initiation of use of contraception and any necessary follow-up after initiating such use, including management side effects relating to contraception.

HTH will not limit refills for any of the above listed services to less than 12 months for contraceptive purposes. Formulary Generic Drug and Brand Drug oral contraceptives that do not have a generic equivalent (single source brand) will have no Copayment for the Member. If the Member purchases

[2] Assembly Bill 249 (2017) Section 7 & 11

Brand Drug oral contraceptives that have a generic equivalent (multi-source brand) the Member will be required to pay the difference between the Brand Drug and the Generic Drug, as is the case with other multi-source Brand Drugs. Non-Formulary Drug Copayments will be applied to Non-Formulary Drug contraceptives. Brand Drug or Non-Formulary Drug contraceptives may be covered with no Cost Sharing for Members who receive a Prior Authorization. To receive the Prior Authorization, the Provider must demonstrate to HTH why the lower cost alternative is not appropriate and that the prescribed Drug is Medically Necessary.

8) Diabetic Supplies

Diabetic supplies include insulin, insulin syringes with needles, pen needles glucose blood-testing strips, ketone testing strips, lancets and lancet devices. Diabetic supplies are covered if Medically Necessary upon prescription or upon Physician's order only at a In-Network Retail Pharmacies or In-Network Mail Order Pharmacies. The Member must pay applicable Deductible, Copayments and Coinsurance. Original and refill prescriptions are limited to a 90-day supply at In-Network Retail Pharmacies unless otherwise limited by HTH or the drug manufacturer. A 30-day filled prescription is required prior to a 90-day filled prescription.

9) Hormone Replacement Therapy

Hormone Replacement Therapy (HRT) Prescription Drugs are covered if approved by the FDA or required by state or federal law and lawfully prescribed or ordered by a Physician when Medically Necessary. Certain Prescription Drugs require Prior Authorization.

10) Topical Ophthalmic Products

Early refills of topical ophthalmic products due to inadvertent wastage, shall be completed on a refill basis with a valid prescription and authorization, except as otherwise provided in the Drug Formulary or through the mail order or online Prescription Drug program.

11) Cancer Treatment

Drugs covered under the Drug Formulary for use in the treatment of an illness, disease or other medical condition will also be covered for the treatment of cancer when Medically Necessary and approved by the FDA or when required by state and federal law. Experimental drugs not approved by the FDA nor required by state and federal law, and used in the treatment of cancer are not covered. Prescription drugs used for the treatment of cancer require Prior Authorization from HTH.

Orally Administered Chemotherapy will be paid consistently with classification of the Prescription Drugs as Formulary Generic, Formulary Brand, Formulary Brand with a Formulary Generic alternative, or Non-Formulary Generic or Brand without a Formulary alternative. Except for Members on a High Deductible Health Plan and for Members who select a Non-Formulary drug with a Formulary alternative, the cost to the Member for Orally Administered Chemotherapy will not exceed $100 per prescription.

12) Sickle Cell Disease and Its Variants

Medically Necessary Prescription Drugs for the treatment of Sickle Cell Disease and its Variants to the extent required by law.

I. COVERED SERVICES UNDER THE PEDIATRIC VISION BENEFIT

Eligibility for this benefit is limited to children between the age of 0 and 19 years and ends the first of the month after a Member achieves his 19th birthday. There is no coverage for any Member outside that age range.

These benefits meet the requirements for the pediatric vision Essential Health Benefits for the State of Nevada.

The benefits available under the Pediatric Vision Plan include an eye exam each calendar year at no cost to the Member. The plan also covers one set of lenses each calendar year and one set of frames from a formulary selection of pediatric frames each calendar year:

1. For members not enrolled in an HDHP, at no cost to the Member; or
2. For members enrolled in an HDHP, subject to the combined Deductible, as provided in the Schedule of Benefits, and then at no additional cost.

In lieu of eyeglasses, a contact lenses eye exam is covered once per calendar year with a choice by the Member of:

1. Standard (one pair annually) = 1 contact lens per eye (total 2 lenses)
2. Monthly (six-month supply) = 6 lenses per eye (total 12 lenses);
3. Bi-weekly (3 month supply) = 6 lenses per eye (total 12 lenses); or
4. Dailies (one month supply) = 30 lenses per eye (total 60 lenses).

Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction.

IV. EXCLUSIONS AND LIMITATIONS

This Policy does not cover certain services. This chapter lists the general medical, pharmacy and pediatric vision benefit exclusions of this Policy. Benefits listed as excluded will not be covered by HTH unless they are explicitly listed as covered elsewhere in the EOC or are otherwise explicitly covered through a separately purchased benefit rider. Any amount You pay toward services that are not covered or otherwise excluded will not count toward Your Deductible and Out-of-Pocket Maximum. Additional exclusions that apply to only a particular service or benefit are listed in the description of that service or benefit in the EOC and Schedule of Benefits.

A. MEDICAL AND GENERAL EXCLUSIONS

The following services and benefits are excluded from medical coverage under this Benefit Plan. They may be covered under the pharmacy or pediatric vision benefits that may be included in this Benefit Plan if explicitly indicated that the benefit is covered.

Additional exclusions that apply to only a particular service or benefit are listed in the description of that service or benefit.

1. Services which are not Medically Necessary or are not required in accordance with accepted standards of medical practice or applicable law are excluded.
2. Complications resulting from procedures, services, medical treatments or medications that are not covered by this Benefit Plan are excluded.
3. Treatment for any injury or illness related to employment is excluded.
4. Charges for care or services provided before the effective date or after the termination date of coverage are excluded.
5. Charges for copies, presentation and preparation of Your records, charts or x-rays, completion of insurance forms, creation of medical or dental reports and costs to forward or mail any such copies, forms, reports, records, charts, or x-rays are excluded.
6. Any loss, expenses, or charges for claims incurred for the care of a Member when that loss, expense or charge was a result of that Member's action for which that Member is convicted of a felony are excluded. This exclusion is not intended to limit coverage for victims of a crime, including victims of domestic violence.
7. Treatment of an illness or injury which is caused by: (a) an act of war (declared or undeclared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy; (c) Your participation in the military service of any country; (d) Your participation in an insurrection, rebellion, or riot; (e) services received as a direct result of Your commission of, or attempt to commit a felony (upon a guilty plea or guilty verdict) or as a direct result of Your engagement in an illegal occupation.
8. Testing and treatment for, non-medical ancillary services such as vocational rehabilitation, work-hardening programs, job related training requirements and employment training and counseling, including services rendered by or billed by a school or Member of its staff are excluded.
9. Services related to job, vocational retraining, or community re-entry are excluded.

10. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement, or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if You do not claim those benefits.
11. Care for military service-connected disabilities and conditions for which You are legally eligible to receive from governmental agencies and for which facilities are reasonably accessible to You are excluded.
12. Care for conditions that federal, state, or local law requires be treated in a public facility, care provided under federally or state funded health care programs (except the Medicaid program), care required by a public entity and care for which there would not normally be a charge are excluded.
13. Routine examinations, care or treatment primarily for insurance, immigration, travel, licensing, school sports, adoption and employment purposes and other third-party physicals are excluded.
14. Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or Partial Hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless We determine that such services are independently Medically Necessary.
15. Termination of pregnancy is excluded, except in the case of rape, incest, or for a pregnancy which, as certified by a doctor, places the women in grave danger.
16. Any services received outside the United States are excluded except services relating to Emergency.
17. Air ambulance services that originate or end outside the United States are excluded.
18. Any Urgent Care services that are received Out-of-Network are excluded.
19. Travel expenses, accommodations and travel insurance are not covered. Oxygen provided while traveling on an airline and oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.
20. Costs related to room and board for family members are excluded.
21. Costs related to room and board for the Member are excluded except if the cost is charged by the Hospital as part of a Medically Necessary inpatient Hospital admission and the expenses are incurred between the time of admission and the time of discharge.
22. Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution or facility are excluded.
23. Cosmetic surgery or procedures are excluded. Cosmetic surgery generally includes any plastic or reconstructive surgery or procedure done to improve the appearance of any portion of the body or restore bodily form without materially correcting a bodily malfunction.

    Excluded cosmetic surgery or procedures include:

    a. Surgery or treatment to remove sagging or extra skin; any augmentation or reduction procedures; electrolysis; liposuction; liposculpting; body contouring or recontouring to remove excess skin on any part of the body including but not limited to: tummy tucks, belt lipectomies, breast reductions, enhancements or lifts are excluded;

    b. Laser treatments, rhinoplasty and associated surgery, epikeratophakia surgery, kerato-refractive eye surgery including but not limited to implants for correction of presbyopia, correction of facial or breast asymmetry (except that breast asymmetry will be provided pursuant to coverage as provided in this EOC for mastectomy benefits), treatment of male-pattern baldness,

electrolysis, waxing or other methods of hair removal, or hair treatment, keloid scar therapy, any procedures utilizing an implant that cannot be expected to substantially alter physiologic functions are excluded;

c. Treatment or service related complications, insertion, removal or revision of breast implants unless provided post mastectomy are excluded;

d. Implants that do not improve physical function are excluded;

e. Psychological and physical factors including but not limited to self-image, difficult social or peer relations, embarrassment in social situations, inability to exercise or participate in recreational activities comfortably, or impact on ability to perform one's job duties are excluded;

f. Complications resulting from excluded cosmetic surgery are excluded; and

g. Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function are excluded.

h. Cosmetic procedures to reduce the appearance of varicose veins are excluded.

24. Cosmetics are excluded.

25. Treatment for the removal, ablation, injection, or destruction of varicose veins is excluded unless deemed Medically Necessary.

26. The removal of port-wine stains is excluded.

27. Charges that result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by Us and present significant symptomatic medical problems) or any treatment of obesity, unless otherwise provided in the EOC are excluded.

28. Dietary supplements, anti-aging treatments (even if FDA-Approved for other clinical indications), vitamins, diet pills, health or beauty aids, vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post-surgery care or other b- complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (except as otherwise covered and described within the EOC and Schedule of Benefits) are excluded.

29. Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or chiropractor's office, or at a retail location are excluded unless otherwise specified in this EOC and Your Schedule of Benefits.

30. Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, Bio-Energetic Synchronization Technique (B.E.S.T.), colonic irrigation, magnetic innervation therapy and electromagnetic therapy are excluded.

31. Charges related to the acquisition or use of marijuana are excluded, even if used for medicinal purposes.

32. Except as otherwise provided in the EOC, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity, or to alter the shape or appearance of a sex organ, or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment are excluded.

33. Any off-label use of growth hormone is excluded;

34. Coverage for human growth hormone or equivalent is excluded unless specifically covered and described within the EOC.

35. Cryopreservation or storage charges for collection and storage of biologic materials, including umbilical cord blood, for artificial reproduction or any other purpose are excluded.
36. Platelet rich plasma and stem cell related musculoskeletal injections are excluded.
37. All experimental or investigational medical, surgical, or other health care procedures and all transplants are excluded except as otherwise described within the EOC. We will consider a procedure or treatment as experimental or investigational as follows:
    a. If outcome data from randomized controlled clinical trials, recommendations from consensus panels, national medical associations, or other technology evaluation bodies and from authoritative, peer-reviewed US medical or scientific literature:
        i. Is insufficient to show that the procedure or treatment is safe, effective, or superior to existing therapy; or
        ii. Does not conclusively demonstrate that the service or therapy improves the net health outcomes for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even in the event that the service, drug, biological, or treatment may be recognized as a treatment or service for another condition, screening, or illness;
    b. If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institutes of Health, the Food and Drug Administration, or Medicare;
    c. When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration or any other state or federal regulatory agency, and such final approval has not been granted for that particular indication, condition, or disease;
    d. When a nationally recognized medical society states in writing that the procedure or treatment is experimental; or
    e. When the written protocols used by a facility performing the procedure or treatment state that it is experimental.
    f. HTH has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

    Refer to the Clinical Trials section (Chapter III – Schedule of Benefits) of this EOC for more information.
38. Experimental, ecological, or environmental medicine is excluded, including, but not limited to the use of chelation or chelation therapy except for Acute arsenic, gold, mercury, or lead poisoning; orthomolecular substances; use of substance of animal, vegetable, chemical or mineral origin not FDA-Approved as effective for such treatment; electrodiagnosis; Hahnemannian dilution and succession; prolotherapy, magnetically energized geometric patterns, replacement of metal dental fillings, laetrile, and gerovital.
39. Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft), ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery) and surgical correction of near or

far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in this EOC and Your Schedule of Benefits.

40. Orthotic braces that straighten or change the shape of a body part are excluded.
41. Cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome.
42. Orthopedic shoes, foot orthotics or other supportive devices of the feet are excluded, except when such devices are:
    a. An integral part of a covered leg brace and its Expense is included as part of the cost of the brace:
    b. For diabetes mellitus and for foot deformity, history of pre-ulcerative calluses, history of previous ulceration, peripheral neuropathy with evidence of callus formation, poor circulation or previous amputation of the foot or part of the foot:
    c. For rehabilitation prescribed as part of post-surgical or post-traumatic casting care; or
    d. Prosthetic shoes for members with a partial foot.
43. Over-the-counter support hose or compression socks are excluded even if ordered by a Physician. Custom hose that must be measured and made specifically for the patient will be covered only for the treatment of burns or lymphedema.
44. Modifications to vehicles, the purchase of medical vehicles or ambulances and the purchase of vehicles with or without lifts or other modifications are excluded.
45. Physician services, supplies, and equipment relating to the administration or monitoring of a Prescription Drug are excluded unless the Prescription Drug is a Covered Service.
46. Barrier-free and other home modifications are excluded.
47. All gym membership fees and/or fees for services received at a gym are excluded, including:
    a. Gym memberships for You and Your child and/or adult dependents;
    b. Services provided by personal trainers or exercise physiologists are excluded even if recommended to treat a medical condition.
48. Membership fees charged by Providers as a condition of treatment, for example, concierge medicine, are excluded.
49. Care or treatment of marital or family problems, occupational, religious, or other social maladjustments, situational reactions, and hypnotherapy is excluded.
50. Religious or spiritual counseling is excluded.
51. Stress reduction therapy or cognitive behavior therapy for sleep disorders is excluded.
52. Charges for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.
53. Sleep therapy (except for central or obstructive apnea when Medically Necessary with a Prior Authorization), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electrosleep therapy, electronarcosis, massage therapy, and gene therapy are excluded.

54. Treatment of developmental disability or down Syndrome that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency is excluded.
55. HTH does not cover treatments or services that are a primary responsibility of a school or school district.
56. Services designed to treat infertility conditions

    The following services are not covered:

    a. Costs related to the actual insemination of a non-covered person, are not covered under the terms of this Benefit Plan.

    b. All other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit are excluded. This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy;

    c. The promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above), serial ultrasounds, services to reverse voluntary surgically-induced infertility, reversal of surgical sterilization, any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization, the cost of donor sperm or eggs, in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; sperm donor for profit or prescription (infertility) drugs, or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are excluded; and

    d. In the case of a surrogate, any services related to determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the Member's ability to become pregnant are excluded; and

    e. Services or supplies provided to a person not covered under the certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). When a member acts as a gestational carrier or surrogate, the maternity coverage of the member is not affected but the newborn child is not eligible for coverage under this plan except as required by applicable law..

B. DRUGS (MEDICAL & PHARMACY) BENEFIT EXCLUSIONS

Medically Necessary Prescription Drugs are only covered as set forth in this EOC. The following services and benefits are excluded from coverage under this Policy.

1. Drugs not Medically Necessary or not required in accordance with accepted standards of medical practice or applicable law are excluded.
2. Drugs to treat complications resulting from procedures, services, medical treatments or medications that are not covered by this Benefit Plan are excluded.
3. Any charges for the administration or injection of Prescription Drugs or Injectable insulin and other Injectable Drugs covered by HTH are excluded.
4. Any refill or administration of a drug in excess of the amount specified by the prescription order is excluded. For Prescription Drugs provided as a 30 day supply, any refill provided prior to 22 days after the previous fill is excluded unless the Member receives Prior Authorization. Before recognizing charges, Hometown Health may require a new prescription or evidence as to need if a prescription or refill or administration of a drug appears excessive under accepted medical practice standards.
5. Compounded medications except for compounded medications for palliative care with Prior Authorization are excluded.

6. Cosmetics or any drugs used for cosmetic purposes or to promote hair growth even for documented medical conditions, including but not limited to health and beauty aids are excluded.
7. Dietary or nutritional products or appetite suppressants or other weight-loss medications (such as appetite suppressants, including the treatment of obesity) whether prescription or over-the-counter are excluded.
8. Vitamins are excluded except those prescribed prenatal vitamins and vitamins with fluoride that require a prescription and are listed on the Drug Formulary.
9. Drugs dispensed by other than a In-Network Retail Pharmacy, In-Network Mail Order Pharmacy,or In-Network Specialty Pharmacy are excluded except as Medically Necessary for treatment of an Emergency or Urgent Care condition.
10. Drugs listed on the Formulary Exclusions List (available in the applicable HometownRxFormulary), designated as Non-Formulary, not included on the Formulary, or included in the Medical Prior Authorization Matrix Exclusions List are excluded.
11. Drugs prescribed by a Provider not acting within the scope of his or her license are excluded.
12. Drugs listed by the FDA as "less than effective" (DESI drugs) are excluded.
13. Experimental and investigational drugs, including drugs labeled "Caution-limited by Federal Lawto Investigation use" are excluded.
14. Drugs either not approved by the FDA as "safe and effective" as of the date this Benefit Plan wasissued or, if so approved, that the FDA has not approved for either inpatient or outpatient use are excluded.
15. Drugs prescribed for a use, condition or diagnosis that was not included in the FDA's approval ofthe drug (off-label prescribed drugs) are excluded.
16. Fertility drugs, drugs for gene therapy, laxatives unless otherwise provided herein or pursuant to the EOC and nutritional additives or any prescription medication or formulation with nutritional or vitamin additives are excluded
17. Growth hormone drugs for persons 18 years or older are excluded. Growth hormone therapy for the treatment of documented growth hormone deficiency in children for whom epiphyseal closure has not occurred is covered when a Prior Authorization is received and the drugs are supplied by HTH's preferred vendor for the medication.
18. Immunization or immunological agents, including but not limited to biological sera, blood, bloodplasma or other blood products administered on an outpatient basis, antihemophilic factors, including tissue plasminogen activator (TPA), allergy sera and testing materials, unless otherwise provided herein or pursuant to the EOC are excluded.
19. Medical supplies, devices and equipment and nonmedical supplies or substances are excluded regardless of their intended use.
20. Medications approved by the FDA for less than six months are excluded unless the HTH Pharmacy and Therapeutics Committee, at its sole discretion, decides to waive this exclusion with respect to a particular drug.
21. Medications for impotence or erectile/sexual dysfunction are excluded.
22. Medication consumed or administered at the place where it is dispensed or while a Member is in a Hospital or similar facility are excluded. Take-home prescriptions dispensed from a Hospital pharmacy upon discharge are excluded unless the pharmacy is an In-Network Retail Pharmacy.

23. Over-the-counter drugs, medicines and other substances for which a prescription order is not required regardless of whether the drug was prescribed by a Physician, or for which an over-the-counter product equivalent in strength is available are excluded, unless the drug is required to be covered by law.
24. Drugs consumed in a Physician's office other than immunizations, allergy serum, and chemotherapy drugs are excluded except as otherwise provided in this EOC.
25. Performance, athletic performance or lifestyle enhancement drugs and supplies are excluded.
26. Prescription drugs purchased from outside of the United States are excluded except from Canadian pharmacies licensed by the Nevada State Board of Pharmacy. A list of licensed Canadian pharmacies can be found on the Nevada State Board of Pharmacy website: www.bop.nv.gov.
27. Prescription medications that are available without charge under local, state or federal programs, including worker's compensation or occupational disease laws, or medication for which a charge is not made are excluded.
28. Prescription refills dispensed more than one year from the date the latest prescription order was written or as otherwise permitted by applicable law of the jurisdiction in which the drug was dispensed are excluded.
29. Prophylactic drugs and immunizations for travel are excluded.
30. Quantities in excess of a 90-day supply are excluded. Prescriptions requiring quantities in excess of the above amount, including early refills of ophthalmic products due to inadvertent wastage, shall be completed on a refill basis with a valid prescription and authorization, except as otherwise provided in the Drug Formulary or through the mail order or online Prescription Drug program.
31. Replacement of lost, stolen, spoiled, expired, spilled or otherwise mishandled medication is excluded.
32. Prescription orders filled or Drug orders filled or administered before the effective date or after the termination date of the coverage provided by this Benefit Plan are excluded.
33. Test agents and devices are excluded, except for diabetic test agents.

Additional Pharmacy Limitations –

1. An In-Network Retail Pharmacy may refuse to fill a prescription order or refill when in the Professional judgment of the pharmacist the prescription should not be filled.
2. Non-Emergency and non-Urgent Care prescriptions will be covered only when filled at an In-Network Retail Pharmacy.
3. After a Member has had three (3) fills of a particular Maintenance Medication, not to exceed a 90-day supply at a retail pharmacy, all future prescription refills for that medication ***must be obtained*** through HTH's In-Network mail-service pharmacy. Your Plan allows for three (3) retail fills, not to exceed a 90-day supply at a retail pharmacy, to ensure that You can tolerate the medication with no side effects that would cause You to stop taking or change the medication. All future refills at a retail pharmacy will denied and You ***must*** obtain Your medication through the In-Network mail-service pharmacy, unless HTH approves an exception this requirement.
4. Members are required to present their ID cards at the time the prescription is filled. A Member who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from HTH, and the Member will be responsible for the entire cost of the prescription.
5. If a Member does not use this Policy (does not use their insurance card) to purchase a Prescription Drug and then requests reimbursement for the purchase of the Prescription Drug in a non-Emergency, non-Urgent Care situation, HTH will only reimburse the Member the amount that HTH would have paid if

the Prescription Drug were purchased using the Policy. Because HTH has access to contract discounts, the amount that HTH pays could be considerably less than the amount the Member can get without using this Policy, resulting in a much higher cost to the Member compared to if the Member used this Policy to purchase the drug.

6. HTH retains the right to review all requests for reimbursement and, at its sole discretion make reimbursement determinations subject to the grievance procedure section of the certificate.
7. HTH is not responsible for the cost of any Prescription Drug for which the actual charge to the Member is less than the required Copayment or payment that applies to the Prescription Drug Deductible amount or for any drug for which no charge is made to the recipient.
8. The contracted reimbursement rate for In-Network pharmacies does not include amounts that HTH may receive under a rebate programs offered at the sole discretion of individual pharmaceutical manufacturers.

C. PEDIATRIC VISION PLAN EXCLUSIONS

The following services and benefits are excluded from pediatric vision coverage under this Benefit Plan. They may be covered under the medical or pharmacy benefits that may be included in this Benefit Plan if explicitly indicated that the benefit is covered.

1. Two pairs of glasses instead of Bifocals are excluded.
2. Replacements of lenses, frames, or contacts are excluded.
3. Surgical or Medical Treatment is excluded.
4. Orthoptics, vision training and supplemental testing are excluded.
5. Contact lens insurance policies or service agreements are excluded.
6. Artistically painted or non-prescription lenses are excluded.
7. Additional Office Visits for contact lens pathology are excluded.
8. Contact lens modification, polishing or cleaning are excluded.

D. OVERALL LIMITATIONS

If the provision of Covered Services provided under this Policy is delayed or rendered impractical due to circumstances not within Our control, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Our Providers' personnel, or similar causes, We will make a good faith effort to arrange for an alternative method of providing coverage. In such event, We and Our Providers will render the Covered Services provided under this Policy insofar as practical and according to their best judgment; but We and Our Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

V. UTILIZATION MANAGEMENT PROGRAM

The utilization management program uses set criteria and protocols to ensure that the most cost- effective preventive, Acute, and Tertiary Care is provided to Our Members consistent with the provision of quality care. You may be subject to a reduction in benefits if You do not comply with this utilization management program. Our utilization management program is conducted with Our written policies and procedures under the direction of Our Medical Director.

A. Delivery of Services

You are entitled to receive Medically Necessary medical care and services as specified in Your Schedule of Benefits and this EOC. These include medical, surgical, diagnostic, therapeutic, and preventive services. . These services generally:

1. Are provided in Our Geographic Service Area;
2. Are performed or ordered by an In-Network Provider; and
3. Require a Prior Authorization according to Our utilization management and quality assurance protocols, if applicable. *If a Prior Authorization is required and You do not obtain the required Prior Authorization, You may be subject to a reduction in benefits or the service may not be covered, even if the service is Medically Necessary*.

A determination that a service is Medically Necessary is not an authorization to receive that service from an Out-of-Network Provider.

HMO

- *As a Member of HTH, Your **HMO** plan has a Network of healthcare providers available to You. If the health care services are not available within the Network, then Your Provider must contact Our Utilization Management department to request a review for an Out-of-Network Provider. Our determination will be sent to You and Your Provider and will specify the approved procedure and servicing Provider.*

EPO

- *As a Member of HTH, Your **EPO** plan has a Network of healthcare providers available to You. If the health care services are not available within the Network, then Your Provider must contact Our Utilization Management department to request a review for an Out-of-Network Provider. Our determination will be sent to You and Your Provider and will specify the approved procedure and servicing Provider.*

PPO

- *As a Member of HTH, Your plan has a Network of healthcare providers available to You. Under Your **PPO** plan, You have the flexibility to utilize providers that are not a part of Our Network. When You choose to see an Out-of-Network Provider, You may have to pay the higher, Out-of-Network Cost Sharing amount and You may be subject to balance billing. For additional information refer to the Schedule of Benefits for your plan.*

If the health care services are not available within the Network, then Your Provider should contact Our Utilization Management department to request a review. Our determination will be sent to You and Your Provider and will specify the approved procedure and servicing Provider.

B. Scope of the Program

Under the utilization management program, a Prior Authorization is required for referrals to Physicians and Providers for certain services. All benefits listed in this EOC may be subject to Prior Authorization requirements and concurrent review depending upon the circumstances associated with the services. Refer to Your Schedule of Benefits for services that require Prior Authorization. You may find a full list of services that require Prior Authorization at hometownhealth.com.

We should be notified upon confirmation of pregnancy so We may better manage Your benefits.

You must comply and cooperate with the utilization management program. Services that require Prior Authorization are subject to all of the terms of Your specific Policy.

C. Approval and Prior Authorization Process

In certain cases, as set forth below, in order for a benefit to be covered, You must receive a Prior Authorization for the service. We use nationally recognized criteria and internal medical Policy guidelines, as reviewed periodically by Our Utilization Management and Quality Improvement Committee, as the standard measurement tool to determine whether benefits are approved and/or authorized. Prior Authorization is provided within 14 days for most service requests.

1) Hospital Admissions

You are responsible for notifying Us of a Hospital stay, and You receive Prior Authorization, before elective admission to a Hospital to ensure that it is covered. Your Physician or other Provider may notify Us but it is ultimately Your responsibility to make sure We are notified. We will review the Provider's recommendation to determine level of care and place of service. If We deny authorization for Hospital admission as not covered or We determine that the services do not meet Our criteria and protocols, We will not pay the Hospital or related charges.

2) Inpatient and Outpatient Surgery

You are responsible for making sure We are notified, and You receive Prior Authorization, before elective inpatient or outpatient surgery is performed to ensure that it is covered. Your Physician or other Provider may notify Us but it is ultimately Your responsibility to make sure We are notified. We will review the Physician's recommended course of treatment.

We will pay benefits only for inpatient/outpatient surgery that We authorize. We will not pay for inpatient or outpatient surgery or related charges if We determine that such charges are not a Covered Service or do not meet Our criteria and protocols.

3) Emergency and Urgent Hospital Admissions

An Emergency Hospital admission means an admission for Hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care. In the absence of such care, You could reasonably be expected to suffer serious bodily Injury or death. Examples of Emergency Hospital admissions include, but are not limited to, admissions for heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal Injuries, and other Acute conditions.

An urgent Hospital admission means an admission for a medical condition resulting from Injury or serious illness that is less severe than an Emergency Hospital admission but requires care within a short time, including complications of pregnancy.

For an Emergency or urgent Hospital admission (including for all covered complications of pregnancy), You are responsible for making sure that We are notified within 24 hours, the next business day, or as soon as reasonable after admission. If You are incapacitated and You (or a friend or relative) cannot notify Us within the above stated times, We must receive notification as soon as reasonably possible after the admission or You may be subject to reduced benefits as provided in Your specific Policy.

4) Healthcare Services and Supplies Review

In-Network Providers may notify Us on Your behalf to obtain Prior Authorization for the services described in Part B – Scope of the Program above.

Out-of-Network Providers may not know or attempt to notify Us to obtain Prior Authorization for services. In such a case, You must confirm that a Prior Authorization has been provided for the service to assure that the service is covered.

We will pay for covered health care services and supplies only if authorized as outlined above. We will not pay for any healthcare services or supplies that are not Covered Services or do not meet Our criteria and protocols.

D. Site of Care

HTH supports efforts, where medically appropriate, to treat patients at nonhospital facilities or in the comfort of their home.

Providers will utilize a designated site-of-care preferred by Hometown Health for the specified non-self-administered drug. In-network options include independent infusion centers and home infusion or the medication may be administered in a physician's office.

The starting dose(s) of the medication subject to this policy may be given at the physician's facility of choice only when multiple administrations are required. This includes hospital outpatient facilities, non-hospital outpatient facilities and home care. If a therapy is represented by a single administration, the policy applies to the first administration. All subsequent doses are subject to the HTH Site of Care for Drug Administration policy, which requires the use of non-hospital outpatient facilities or home care.

Documentation must be provided for review of Medical Necessity exceptions.

Criteria for medical necessity;

1. The member is new to therapy or reinitiating therapy after not being on therapy for at least 6 months.
2. The member is switching to a product that he/she has not received before.
3. The member has experienced a gap in therapy.

For situations where administration of the medication does not meet the criteria for outpatient hospital administration, coverage for the medication is provided when administered in alternative sites such as; physician office, home infusion or ambulatory care.

E. Concurrent Review and Case Management

After admission to a facility, We will continue to evaluate the patient's progress to monitor appropriate level of care and services via concurrent review. If, after consulting with the Physician or a representative of Your treatment team or the Hospital case management team, We determine a lower level of care is appropriate or a service does not meet Our criteria standards, HTH may arrange for transfer to an appropriate level of care and in-network facility through medical, non-emergent transport options, that HTH will cover the cost of, if the member refuses or is unable to return by their own means. If these conditions are not met HTH will not extend continued authorization. We use nationally recognized criteria and internal medical Policy guidelines as the standard measurement tool for this process for Acute care facilities. We also use nationally recognized criteria as the standard assessment tool for skilled nursing facilities, rehabilitation facilities and mental health and substance abuse facilities and programs.

Case management is a service provided by Us to coordinate all services or alternate methods of medical care or treatment that may be used in replacement of or in combination with Hospital confinement. Our case managers will work in coordination with the attending Physician or other Professionals and community resources to

develop a plan of treatment per the benefit level of this Policy. Discharge planning may be initiated at any stage of the process, and begins immediately upon identification of post discharge needs during Prior Authorization or concurrent review.

F. Retrospective Review

We evaluate the medical records of those Members whose medical treatment or Hospital stay was not reviewed under authorization, Prior Authorization, or concurrent review as described above.

We will pay benefits only for those days or treatment that would have been authorized under the utilization management program.

G. Second Opinions

We will authorize a second opinion upon Your request in accordance with the terms of Your specific Policy. Examples of instances where a second opinion may be appropriate include:

1. Your Physician has recommended a procedure and You are unsure whether the procedure is necessary or reasonable;
2. You have questions about a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions;
3. You are unclear about the clinical indications about Your condition;
4. A diagnosis is in doubt due to conflicting test results;
5. Your Physician is unable to diagnose Your condition; and
6. A treatment plan in progress is not improving Your medical condition within a reasonable period of time.

VI. RELATIONSHIP OF PARTIES

A. Independent Contractors

Our relationship with Our In-Network Physicians and Providers is that of an independent contractor relationship. Providers are not Our agents or employees nor are We, or any of Our employees, an employee or agent of the Providers. We are not liable for any claim or demand because of damages arising out of, or in any manner connected with, any Injuries that You suffer while receiving care from any Provider or in any Provider's facilities.

B. Provider Relationship with Patient

We are not responsible for and will not intervene in the provision of medical services by a Provider to his or her patient. The traditional relationship between a Provider and a patient will be maintained and the Provider retains full control of and authority of all medical decisions and recommendations regarding medical treatment. Our determination that a particular course of medical treatment is not a Covered Service or is inconsistent with Our criteria and protocols shall not be considered a medical determination. The Provider maintains full authority and responsibility for all medical determinations regardless of the availability of coverage for any such medical treatment.

C. Groups and Members

Neither any Group nor any Member is Our agent or representative.

VII. ELIGIBILITY AND ENROLLMENT

This chapter describes HTH's eligibility and enrollment requirements. It provides the Who, When and How of eligibility and enrollment:

1. Who is eligible for coverage?
2. When can You enroll in or change coverage and when are those changes effective?
3. How do You enroll in coverage?

You and Your dependents may not enroll in this Policy unless You meet the requirements provided in this chapter, You provide Your enrollment information within the time periods described here and payment is made by the applicable due dates.

A. WHO IS ELIGIBLE FOR COVERAGE?

The following describes those individuals who may enroll in this Policy.

1) Subscriber

The Subscriber is a person who meets all applicable eligibility requirements of this EOC, whose enrollment form has been accepted by HTH and in whose name the membership is established. The Subscriber is the Policy holder. To be eligible for membership as a Subscriber under this EOC, You must:

- Be a United States citizen, national or lawfully present non-citizen for the entire period forwhich coverage is sought;
- Be a legal resident of Nevada;
- Reside in the Geographic Service Area; Provide a valid, state-issued Nevada ID withphysical address;
- Provide copy of lease and/or mortgage AND another form of proof of residency (ex: utility bill);
- Agree to pay for the cost of Premium set by HTH;
- Not be incarcerated (except pending disposition of charges);
- Not be covered by any other HTH individual health benefit Policy;
- Complete and submit all enrollment forms and other required documents; and
- Satisfy any probationary or waiting period requirements.
    - Probationary waiting periods will apply, but are not limited to ICHRA coverage.

2) Dependents

A Subscriber may enroll an eligible dependent during the appropriate enrollment period if the dependent is listed on the Subscriber's online enrollment application and all other required documents are completed and submitted to Us.

The following is a list of dependents that may be enrolled in a HTH plan, if eligible pursuant to the other rules found in this EOC:

- The Subscriber‘s lawful spouse (We may require You submit a marriage certificate);

- The Subscriber's lawful domestic partner if the Subscriber provides to Us a current Domestic Partnership Certificate issued by a state or county government upon request;
- A natural child, stepchild, or legally adopted child of either the Subscriber, the Subscriber's spouse, or the Subscriber's domestic partner, provided that the child is under age 26;[3]

    i. A newborn child, adopted child or child placed for adoption will be eligible for coverage effective on the child's date of birth, adoption or placement for adoption (as applicable). Coverage for the child will cease after 31 days unless the Subscriber enrolls the child within the appropriate enrollment period. We require a copy of the birth certificate, adoption certificate or certification of placement by the placing agency.

    During the first 31 day-period after birth adoption or placement for adoption, coverage for the child shall consist of Medically Necessary care for Injury and sickness, including well child care and treatment of medically diagnosed congenital defects and birth abnormalities. All services provided during the first 31 days of coverage are subject to the Cost Sharing requirements such as Deductibles, Copayments and Coinsurance that are applicable to other sicknesses, diseases and conditions otherwise covered. [4]

    "Placement for adoption" means circumstances under which a Subscriber assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. Coverage for a child to the child's placement for adoption is subject to certification of the child's placement by the placement agency. A placement terminates when the legal obligation for support terminates.

    If the Subscriber is not the natural parent or the adoptive parent, but rather, the spouse or domestic partner is the natural parent or adoptive parent, and the date of birth, adoption or placement for adoption occurs before the date of marriage or domestic partnership, eligibility for coverage for the child begins when the spouse or domestic partner becomes eligible for coverage.

    ii. Step-children (children of the spouse or domestic partner) become eligible for coverage no earlier than the date the spouse or domestic partner becomes eligible for coverage. If You choose not to enroll Your spouse or domestic partner, but You would like to enroll Your spouse's or domestic partner's child, in addition to the standard documentation required for a child, You will also be required to provide the applicable marriage certificate or domestic partnership certificate linking the child to You through Your spouse or domestic partner.

- A child for whom there is a Qualified Medical Child Support Order (QMCSO) or other court order. Generally, a QMCSO is an order or judgment from a court or produced as a result of a state-authorized administrative process directing the Subscriber, covered spouse, or covered domestic partner to provide coverage to an eligible dependent. The date the court order is effective is the date indicated on the QMCSO or, if the QMCSO does not include a specific date of coverage, the date the QMCSO was signed by the court.
- A legal ward of the Subscriber, spouse or domestic partner is eligible for coverage if the child is a legal ward (pursuant to court order) permanently placed in the home of the Subscriber, spouse

[3] 45 CFR § 147.120
[4] NRS 689A.043; NRS 689B.033

or domestic partner and meets the other eligibility provisions of this EOC. You will be required to provide a copy of the court order.

Legal wards not permanently placed in the Subscriber's home, children placed in the Subscriber's home, or any other person not defined within this section are not eligible dependents.

- A foster child, if the Subscriber provides documentation indicating that the child is a foster child under the care of the Subscriber, spouse or domestic partner. [5]
- A child born to a surrogate is eligible for coverage in the same manner that a natural child described in paragraph (c) above is covered if the intended parent is a Member.

  If the intended parent is not a Member, then the child born to a surrogate is not eligible for coverage, even if the surrogate is a Member. The child is not eligible for coverage during the first 31 days of life, nor is the child eligible for coverage as a dependent of the Member.[6]

Dependents of a dependent child are not eligible for coverage other than the first 31 days of life.

3. Special Eligibility Requirements for Enrollment in a Catastrophic Plan

An individual described above may also enroll in a HTH Catastrophic Plan if the individual:

- Is under age 30 prior to January 1; or
- Has received a certificate of exemption from the applicable exchange related to:
  i. The ability to purchase affordable coverage; or
  ii. A hardship.

If an individual described above covers dependents, all such dependents must also meet the criteria in this section.[1]

The Following Sections (4 thru 6) only apply to policies purchased through the Nevada State Health Exchange

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4) Eligibility of Applicants who Purchased this Plan Through the Nevada HealthLink:

Nevada HealthLink will determine whether You are eligible for coverage under this Plan based on Your Application. If You are eligible and decide to enroll, Nevada HealthLink will assist with Your enrollment. If Nevada HealthLink determines that You are ineligible for coverage, the Nevada HealthLink will notify You. Nevada HealthLink will allow You to appeal the determination.

For an individual to be eligible to enroll as a subscriber, they must meet the following criteria:

i. Live in HTH Plan's Service Area
ii. Complete and submit enrollment applications, forms, and other documentation that Nevada HealthLink may require.
iii. Be a United States citizen or national.

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[5] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)(2)(i)
[6] Assembly Bill 472 (2019)
[1] 45 CFR § 155.305(h); 45 CFR § 156.155(a)(5)

Nevada HealthLink will also determine whether Your Dependents are eligible for coverage under this Plan. If one or more of Your dependents are eligible for coverage, Nevada Health Link will assist with their enrollment. If Nevada HealthLink determines that one or more of Your dependents are ineligible for coverage, Nevada HealthLink will notify You. Nevada HealthLink will allow You to appeal the determination.

To determine if Your dependent is eligible for coverage, please review the **Dependents** section above.

5) Eligibility for Premium Advances for Members who Purchased this Plan Through the Nevada HealthLink:

Certain Members may be eligible for help to pay their Plan Premium. Nevada HealthLink or HHS will decide if You should receive Premium Advances when You apply. In general, You must meet certain household income requirements to be eligible for Premium Advances. You also must not be eligible for Minimum Essential Coverage (other than through the individual market or through an employer-sponsored Plan that is unaffordable or does not provide minimum value).

If You are eligible for Premium Advances, the Federal government will send a payment each month to the Plan. This payment may pay for all or part of Your Premium.

6) Eligibility for Cost-Sharing Subsidies for Members who Purchased this Plan Through the Nevada HealthLink:

Certain Members who receive Premium Advances will be eligible for financial help in paying their Deductibles, Copayments, and/or Coinsurance costs when they receive Covered Services. Nevada HealthLink will decide if You are eligible for Cost-Sharing Subsidies. You must be eligible for Premium Advances in order to be eligible for Cost-Sharing Subsidies. You must also enroll in a Plan that Nevada HealthLink deems a "Silver" level Plan. Alternatively, You must be an Indian in a Nevada HealthLink Plan. The term "Indian" is defined by the Indian Health Care Improvement Act. Zero and Limited Cost Sharing Options for American Indian and Alaska Natives (AIAN) Plan Variants

Zero Cost Sharing plan variant

- You do not have to pay copayments, deductibles, or coinsurance when getting care from an Indian health care provider or when getting essential health benefits through a Marketplace plan.
- You do not need a referral from an Indian health care provider when getting essential health benefits through a Marketplace plan.

Limited Cost Sharing

- You do not have to pay copayments, deductibles, or coinsurance when getting care from an Indian health care provider.
- You do need a referral from an Indian health care provider when getting essential health benefits through a Marketplace plan to avoid paying copayments, deductibles, or coinsurance.
- The amounts listed as cost share will be charged if you do not receive a referral from an Indian health care provider in obtaining essential health benefits through a Marketplace plan.

B. WHEN CAN YOU ENROLL OR CHANGE COVERAGE?

There are very specific rules regarding when a person can enroll in or change coverage and when the changes take effect. These rules help protect Us from adverse selection and help Us keep Your premiums as low as possible. The following enrollment periods describe when You and Your dependents can enroll or change coverage and when Your coverage will become effective. There is no coverage for services received or rendered to the Member prior to the effective date of the Member's coverage.

1) Open Enrollment Period

Open Enrollment is just that – open. If You are eligible for coverage under the Benefit Plan, You may enroll in the Benefit Plan during the Open Enrollment Period. Your eligible spouse, domestic partner and dependents may also enroll during the Open Enrollment Period. The Open Enrollment Period for this product begins on November 1 and lasts through December 15. Complete applications and Premium payment must be received by December 15 to ensure coverage is effective by January 1.[7]

Nevada HealthLink Open Enrollment: If You purchase Your Plan through the Nevada HealthLink, You must enroll during Nevada HealthLink's Open Enrollment Period beginning November 1 and ending January 15. In order to receive coverage by January 1, you must complete your application by December 31. If enrolling for coverage January 1st – January 15th, the coverage effective date will be February 1st. If You do not enroll Yourself and/or Your eligible dependents in the Plan during Open Enrollment, You must wait until the next annual Open Enrollment Period or experience a qualifying life event to submit Your application. Nevada HealthLink will inform You of the date Your coverage becomes effective.

2) Qualifying Life Events

There are certain events in Your life, such as a birth or marriage, which allow You and Your eligible dependents to enroll in or change coverage. These Qualifying Life Events create a Special or Limited Enrollment period (outside of the annual Open Enrollment Period) during which time You can enroll in this Benefit Plan or enroll in another plan (if You are eligible to enroll in that plan).

You have 60 calendar days from the date of a Qualifying Life Event to request special enrollment for this Benefit Plan.[8] If You do not complete the enrollment application and pay Your Premium in that time period and provide any other necessary documentation upon request, You and Your eligible dependents will not be allowed to enroll under the rules of a Qualifying Life Event, unless another Qualifying Life Event occurs.

You have the right to enroll (or enroll Your dependent) in this Benefit Plan if You (or Your dependent) have one of the following Qualifying Life Events:

- Loss of other health plan coverage – You or Your dependent were covered under another insurance plan or program and You or Your dependent lost coverage due to legal separation, divorce, dissolution of domestic partnership, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment, a permanent move, exhaustion of COBRA benefits, termination due to a loss of a plan's availability, or loss of Medicaid or other government program coverage.[9]

[7] 45 CFR § 147.104(b)(1)(ii); 45 CFR § 155.410(e)(3); 45 CFR § 155.410(f)(2)(i)
[8] 45 CFR § 147.104(b)(4)(ii)
[9] 45 CFR § 147.104(b)(4)(i); 45 CFR § 155.420(d)(1); 45 CFR § 155.420(e); 26 CFR § 54.9801-6(a)(3)

Loss of coverage does not include cessation of coverage due to Your failure to pay premiums, including COBRA premiums prior to the expiration of COBRA coverage, fraud or situations that allow for a rescission of Your coverage.[10]

Loss of eligibility status for Medicaid or CHIP – Loss of eligibility status for Medicaid or CHIP is not considered a loss of coverage unless that individual was covered by that program to begin with or the Member applied for Medicaid or CHIP during the annual enrollment period and the individual was determined to be ineligible for coverage as a result of that application.[11]

The completion of a non-Calendar year qualified health insurance plan – If You are enrolled in a qualified group or individual health insurance plan that ends on any date other than December 31, the natural completion of that plan's plan year is considered loss of other coverage. Disenrollment from a short term or temporary health insurance Policy that lasts less than one year does not satisfy the requirements of this section. Voluntary disenrollment from a qualified health insurance plan prior to the completion of that plan's plan year does not satisfy the requirements of this section;[12]

You must provide proof that You had other coverage and the date such coverage ended.

- Gain of a dependent – You acquire a new dependent as a result of a birth, adoption, placement for adoption, placement in foster care, or through a QMCSO or other court order.[13] You must provide the birth certificate, certificate of adoption, placement for adoption or foster care, QMCSO or other court order;
- Gain of a dependent through marriage – You acquire a new dependent as a result of marriage or domestic partnership. To be eligible for coverage, You must provide:
    i. The marriage certificate or certificate of domestic partnership; and
    ii. Except in the case of American Indians or those covered on a HTH plan on the date of marriage or domestic partnership, proof of at least one spouse having minimum essential health insurance coverage for at least one (1) day during the 60 days preceding the date of marriage or domestic partnership;[14]
- Move – You or Your dependent became newly eligible for this Benefit Plan as a result of a move into the Geographic Service Area for the Benefit Plan. To be eligible for coverage, You must provide:
    i. The date You moved;
    ii. Recent proof of residency such as a driver's license, rental agreement or utility bill that includes the Subscriber's name and address for both the previous and new address; and
    iii. Except in the case of individuals moving from a foreign country or U.S. territory, American Indians or those covered on a HTH plan on the date of the move, proof of having minimum essential health insurance coverage for at least one (1) day during the

[10] 45 CFR § 155.420(e)
[11] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)(11)
[12] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)(1)(ii)
[13] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)(2)(i)
[14] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)(2)(i) ; 45 CFR § 155.420(a)(5)

60 days preceding the date of move for all individuals who wish to be covered under this Policy;[15]

- Enrollment error – Your enrollment or non-enrollment in a health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the State, HHS, its instrumentalities or other entity providing enrollment assistance or conducting enrollment activities. You must provide a letter from the State of Nevada or the entity that made the error, misrepresentation, misconduct, or inaction indicating coverage was unintentional or there was a substantial violation of the contract. If such error, misrepresentation, misconduct, or inaction was caused by a licensed producer, broker or agent, You must provide Us information regarding the hearing or other punitive measure taken by the State of Nevada Division of Insurance against the producer, broker or agent;[16]
- Plan violated contract – You have adequately demonstrated to the State of Nevada that the plan in which You were enrolled substantially violated a material provision of its contract with You. You must provide a letter from the State of Nevada indicating that You are eligible for coverage under this provision because of such violation;[17]
- Victim of domestic abuse or spousal abandonment – You are victim of domestic abuse or spousal abandonment, You are enrolled in minimum essential coverage and You seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. You must provide proof of coverage and a notarized affidavit stating the circumstances of the situation.
- Newly eligible for Individual Coverage Health Reimbursement Account – Per 45 CFR 155.420(c)(2), qualifying individuals may apply for individual and family coverage and select a plan within 60 days before or after the qualifying event.
- Gaining U.S Legal StatusChange of immigration status
- Release from incarceration (prison or jail)
- Change in status as an American Indian/Alaska Native or tribal status
- **For plans purchased on the Nevada HealthLink ONLY:** An Indian, as defined in Section 4 of the Indian Health Care Improvement Act, may enroll in a qualified health plan or change from one qualified health pan to another once per month.

Only You, Your spouse or domestic partner and the dependent child who has the Qualifying Life Event is eligible for enrollment. Other individuals who do not have current coverage, would not be eligible to enroll at this time, unless they also have a qualifying event.[18]

For example, for a birth, the Subscriber may enroll the Subscriber's spouse/domestic partner and/or the newborn, together or individually, but not any other siblings. For a marriage, the Subscriber may enroll the Subscriber's new spouse/domestic partnership and the spouse's/domestic partner's children, but not the Subscriber's children.

The following events are *not* considered Qualifying Life Events and *do not* create eligibility for a Special or Limited Enrollment period without an event listed above that is considered a Qualifying Life Event. This is not a comprehensive list:

[15] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)(7); 45 CFR § 155.420(a)(5)
[16] 45 CFR § 147.104(b)(2)(i); 45 CFR §155.420(d)(4)
[17] 45 CFR § 147.104(b)(2)(i); 45 CFR §155.420(d)(5)

[18] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)

[19] 45 CFR § 147.104(b)(2)(i)(A); 45 CFR § 155.420(d)(4); 45 CFR § 155.305(a)(1)

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- Loss or change of Advance Premium Tax Credits or Cost Sharing Reductions provided through an exchange authorized by the Affordable Care Act is not a Qualifying Life Event;[21]
- A change in eligibility status for Medicaid, CHIP or other government program is not a Qualifying Life Event unless the Member applied for Medicaid or CHIP during the annual enrollment period and the individual was determined to be ineligible for coverage as a result of that application.[23]

If You provide the completed enrollment application, including documentation and payment, coverage is effective as follows:

- For a birth, adoption, placement for adoption or placement in foster care, the effective date of coverage is the date of the event;[24]
- For coverage required through a QMCSO or other court order, the effective date of coverage is the effective date of the court order;[25]
- For a marriage or domestic partnership, the effective date of coverage is the first of the month following completion of the application and payment of the first month's Premium;[26]
- For a loss of other health plan coverage or gaining access to a plan (for instance, due to a moving into the service area) –
    i. For an application received on or before the loss of other health plan coverage or gaining access to a plan, the effective date of coverage is the first of the following month; and
    ii. For an application received after the loss of other health plan coverage or gaining access to a plan, the effective date will be in accordance with paragraph (.466□) below;[27] and
- For all other Qualifying Life Events –
    i. For an application received on or before the 15th of a month, the effective date of coverage is the 1st of the following month; and
    ii. For an application received after the 15th of a month, the effective date of coverage is the 1st of the next following month.[28]

    For instance, if a complete application is received on August 15th, coverage would be effective on September 1st; if the complete application is received on August 20th, coverage would be effective on October 1st.

3) Selection Outside of Open or Special Enrollment Periods

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[20] 45 CFR § 147.104(b)(2)(i)(A); 45 CFR § 155.420(d)(4); 45 CFR § 155.305(a)(2)
[21] 45 CFR § 147.104(b)(2)(i)(B); 45 CFR §155.420(d)(6)
[22] 45 CFR § 147.104(b)(2)(i)(C); 45 CFR §155.420(d)(8)
[23] 45 CFR § 147.104(b)(2)(i); 45 CFR § 155.420(d)(11)
[24] 45 CFR § 147.104(b)(5); 45 CFR § 155.420(b)(2)(i)
[25] 45 CFR § 147.104(b)(5); 45 CFR § 155.420(b)(2)(v)
[26] 45 CFR § 147.104(b)(5); 45 CFR § 155.420(b)(2)(ii)
[27] 45 CFR § 147.104(b)(5); 45 CFR § 155.420(b)(2)(iv)
[28] 45 CFR § 147.104(b)(5); 45 CFR § 155.420(b)(1)

This Policy is not available for enrollment outside of the Open Enrollment and Special Enrollment Periods.

C. HOW DO YOU ENROLL IN COVERAGE?

To apply for coverage, You must complete an enrollment application and may be required to submit other necessary documentation. Applications should be submitted on-line through hometownhealth.com. Submission of an application does not guarantee the applicant enrollment or eligibility for coverage. The enrollment application must be accurate, complete, legible, signed and delivered to Us within the enrollment periods described in the previous section.

When You apply for coverage, You may also apply for coverage for eligible dependents by listing the dependents on Your enrollment application and providing supporting documentation, if requested. If You want to add or delete an eligible dependent from coverage later (due to the dependent having a Qualifying Life Event), the Subscriber must do so at hometownhealth.com or submit an Enrollment/Change Form. Additional forms may be required for special dependent status.

We may require other forms and/or supporting documentation as part of the eligibility verification process. These forms and or documents may include, but are not limited to:

1. A notice of creditable coverage;
2. A coordination of benefits form;
3. A birth certificate;
4. A marriage certificate;
5. A Domestic Partnership Certificate issued by a state or county government;
6. Qualified Medical Child Support Order (QMCSO);
7. A court order;
8. Proof of Your legal right to work or reside in the U.S.;
9. Proof of residency such as a driver's license, rental agreement or utility bill that includes the Subscriber's name and address;
10. A valid Social Security number; and
11. Adoption papers or certification from placing agency.

You must provide Us with the requested forms or documents no later than 30 days after Our request. Failure to provide any requested forms or documents within 30 days of the request will result in Your loss of the right to make a change to Your enrollment status due to the enrollment event. If We changed Your enrollment, or that of Your dependents, based on an application for which You did not provide required documentation, Your enrollment and the enrollment of Your dependents will be corrected back to the enrollment status that would have resulted had You never provided the application. This could result in the loss of coverage and the transfer of financial responsibility to You for claims incurred (You may have to pay medical costs) for the period between the initial change and the correction. We will make every effort to correct Your eligibility status and the eligibility status of Your dependents and to inform You of the correct status as quickly as possible.

Subscribers may view the requirements for their particular situation and obtain the necessary forms on-line at: hometownhealth.com or by contacting HTH's Customer Service.

There is no coverage for services received or rendered to the Member prior to the effective date of the Member's enrollment.

ENROLLMENT IN PLANS PURCHASED THROUGH NEVADA HEALTH LINK

If You wish to purchase this HTH Plan through the Exchange, please visit the Nevada HealthLink website to enroll at https://www.nevadahealthlink.com/. You must submit a complete application and provide any additional required forms and documentation to Nevada HealthLink. The Nevada HealthLink will review Your application and assist with You and/or Your dependents enrollment in coverage if You are eligible.

D. OTHER IMPORTANT INFORMATION

1) Notice of Ineligibility

It is Your responsibility to notify HTH of any changes that can or will affect Your eligibility or that of Your dependents. Failure to notify Us of any changes affecting Your eligibility or Your dependents' eligibility may lead to retroactive termination of coverage back to the date for which the event took place that caused You or Your dependents to be ineligible for coverage and You may be responsible for any claims submitted for care provided to them from the event date forward.

2) Medicare-Eligible Members

Medicare Eligible individuals may purchase individual and family coverage. For the purpose of coordination of benefits, Medicare will be the primary payer under this Individual and Family Policy.

3) Enrollment in Multiple Hometown Health Plans

If a Member is covered under this Policy and is also covered by another HTH individual Policy, the Member is limited to the one Policy elected by the Member, the Member's beneficiary or the Member's estate, as the case may be, and HTH will return all premiums paid for all other such policies. However, HTH will deduct any benefits paid under the individual Policy from the Premium being refunded.

4) End Date of Coverage

All HTH individual and family plans end on December 31, regardless of whether the individual enrolls during Open Enrollment or if they enroll later in the year. This coverage is guaranteed renewable provided that the Subscriber continues to make Premium payments according to Our rules, and there have been no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage. The Subscriber must continue to meet the eligibility criteria as detailed in this Chapter.

VIII. PRIMARY CARE AND SPECIALTY CARE PHYSICIANS

HTH recommends to receive maximum benefits for Covered Services through your health insurance plan, You must follow the terms of this Policy, including, if applicable, receiving care from Your PCP, using In-Network Providers, receiving a referral from your PCP prior to receiving services from a Specialty Care Physician (HMO Plans only), and obtaining any required Prior Authorizations. PCPs include family practice, internal medicine, general practice, and geriatric medicine. Regardless of Medical Necessity, this Policy will not provide benefits for care that is not a Covered Service even if performed by Your PCP or other In-Network Provider. If services are authorized or provided by Your PCP and covered by this Policy, You may receive a higher level of benefits, as set forth in Your plan-specific Schedule of Benefits.

A. HMO Requirement for a Primary Care Physician (PCP)

Following the terms of your HMO plan, adult Members must choose a Renown or Geriatric Specialty Care, Alpine Family Medicine, Virginia Family Care Center, or Reno Family Physician PCP on the Renown HMO Network at the time of enrollment or HTH will choose one for You based on Your geographic location. In addition, if You have a child enrolled in coverage, HTH will permit You to designate any pediatrician, Renown or Community, as the child's PCP if such pediatrician is an In-Network Provider. HTH will permit your child to see an In-Network primary care provider as their pediatrician if pre-notified prior to services received of the primary care provider your child will be seeing.
Eligibility of services rendered by a pediatrician is limited to children between the age of 0 and 18 years and ends the first of the month after a member achieves their 18th birthday. There is no coverage for PCP services outside of the Renown HMO network therefore, establishing with an approved PCP is essential to receiving maximum benefits for covered services on your HMO plan. Family members can choose the same PCP or different ones. A directory of PCPs is available on Our website at hometownhealth.com or by calling HTH, Customer Service at (775)982-3232 or (800)336-0123.

B. EPO Selection of Primary Care Physician (PCP)

Members enrolled in a HTH EPO plan may designate any PCP on the HTH Nevada EPO Network who is available to accept You as a patient. In addition, if You have a child enrolled in coverage, We will permit You to designate any pediatrician as the child's PCP if such pediatrician is an In-Network Provider. Eligibility of services rendered by a pediatrician is limited to children between the age of 0 and 18 years and ends the first of the month after a member achieves their 18th birthday.

C. PPO Selection of Primary Care Physician (PCP)

Members enrolled in a HTH PPO plan may designate any PCP on the HTH Network who is available to accept You as a patient. In addition, if You have a child enrolled in coverage, We will permit You to designate any pediatrician as the child's PCP if such pediatrician is an In-Network Provider. Eligibility of services rendered by a pediatrician is limited to children between the age of 0 and 18 years and ends the first of the month after a member achieves their 18th birthday.

D. Responsibilities of Your Primary Care Physician

Your PCP provides and coordinates Your overall health care. When You need medical services, contact Your PCP. Your PCP can provide most of Your care, including routine physical examinations, treatment of sickness or Injury, and administration of Medically Necessary injections and immunizations. When Your PCP determines that You need specialized care on an HMO plan, he or she will refer You to a Specialty Care Physician or coordinate any Hospital or other care You may need. Members enrolled in an HMO plan must receive PCP referral to a specialty physician to receive maximum benefits for Covered Services. Members enrolled in an EPO or PPO plan may also self-refer to a specialty care physician.

E. Continuity of Care

If You are undergoing a course of treatment and Your PCP or other In-Network Provider withdraws from Our Network, We will notify You of the withdrawal. In the case of the withdrawal of Your PCP from the Network, You will be able to choose another. In addition, You may be permitted to continue receiving care from the withdrawing Provider in accordance with applicable law.

F. Referrals (required for HMO Plan members)

This Policy provides extensive Benefits when health care services are provided or coordinated by Your PCP. You will receive most of Your health care services from Your PCP. If Your PCP determines that You need specialized care, he or she will refer You to a Specialist or other In-Network Provider. If a Specialist or other Provider determines that You need care from another Provider who is not Your PCP, Your PCP must initiate the new referral. The decision as to whether or not a Member needs to schedule an appointment with the PCP is up to the PCP.

You must get a referral from Your PCP for all Specialist Office Visits and Services except for OB-GYN Office Visits.

If Your Specialist needs to extend Your care beyond the initial visit or Prior Authorization, he or she can do so without involving Your PCP. However, the Specialist must request a Prior Authorization from HTH if the additional care extends beyond the limits of the original Prior Authorization. Extension of care beyond one year must be managed by Your PCP.

A Referral from Your PCP is not a guarantee of coverage for those services. The service must also be covered within the terms of this EOC and You must receive a Prior Authorization from HTH. Thus, regardless of whether a service is Medically Necessary, no benefits will be provided for care that is not a Covered Service, even if performed by Your PCP or other In-Network Provider. You may call HTH Customer Service at (775)982-3232 or (800)336-0123 to determine if a service is a Covered Service.

You may require services that are not available from an In-Network Provider. Your PCP or other In-Network Provider must contact Us to seek Prior Authorization for You to receive treatment from an Out-of-Network Provider. *A Prior Authorization to receive a service does not necessarily mean the service will be covered at an Out-of-Network Provider, unless the Prior Authorization explicitly states that We will cover the service provided by an Out-of-Network Provider.*

The amount of Your benefits is determined each time You seek health care services in accordance with Your plan-specific Schedule of Benefits. For certain services and supplies You must obtain Our Prior Authorization for such services and supplies. You should refer to Chapter V – Utilization Management Program of this EOC for more information about certain services that require Our Prior Authorization.

IX. INSURANCE PREMIUMS

Premiums are the monthly charges the Member must pay HTH to establish and maintain coverage. Think of HTH as a pot. Each Subscriber puts their monthly premiums into the pot. Whenever You go to Your doctor, We pull money out of the pot to pay Your doctor.

Our goal is to always ensure there is enough money in the pot to pay Your doctor. In fact, the Nevada Division of Insurance requires that We have a certain level of cash reserves available to pay claims.

But predicting exactly how much to charge in Premium isn't easy. We have to predict how much You and the rest of Your fellow Members are going to utilize services in a given year, take into account the cost of new drugs and new technologies, predict shifts in Provider usage based on changes to Our Provider contracts and much, much more.

If We set the premiums too low, We lose money. If We set premiums too high and make too much money, We are required to pay some of it back to Policy holders. Even if We get the premiums just high enough to make a little bit of money, because We are Northern Nevada's only non-profit health insurance company, any money that We make goes back into the community or assists Us in keeping premiums as low as possible in the future.

The rate setting process is highly regulated. Every assumption that We make to create Our premiums is reviewed and studied by the Nevada Division of Insurance. If We have an assumption that doesn't make sense, We are required to adjust the assumption and the resulting premiums. The premiums aren't approved until the Nevada Division of Insurance agrees that Our assumptions are reasonable.

Once We have established premiums, HTH is required to send out written notification 60 days in advance of such change via email. Please note that We can only change rates at renewal. If the Member's Premium is paid beyond the effective date of the change, HTH may require the Member to pay an additional Premium or accept a refund, whichever is necessary. If the age of the Member is misstated, all amounts payable for the correct age shall be adjusted and billed to the Member.

A. How and When to Pay Premiums

Generally, the portion of the Premium paid by employees is paid through payroll deductions, but each employer is different and the method of payment varies by employer.

The first Premium must be paid on or before the effective date of coverage under this Policy. Members will not be covered until HTH receives that first payment. Coverage will be effective at 12:01 a.m. on the effective date as stated when You accept the rates on-line.

After the first payment, the Member's entire Premium shall be due on the first day of the applicant's Billing Cycle. Premiums for dependents added mid-Billing Cycle may be prorated for the remainder of the applicant's Billing Cycle. Any premiums following will be due on the first day of the applicant's Billing Cycle. Premiums preferably should be paid through the on-line application web site. It is the Subscriber's responsibility to pay premiums to HTH.

The Member may be responsible for an additional $50 charge for any item returned or dishonored by the bank as non-payable to HTH for any reason.

The Subscriber must notify HTH of any address or email changes by signing into HometownHealth.com or calling Customer Service. Failure to receive a Premium notice due to an unreported email change (or any other reason) does not relieve the Member from the responsibility to pay required premiums by the Premium due date.

B. Premium Not Received on Time

If the entire Premium due is not paid within the 31 day grace period (with the exception of the first Premium), coverage under this certificate will automatically terminate. Cancellation will be effective retroactively to the last date of the period for which Premium has been paid in full. HTH will not pay for any services provided to members after the date of termination. All claims paid after termination will be retroactively adjusted. HTH will provide written notice of any intention to terminate this Policy HTH will provide the notice to the Subscriber's latest physical or email address in HTH's membership record.

C. Premium Received from Non-Members

HTH will not accept a payment for Premium made by one of the following individuals on behalf of a Member. The receipt of a Premium payment from one of these individuals may result in cancellation of coverage:

- Entities that have a financial interest;
- Providers;
- Kidney foundation; and
- Brokers/producers with the exception of brokers/producers licensed as third party administratorsto distribute premiums.

D. Reinstatement

If Your coverage is terminated for non-payment and You wish to re-enroll in an individual and family plan, You will be required to re-apply on-line for coverage for You and Your dependents. Any determination of eligibility for coverage will be based on Your new circumstances as of the date of the new application. If coverage is issued again, the effective date of coverage will be based on the rules governing a new enrollment as provided in Chapter VII – Eligibility and Enrollment. Loss of coverage due to failure to pay Premium is not a Qualifying Life Event. You would need to wait until the annual Open Enrollment Period. Coverage will not be reinstated retroactively to Your original termination date.

E. Refunds

If Your coverage is terminated, Premiums that We receive for coverage applicable to periods after the effective date of termination will be refunded within 30 days, less any medical costs incurred by Us for that period. Any claims for refunds must be made in writing within 90 days from the date of termination of Your coverage or otherwise the right to such refunds will be deemed waived.

F. Premium Advances

Note: This section only applies to those who purchased their Plan through the Nevada HealthLink. You must qualify for Advanced Premium Tax Credit (APTC) to receive Premium Advances.

Your Premiums may be reduced if You are eligible for Premium Advances. Premium Advances will be sent directly to HTH from the Federal government.

X. TERMINATION

A. Equality

This Policy is guaranteed issue and guaranteed renewable. Your coverage cannot be denied or terminated due to Your age, health status, economic status, health care needs, or prospective health care costs. However, there are some circumstances which may result in the termination of Your coverage under this Policy.

B. Termination Events

Coverage for a Member ends on the first occasion of any of the following events:

1. Death of the Subscriber. Coverage for all dependents ends on the last day of the month in which the Subscriber dies, assuming payment was provided to HTH in full for the Premium month. Dependents will have the option to enroll in any individual and family HTH plan for which they are eligible effective the first of the following month as provided in Chapter VII – Eligibility and Enrollment.
2. Fraud or material misrepresentation. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact could result in termination or rescission of the Subscriber's and all dependent's coverage. See Section C – Termination for Cause and Rescission
3. Request to terminate. When HTH receives a request to cancel coverage for any Member, coverage will end:
    a. At the end of the month if the request to terminate is received prior to the 20th of the month; or
    b. At the end of the month following the month the request is received if the request to terminate is received on or after the 20th of the month.

    HTH will not credit membership Premium paid in advance on behalf of cancelled members, unless HTH receives the cancellation request prior to the 20th of the month prior to the effective date of termination. You may provide Your request to terminate in writing or on-line at HometownHealth.com.
4. Failure to pay Premium. If We do not receive payment of the Premium for Your coverage by the applicable Premium due date and payment is not made and accepted within 31 days of its due date, Your coverage and coverage for any dependents will be terminated. Termination due to non-payment will be effective the end of the month for which We received payment in full. We will not be responsible for the cost of any services with a date of service that is after Your termination date.

    If Your coverage is terminated and You wish to re-enroll in an individual and family plan, You will be required to re-apply on-line for coverage for You and Your dependents. Any determination of eligibility for coverage will be based on Your new circumstances as of the date of the new application. If coverage is issued again, the effective date of coverage will be based on the rules governing a new enrollment as provided in Chapter VII – Eligibility and Enrollment. Loss of coverage due to failure to pay Premium is not a Qualifying Life Event. You would need to wait until the annual Open Enrollment Period. Coverage will not be reinstated retroactively to Your original termination date.
5. Out-of-Area. The member no longer meets eligibility requirements for coverage if the memberhas temporarily located outside the geographic service area for longer than 90 days.
6. Permanent move. Coverage will terminate when the Subscriber establishes a permanentresidence outside the Geographic Service Area of the Benefit Plan.

7. Plans no longer offered. If HTH elects to discontinue offering all of its individual and family health Benefit Plans in Your service area, coverage will end on December 31. In this case HTH will meet all notice requirements to the Subscribers as required by law.
8. HTH ceases to operate. In the unlikely event that HTH ceases to operate, HTH will meet all regulations that require for payment for services rendered during the insured's coverage period for which premiums had already been paid.

The two sections below only apply to members who have purchased their Plan on the Nevada HealthLink:

1) If you fail to pay Premium and You **are** receiving Premium Advances, HTH will allow a three (3) month grace-period as long as You have paid at least one (1) full month of Premium during the Plan Year. We will notify You of Your failure to pay. During the first month of the grace period, We will continue to pay for Your covered Services (and Your covered dependent's Covered Services). However, We may pend (hold without paying) any claims We receive during the second and third month of the grace period relating to You or Your covered dependents. If You fail to pay Your outstanding Premiums within the three (3) month grace period, Your coverage (and Your covered dependent's coverage) will end on the last day of the first month of the three (3) month grace period.

2) If you fail to pay Premium and You **are not** receiving Premium Advances, HTH will allow a thirty-one (31) day grace period, during which Your coverage (and Your covered dependents' coverage will remain in effect. We will continue to pay for Your Covered Services (and Your covered dependents' Covered Services during the grace period. We will notify You of Your failure to pay. If You fail to pay Your outstanding Premiums within the thirty-one (31) day grace period, We will terminate Your coverage (and the coverage of Your covered dependents) effective as of the last day of the month preceding the grace period.

C. Termination for Cause and Rescission

If You perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact in connection with Your coverage, We may retroactively terminate Your coverage. This is known as rescission. Your coverage and Your dependents' coverage can be terminated or rescinded if there is any evidence of the following actions:

1) You materially misstate information about yourself or Your dependents on Your enrollment application or any other document provided during the coverage application process.
2) You knowingly allow someone else to use Your identity for the purpose of seeking medical care under this Policy.
3) You knowingly engage in an activity to defraud Us or any organization that We have engaged to provide services under Our policies.

In some cases Your coverage may be rescinded back to the date of the fraudulent act.. If We rescind Your coverage, We will provide at least 30 days prior written notice in accordance with applicable law. You will be responsible for the claims submitted for care provided to You after the effective date of termination or rescission.

If Your coverage is terminated because of Your fraudulent actions, You will not be eligible for reenrollment.

We have the sole discretion to determine the materiality of Your actions and to apply any and all legal remedies.

D. Dependent Coverage Termination

To remove a dependent from coverage, the Subscriber must notify HTH in advance either in writing, on-line at HometownHealth.com or by calling Our Customer Service Center. Coverage will end:

1. At the end of the month if the request to terminate is received prior to the 20th of the month; or
2. At the end of the month following the month in which the request is received if the request to terminate is received on or after the 20th of the month.

HTH will not credit membership Premium received in advance on behalf of the terminated dependent unless HTH receives notification prior to the 20th of the month of the effective date of the change or if HTH has paid any claims on behalf of the terminated dependent in the period for which the credit would otherwise be owed.

Coverage for a dependent child ends on the last day of the current policy during which the dependent child reaches age 26. If that dependent wants to become a Subscriber under his or her own individual and family plan, he or she must meet all of the eligibility requirements of a Subscriber as listed in the plan.

Otherwise, coverage for a dependent ends on the last day of the current policy during which the following events occur:

1) A final divorce decree, legal separation or termination of domestic partnership for a spouse or domestic partner and any children (who are not also children of the Subscriber) of the spouse or domestic partner;
2) Legal custody of a child is terminated; or
3) The dependent loses status as a dependent for any other reason, including death of the Subscriber.

HTH reserves the right to recoup any benefit payments made beyond the termination date.

E. Certificate of Creditable Coverage

When a Member's coverage with HTH terminates, HTH will send the Subscriber a Certificate of Creditable Coverage, which will identify the length of the Member's coverage with HTH. The Member may need this letter as proof of prior coverage when the Member enrolls with another company.

F. What Hometown Health Will Pay for After Termination

After the effective date of termination of a Member, HTH will continue to pay claims that were incurred by the Member during the period of time the Member was covered under this Policy. Payment of claims by HTH is subject to normal claim payment procedures and limitations described elsewhere in this EOC.

HTH will not pay for any services provided after the Member's coverage ends, even if a Prior Authorization was received. HTH is only responsible for payment of expenses for Covered Services provided during the effective period of this Policy. HTH is not responsible for expenses incurred after coverage under this Policy is terminated or following any amendment(s) made to this Policy in accordance with applicable law that may affect a change in such payment. Benefits cease on the date the Member's coverage ends as described above. A Member may be responsible for benefit payments made on behalf of the Member for services provided after the Member's effective date of termination, even if the termination was retroactive.

HTH will not cover services received after the Member's date of the termination regardless of whether:

1. HTH issued a Prior authorization for the services;
2. The services were made necessary by an accident, illness or other event that occurred while the coverage was in effect;
3. The Member was hospitalized at the time of the termination; or
4. For any other reason.

XI. CONTINUATION OF COVERAGE

There are situations, such as a child attaining age 26, divorce, etc., in which Your dependents will lose eligibility under this individual and family Policy. In the past, guarantees of continued coverage were limited to group insurance provided by employers. Individuals who lost eligibility in the individual and family market could not necessarily get continued coverage.

Now, however, with the new guaranteed issue rules, a dependent that loses coverage can get insurance coverage in the individual and family market by applying for it as a Subscriber (does not apply to rescinded coverage). To enroll in new coverage, Your dependent needs to fill out an on-line application, upload his/her Certificate of Creditable Coverage, provide additional documentation if requested and payment within 60 days of the loss of coverage. Coverage will begin in the timeframes provided in Chapter VII – Eligibility and Enrollment. Please note that loss of coverage due to non-payment does not constitute a Qualifying Life Event.

XII. DOUBLE COVERAGE

Coverage for HTH individual and family plan members is limited to one effective policy elected by the insured or the beneficiary or estate of the insured, as the case may be. HTH will return all premiums paid for all other such duplicate policies.

A. Workers' Compensation

The benefits provided in this Policy are not designed to duplicate any benefit to which such Members are eligible under applicable workers' compensation laws. Coverage under this Policy is not in lieu of, and will not affect any requirements for coverage under such workers' compensation laws.

B. Medicare

Except as otherwise provided by applicable law, the benefits under this Policy for Members otherwise covered by Medicare, do not duplicate any benefit to which such Members are entitled under Medicare, including Medicare Parts A, B and D. If You maintain coverage under this Policy, this Policy becomes secondary to Medicare for the purpose of Coordination of Benefits.

XIII. COORDINATION OF BENEFITS

This section explains how other health Benefit Plans and/or insurance You may have affect Your coverage under this Policy. Coordination of Benefits (COB) is a process by which other insurers, Benefit Plan sponsors or other programs that provide health care services (such as Medicare), may be responsible for claims payment either as the primary or secondary carrier. The plans that apply to the Coordination of Benefits Provision for this Policy include group insurance, Hospital, surgical, medical or major medical benefits provided by individual or family-type coverage, government programs or workers' compensation.

Some plans are excluded from COB for this individual plan by statute. These include group insurance, automobile medical payments or third-party liability coverage.

A. The Purpose of Coordination of Benefits

Many people have health coverage provided by more than one plan at the same time. Each plan has rules for coordination of benefits if there is double coverage to prevent the total amount of all their benefit payments from exceeding the contracted cost of the Covered Services. This coordination of benefits provision helps to contain the cost of health care coverage.

B. Benefits Subject to Coordination of Benefits

All the health benefits provided in this EOC are subject to this section. You agree to permit Us to coordinate its obligations under this Policy with payments under any other eligible plan that covers You. All provisions of this EOC, including but not limited to the use of In-Network Providers and Prior Authorization requirements continue to apply whether this Policy is primary or secondary.

C. Definitions

Some of the words used in this section have a special meaning to meet the needs of this section. These words and their meanings when used in this section are:

Allowable Expense – 100 percent of the Allowable for any Medically Necessary, reasonable and customary item of Expense which is a Covered Service, in whole or in part, as a Hospital, surgical, medical or major medical Expense under this Policy.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be an allowable Expense and a benefit paid.

If the Primary Plan reduces benefits because of the Member's or Provider's failure to follow the Primary Plan's rules, any such reduction is not part of the Allowable Expense.

Coordination of Benefits Provision – This provision and any other provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage.

Plan – An entity providing health care or dental benefits or services through:

- Group or individual insurance or any other arrangement for coverage for individuals whether on an insured or uninsured basis;
- Group service plan contracts, group practice, individual practice and other prepayment coverage;
- Any group coverage for students that is group-sponsored by or provided through school or other educational institutions, other than accident coverage for grammar school or high school students for which the parent pays the entire Premium;
- Any coverage under labor management trustee plans, union welfare plans, employer organization plans, employee benefits plans, or employee benefit organization plans;

- Any group automobile third party insurance required under any law of a state, but only to the extent of benefits required under such third-party no fault law and only to the extent coordination of benefits is permitted under such third-party no fault law;
- Coverage under a governmental program, including Medicare and Worker's Compensation plans; or
- Any coverage under an Individual plan for the Member.

The term "Plan" will be construed separately with respect to each Policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such Policy, contract, or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion that does not.

Primary or Primary Plan – A Plan that, in accordance with the rules regarding the order of benefits determination, provides benefits or benefit payments without considering any other Plan.

Secondary or Secondary Plan – A Plan that, in accordance with the rules regarding the order of benefit determination, may reduce benefits or benefit payments and/or recover from the primary Plan benefit payments.

D. When Coordination of Benefits Applies

Coordination of benefits applies when You are covered under this Policy and You are entitled to receive payment for, or provision of, some or all of the same Covered Services from another Plan.

E. How Coordination of Benefits works

Plans use coordination of benefits to decide which health care coverage programs should be the Primary Plan for the Covered Service. If the Primary Plan payment is less than the Allowable Expense for the Covered Service, then the Secondary Plan will apply its allowable Expense to the unpaid balance. In no event will HTH pay more than it would have paid if it were the Primary Plan.

You must first file a claim with the Primary Plan to receive any benefits from the Secondary Plan.

HTH may pay benefits to any insurer providing other valid coverage in the event of overpayment by such insurer. Any such payment shall discharge the liability of HTH as fully as if the payment had been made directly to the insured or the assignee or beneficiary of the insured. If HTH pays benefits to the insured or the assignee or beneficiary of the insured, in excess of the amount which would have been payable if the existence of other valid coverage had been disclosed, this insurer shall have a right of action against the insured or the assignee or beneficiary of the insured to recover the amount which would not have been paid had there been a disclosure of the existence of the other valid coverage. The amount of other valid coverage which is on a provision of service basis shall be computed as the amount the services rendered would have cost in the absence of such coverage.

F. Determination Rules

The Policy determines the order of benefit determination using the first of the following that applies:

1. No Coordination of Benefits Provision. If another Plan does not contain a provision coordinating its benefits with those of this Policy, then the benefits of such other plan will always be determined before the benefits of this Policy.

1. Dental Plans. If a claim for services provided by an oral or maxillofacial surgeon is submitted and the Member is also covered under a Dental Plan, then the Dental Plan is the Primary Plan.

2. Non-Dependent/Dependent. The benefits of the Plan that covers a person as a Subscriber are Primary to those of the Plan that covers the person as a dependent. The benefits of the plan that covers a newborn,

adopted child or child placed for adoption as the enrolled Subscriber or enrolled dependent are primary to the Plan that is required to cover such individuals pursuant to NRS 689A.043, 689B.033 or similar requirement but has not received the required notification and applicable payment to continue coverage beyond 31 days after the date of birth, adoption or placement for adoption.

3. Dependent Child/Parents Not Separated or Divorced. When this Policy and another Plan cover the same child as a dependent of different persons, called "parents":
    a. The Plan of the parent whose birthday falls earlier in the calendar year is Primary to the Plan of the parent whose birthday falls later in the year; and
    b. If both parents have the same birthday, the benefits of the Policy that covers a parent longer is the Primary Plan.
4. Dependent Children/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    a. First, the Plan of the parent with custody of the child;
    b. Then, the Plan of the spouse of the parent with custody of the child; and
    c. Finally, the Plan of the parent not having custody of the child;

    With respect to a, b, and c above, if there is a court decree that would otherwise establish financial responsibility for the health care expenses with respect to the child, the benefits of a plan that covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other plan that covers the child as a dependent child.
5. Active/Inactive Employee. A Plan that covers a person who is neither laid off nor retired (or that eligible employee's dependents) is primary to a plan that covers that person as a laid off or retired eligible employee (or that eligible employee's dependents). If the other plan does not have this rule, and if, as a result, the plans do not agree about the benefits, this rule is ignored;
6. COBRA/Non-COBRA. A Plan that covers a person and such coverage is not provided pursuant to COBRA is primary to a plan that covers that person pursuant to COBRA. If the other plan does not have this rule, and if, as a result, the plans do not agree about the benefits, this rule is ignored;
7. Longer/Shorter Length of Coverage. When none of the above applies, the Plan in effect for the longest continuous period of time pays first. (The start of a new Plan does not include a change in the amount or scope of the Plan's coverage, a change in the entity that pays, provides, or administers the plan's coverage, or a change from one type of plan to another.)
8. Equal liability. If none of the above rules determine which plan is primary and which is secondary, the allowable expenses shall be shared equally between the plans.

G. Right to Receive and Release Information

To decide if this coordination of benefits section (or any other plan's coordination of benefits section) applies to a claim, We (without the consent of or notice to any person) have the right to:

1. Release to any person, insurance company, or organization, the necessary claim information;
2. Receive from any person, insurance company, or organization, the necessary claim information; and
3. Require any person claiming benefits under this Policy to give Us any information needed by Us to coordinate those benefits.

H. Right to Recover Payment

If the amount of benefit payment exceeds the amount needed to satisfy Our obligation under this section, We have the right to recover the excess amount from one or more of the following:

1. Any persons to or for whom such payments were made;
2. Any group insurance companies or service plans; and
3. Any other organizations.

XIV. MEMBER CLAIMS AND APPEAL PROCEDURES

I. Definitions

Some of the words used in this section have a special meaning to meet the needs of this section. These words and their meanings when used in this section are:

Adverse Benefit Determination – Any of the following:

- Our rescission of Your coverage;
- Our denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit including a denial, reduction, or termination or failure to provide or make payment that is based on a determination of Your or Your beneficiary's eligibility for coverage under this Policy;
- Our denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of Our utilization management program; or
- Our failure to cover an item or service for which benefits are otherwise provided because We determine that such item or service is experimental or investigational or is not Medically Necessary.

Authorized Representative – A person that You designate to act on his or her behalf in pursuing a claim for benefits, grievance or an appeal of an adverse benefit determination.

Claim for Benefits – A request for a benefit or benefits under this Policy made by You, including any pre-service claims (requests for Prior Authorization or pre-determination) and any post-service claims.

Expedited Appeal – The process that You can use to request a review of an adverse benefit determination of an Urgent Care claim.

Final Internal Adverse Benefit Determination – An adverse benefit determination that We have upheld at the completion of Our internal review process.

Formal Appeal – The formal process You can use to request review of an adverse benefit determination.

Grievance- An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination.

Informal Appeal – An appeal that You direct to Our Customer Services department via phone or in person. If an informal appeal is resolved to Your satisfaction, the matter ends. The informal appeal is a voluntary level of appeal.

Reopening**:** A remedial action taken to change a binding determination or decision even though

the determination or decision may have been correct at the time it was made based on the

evidence of record.

Urgent Care Claim – A claim for medical care or treatment for which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize Your life, health, or ability to regain maximum function or, in the opinion of a Physician with knowledge of Your medical condition, would subject You to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The determination of whether a claim is an Urgent Care Claim will be made by an individual acting on Our behalf applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

J. Internal Claims Procedures

1) Failure to Obtain Prior Authorization

   If You fail to follow Our procedures for filing a pre-service claim, We will notify You of the failure and the proper procedures to be followed if Your communication to Us is received by a person or department customarily responsible for handling benefit matters and the communication specifically names Your name, the specific medical condition or symptom, and the specific treatment, service, or product for which approval is requested. We will provide You with this notification as soon as possible, but no later than five days (72 hours in the case of an Urgent Care claim) following the failure. Our notification may be oral unless You specifically requested in writing.

2) Full and Fair Review

   We will permit You to review Your claim file and to present evidence and testimony as part of Our internal claims. Specifically:

   - We will provide You, free of charge and sufficiently in advance of the date on which We provide a final adverse benefit determination to give You a reasonable opportunity to respond with any new or additional evidence that We consider, rely upon, or generate in connection with Your claim; and
   - Before We issue a final adverse benefit determination based on a new or additional rationale, We will provide You with such rationale sufficiently in advance of the date on which We provide a final adverse benefit determination to give You a reasonable opportunity to respond.

3) Timing of Notification of Benefit Determination

   - Urgent Care Claims

     If the claim involves an Urgent Care claim, We will notify You of the benefit determination (whether adverse or not) as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless insufficient information to determine whether, or to what extent, benefits are covered or payable under this Policy.

     If We receive insufficient information to decide Your claim, We will notify You as soon as possible, but not later than 72 hours after receipt of the claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. We will notify You of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

     i. Our receipt of the specified information; or

     ii. The end of the period afforded You to provide the specified information.

   - Concurrent Care Decisions

     If We have approved an ongoing course of treatment to be provided over a period of time or number of treatments and reduces or terminates coverage of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments, We will notify You at a time sufficiently in advance of the reduction or termination to allow You to appeal and obtain a determination before the benefit is reduced or terminated.

     We will decide any request by You to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care claim as soon as possible. We will notify You within

72 hours after Our receipt of the claim if We receive the request at least 24 hours prior to the expiration of the authorized period of time or number of treatments.

- Pre-Service Claims

  We will notify You of Our benefit determination (whether adverse or not) within a reasonable period appropriate to the medical circumstances, but not later than 15 days after Our receipt of the request. We may extend this period one time for up to 15 days if the extension is necessary due to matters beyond Our control and We notify You prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which the Policy expects to make a decision. If the extension is necessary due to Your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and You have at least 45 days from receipt of the notice to provide the information.

- Post-Service Claims

  We will notify You of any denial of a post-service claim within a reasonable period, but no later than 30 days after receipt of the claim. We may extend this period one time for up to 15 days if the extension is necessary due to matters beyond Our control and We notify You prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which We expect to render a decision. If the extension is necessary due to Your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and You will be afforded at least 45 days from receipt of the notice to provide the information.

4) Conflicts of Interest

   We will ensure that We adjudicate all claims and appeals in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will not be based upon the likelihood that the individual will support a denial of benefits.

5) Compliance with Law

   In all circumstances, Our internal claims and appeals process will initially incorporate the internal and external claims and appeals procedures (including urgent claims) set forth in regulation[29] and will update such process in accordance with any applicable standards established by the U.S. Department of the Treasury, U.S. Department of Labor, the U.S. Department of Health and Human Services.

K. Internal Appeals and Grievance Procedures

In order for Us to remain responsive to Your needs, We have established both a grievance process and an Appeal process. Should you have a problem or question; a Customer Services representative can assist You. Most problems and questions can be handled in this manner. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the formal Appeal or Grievance process. You may contact Customer Services at the telephone number on Your Identification Card. You may also file a written Grievance or Appeal with Us.

Contact Us when You:

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[29] 26 CFR § 54.9815-2719T – Internal claims and appeals and external review processes; 29 CFR § 2560.503-1 – Claims procedure; 29 CFR § 2590.715-2719 – Internal claims and appeals and external review processes; 45 CFR § 147.136 – Internal claims and appeals and external review processes

1) Do not understand the reason for the denial;
2) Do not understand why the health care service or treatment was not fully covered;
3) Do not understand why a request for coverage of a health care service or treatment was denied;
4) Cannot find the applicable provision in Your EOC or Certificate of Coverage;
5) Want a copy (free of charge) of the guideline, criteria or clinical rationale that We used to make Our decision; or Disagree with the denial or the amount not covered and You want to appeal

1. Authorized representative

In order for a person to submit an appeal or grievance on your behalf, You must designate Your authorized representative in writing unless the claim or appeal involves an Urgent Care claim and a health care Professional with knowledge of Your medical condition is seeking to act on Your behalf. You must send Your designation to Our customer service department.

If no authorized representative has been designated, the appeal or grievance will be deemed waived.

2. Internal Grievance Procedures

Grievances typically involve issues such as dissatisfaction about our services, quality of care, the choice of and accessibility to Hometown Health Providers and network adequacy.

Concerns about medical services are best handled at the medical service site level before being brought to Our attention. If You contact Us regarding an issue related to the medical service site and have not attempted to work with the site staff, You may be directed to that site to try to solve the problem there. The procedures outlined in this chapter will be followed if a medical service site matter cannot be resolved at the site or if the concern involves a claim for benefits.

Upon receipt, Your Grievance will be reviewed and investigated. You will receive a response within 30 calendar days of Our receipt of Your Grievance. If We are unable to resolve Your Grievance in 30 calendar days, You will be notified on or before calendar day 30 that a 15 calendar day extension is required to resolve Your Grievance.

3. Internal Appeals Procedures

Hometown Health is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions You find unacceptable, whether the decision is a claim denial or a rescission of coverage. Appeals involve a request to reverse a previous adverse benefit determination made by Hometown Health. You have a right to appeal any decision We make that denies payment on Your claim or Your request for coverage of a health care service or treatment.

Types of Appeals include:

- Post-service claims are all claims other than pre-service claims and Urgent Care Claims. Post-service claims include claims filed after services are rendered.
- Pre-service claims are claims for a service where the terms of the EOC require the Member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If You call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

- Expedited Appeals are made available when the application of the time period for making pre-service Appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Expedited appeals are not available for appeals regarding post-service claims.

A. Informal Appeal

If You question the manner that a claim for benefits is decided, You may file an informal appeal. You must make all informal appeals to Our customer services department within 60 days of an adverse benefit determination. If You do not file an informal appeal in a timely manner, We will deem Your appeal waived. The informal appeal is a voluntary level of appeal and You may immediately make a formal appeal.

Upon the initiation of an informal appeal, Our customer services department will record at least the following information:

- Name of person on whose behalf the appeal is filed (complainant);
- Complainant's name and membership number;
- Name of person(s) involved;
- Date(s) of occurrence;
- Location;
- Nature of appeal; and
- Name of person filing the appeal.

Our Customer Services department representative will inform You of the resolution or proposed resolution of the appeal within 30 days, unless more time is required for fact-finding.

B) Formal Appeal

If We do not resolve an informal appeal to Your satisfaction or if You choose not to file an informal appeal, You may file a formal appeal. You must submit the formal appeal in writing (or orally, at Your option, in the case of an appeal of an Urgent Care claim) to the customer services department within 180 days after We inform You of Our resolution of the informal appeal or within 180 days of the adverse benefit determination if the formal appeal is Your initial appeal. There is an exception to the 180-day filing timeframe; if You are able to demonstrate that You were incapacitated and unable to file an appeal within the standard timeframe, We will grant You a reasonable extension. If You do not file a formal appeal in a timely manner, We will deem Your appeal waived with respect to the adverse benefit determination to which the appeal relates.

The formal appeal must contain, at least:

- Your name (or name of You and Your authorized representative), address, and telephone number;
- Your membership number; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why You feel that the adverse benefit determination was wrong.

Additionally, You may submit any supporting medical records, Physicians' letters, or other information that explains why We should cover the claim for benefits. All appeals and related documentation must be sent to:

Hometown Health Customer Service

10315 Professional Circle

Reno, NV 89521

The review of your appeal will be made by an individual who is neither the individual who made the initial adverse benefit determination nor the subordinate of such individual and will not afford deference to such adverse benefit determination.

When the review is complete, We will inform You in writing of the resolution no later than:

- 72 hours, in the case of an expedited appeal;
- 30 days, in the case of an appeal of a pre-service claim; or
- 60 days, in the case of an appeal of a post-service claim.

We may extend this period one time for up to 15 days if the extension is necessary due to matters beyond Our control and We notify You prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which the Policy expects to make a decision.

If the proposed resolution to the formal appeal is not acceptable to You, You may be entitled to proceed directly to external review outlined below. We will inform You of this right at the time We inform You of the resolution of Your formal appeal.

You may receive, free of charge, reasonable access to, and copies of, all documents and records and other information in Our possession relevant to the adverse benefit determination including, but not limited to, any applicable internal rule or guideline of ours on which We relied in making the adverse benefit determination and, if the adverse benefit determination related to Medical Necessity, a statement of the scientific or clinical judgment for the determination applying the terms of the EOC to Your medical circumstances.

C) Appeal Reopening

If you obtain additional information that was not considered by Hometown Health during the review of your appeal, or you feel as though there was an error made in the determination of your appeal, you may ask Hometown Health to re-open your appeal. A request to reopen your appeal must be filed within four (4) months from the date of your initial appeal determination. There is an exception to the 4 month filing timeframe; if You are able to demonstrate that You were incapacitated and unable to file an appeal reopening within the standard timeframe, We will grant You a reasonable extension. If You do not file a formal appeal in a timely manner, We will deem Your appeal reopening waived with respect to the adverse benefit determination to which the appeal relates.

There are two circumstances in which Hometown Health will allow an appeal reopening.

- There is new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.
- The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision. In other words, the decision was clearly incorrect based on all the evidence presented in the appeal file.

If Hometown Health grants your request to reopen your appeal We will inform You in writing of the resolution no later than:

a. 72 hours, in the case of an expedited appeal;

b. 15 days, in the case of an appeal of a pre-service claim; or

c. 30 days, in the case of an appeal of a post-service claim.

We may extend this period one time for up to 15 days if the extension is necessary due to matters beyond Our control and We notify You prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which the Policy expects to make a decision.

3. External Review of an Appeal or Grievance

If You have been unable to contact or obtain satisfaction from our internal Appeal or Grievance procedures, You may contact the Nevada Office for Consumer Health Assistance (OCHA) for review at:

Office for Consumer Health Assistance
555 East Washington #4800
Las Vegas NV 89101

(702) 486-3587
(888) 333-1597
(702) 486-1597 (fax)

http://dhhs.nv.gov/Programs/CHA/

Exhaustion of the internal appeal or grievance procedure is a precondition to filing a complaint with OCHA. This level of appeal is optional. You or Your authorized representative must submit this appeal in writing on within four (4) months after You have been informed of the resolution of the internal appeal or grievance. If You do not file Your appeal or grievance in a timely manner, We will deem it waived with respect to the adverse benefit determination to which it relates

4. External Review of Adverse Utilization Review Decisions

If, upon Our review of your internal appeal, We deny Your claim for benefits and You disagree with Our decision, You may have the right to request an independent external review of Our decision by health care professionals who have no association with Us if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested (including whether the service or treatment was determined to be Experimental or Investigative). The external review process is available only if You have exhausted Our internal appeal procedure.

All external reviews are conducted by an independent third party with clinical and legal expertise and with no financial or personal conflicts with Us. These third parties are known as “independent review organizations.” The reviewer will not defer to the decisions made during the internal review process and will look at Your claim anew. The reviewer will consider all the information and documents that it receives in a timely manner when making its decision. If the independent review organization reverses Our denial of Your claim, the decision will be final and We must immediately provide coverage or payment.

All requests for external review will be processed as a standard request unless You make a written or oral request for an expedited external review and the follow criteria is met:

A) You have a medical condition where the time for completing the standard review process would seriously jeopardize Your life, health, or ability to regain maximum function.

B) Your treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

C) You have filed a request for an expedited internal appeal.

D) The final adverse benefit determination concerns the admission, availability of care, continued stay, or health care item or service for which You received services, but You have not been discharged from a facility.

To request a standard or expedited external review You must submit your request within four (4) months of the date You receive an adverse benefit determination or final adverse benefit determination. You may file a request for external review by contacting the Nevada Office for Consumer Health Assistance (OCHA) at:

Office for Consumer Health Assistance
555 East Washington #4800
Las Vegas NV 89101

(702) 486-3587
(888) 333-1597
(702) 486-1597 (fax)

http://dhhs.nv.gov/Programs/CHA/

When filing a request for external review, You will be required to authorize the release of any of Your medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Standard and Expedited External Review Timeframes

Should You file a request for a standard or expedited external review by the OCHA, You can anticipate the timeframe for review to be as follows:[30]

A) Within five (5) days after receiving Your request for external review, OCHA will notify HTH that the request has been filed (within 72 hours for expedited requests).

B) As soon as practicable after receiving Your request, OCHA will assign an Independent Review Organization (IRO). OCHA will assign the IRO within one (1) business day for expedited requests.

[30] NRS 695G.251 through 695G. 271

C) Within five (5) days after receiving notification from OCHA, HTH will provide to the IRO all documents and materials relating to the adverse determination (within 24 hours for expedited requests).

D) Within five (5) days after receiving the request, the IRO will:

1. Review the request, documents and materials submitted; and
2. Notify You if any additional information is required to conduct the review.

E) You must provide that information to the IRO within five (5) days after receiving the request for additional information. Any information submitted to the IRO by You after five (5) business days has passed, MAY be considered as well. The IRO will forward to HTH any additional information provided to them within one (1) day of receipt.

F) If We fail to provide the information within the specified time, the IRO may terminate the review and reverse the adverse determination. The IRO must notify Us, You and the OCHA of its decision to do so.

G) Upon receipt of the information, We may reconsider Our original determination or terminate the review and immediately provide coverage for the service. We must notify the IRO, You and OCHA of Our decision to do so.

H) The IRO will approve, modify or reverse the adverse determination within fifteen (15) days (within 48 hours for expedited requests). The IRO will submit its determination to You, Your Physician, if necessary, and HTH. For expedited requests, You, Your Physician and HTH will be notified within 24 hours of completion of the review and a written notice will be provided within 48 hours.

I) We will immediately approve the coverage or recommended treatment upon receipt of a notice reversing the adverse determination.

XV. GENERAL PROVISIONS

A. Assignment

You may not assign this EOC or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Our prior written consent.

B. Authorization to Examine Medical Records

By accepting benefits under this Policy, You consent to and authorize all health care Providers including, but not limited to, Physicians, Hospitals, skilled nursing facilities, and other Providers to permit the examination and copying of any portion of the Your Hospital and medical records in accordance with applicable law, when requested by Us.

C. Balance Billing

If the billed charges exceed the contracted amount agreed to by an In-Network Provider for Covered Services that You receive, such Provider is prohibited from billing You for the difference. Because this Provider is an In-Network Provider, You are not responsible for the difference between the billed charges and the contracted charges.

D. Charge for Service or Purchase

We will deem the charge for service or purchase to have been incurred on the date the service is performed or the date the purchase occurs.

E. Clerical Error

Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage that would otherwise be validly in force nor continue coverage that would otherwise be validly terminated. Upon discovery of such errors or delays, an equitable adjustment of Premiums will be made. In no event will credits be made retroactive more than two Premium due dates prior to the date that We are notified in writing in a form satisfactory to Us of a requested addition/deletion to, or change in, Your coverage status.

F. Entire EOC

This EOC, the Schedule of Benefits, riders, the individual applications, questionnaires, applicable attachments if any and Your on-line signature accepting coverage constitute the entire contract between the parties. As of the effective date of coverage, it supersedes all other agreements between the parties. Any statements made to Us by the Member shall, in the absence of fraud, be deemed representations and not warranties. No such statement, unless it is contained in a written application for coverage, may be used in defense to a claim under this Policy.

G. Form or Content of EOC

No agent or employee of Us is authorized to change the form or content of this EOC. Such changes can be made only through endorsement signed by an authorized officer of Us.

H. Gender

The use of any gender herein shall include the other gender and the use of the singular shall include the plural (and vice versa).

I. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with the laws of the state of Nevada and any provision that is required to be in this EOC by state or federal law shall bind Us and each Member whether or not set forth in this EOC.

J. Membership Card

Cards that We issue to Members are for identification only. Possession of a membership card confers no right to services or other benefits under this Policy. To be entitled to such services or benefits, the holder of the card must, in fact be an eligible Member on whose behalf all applicable Premiums due under this Policy have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to the provisions of this Policy and any Member assisting such person shall be liable for the actual cost of such services or benefits.

K. Modifications

This EOC shall automatically be modified to comply with provisions of applicable federal and Nevada law. By electing medical and Hospital coverage under this Policy or accepting this Policy's benefits, all Members legally capable of contracting, and the legal representative of all Members incapable of contracting, agree to all terms and conditions hereof.

L. Notice

You may give any notice under this Policy by United States mail, first class, postage prepaid, addressed as follows:

Hometown Health
Customer Service Department
10315 Professional Circle
Reno, Nevada 89521.

We will send Our notices to You to the most recent address that We have on file. You are responsible for notifying Our customer services department of any change in address.

M. Notice of Claim

If submission of a claim is required to receive benefits under this Policy, such claim will be allowed only if notice of the claim is submitted to Us within 120 days from the date on which the covered expenses were first incurred. However, if it was not reasonably possible to give notice within the above time limit, and notice was furnished, as soon as was reasonably possible, the submission date will be extended accordingly. However, in no event will We pay benefits if notice of claim is made beyond one year from the date on which the Expense was incurred.

N. Policies and Procedures

We may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Policy.

O. Nondiscrimination

We do not discriminate in the delivery of services on the basis of sex, age, race, religion, national origin, sexual orientation, or genetic information.

P. Return of Overpayment

Payment made for charges must be returned to Us if found that such charges were paid in error.

XVI. DEFINITIONS

The following definitions apply to all provisions of this EOC and to the applicable Schedule of Benefits.

A. GENERAL DEFINITIONS

Acute – A short illness or Injury, generally of a sudden onset and/or infrequent occurrence, in which illness or Injury is not always present. An Acute condition may become Chronic.

Allowed Amount – The contracted amount for a Covered Service or, if there is not a contracted amount, the Usual and Customary amount.

Benefit Plan – The specific health insurance Policy outlined in this EOC and Your Schedule of Benefits.

Benefit Summary Table – A table found in the Schedule of Benefits that includes the specific level of Cost Sharing for various benefits that must be paid by the Member upon receipt of the benefit.

Billing Cycle – The period between the Premium due date and the day before the next Premium is due. The Premium due date is the day following the date of Subscriber acceptance of Policy. Eligibility for coverage and membership will not begin until the Premium is collected and the effective date of coverage will vary depending upon the circumstances around the enrollment. This is detailed in the eligibility section of the Policy.

Chronic – An illness, condition, or Injury that continues or is expected to continue for at least six months that can recur frequently or is always present. Chronic conditions may have Acute episodes.

Chronic Pain – Ongoing pain that is due to non-life threatening causes may continue for the remainder of life and that has not responded to currently available treatment methods.

Coinsurance – The percentage of the Allowed Amount for a Covered Service that is due and payable by the Member to a Provider upon receipt of the service. There may be separate Coinsurance for medical, pharmacy and other benefits according to the Benefit Plan that is in place. Coinsurance applies after all Deductibles have been paid, unless otherwise stated within the Schedule of Benefits or EOC. Coinsurance paid by the Member applies to the Out-of-Pocket Maximums.

Concurrent Review – We may evaluate patient care while the member is in the hospital or undergoing outpatient treatment. The goal is to help make sure the member gets the right level of care at the right time. The concurrent review process includes:

- Collecting information from the care team about the person’s condition and progress
- Determining coverage based on this information
- Informing everyone involved in the patient's care about the coverage determination
- Identifying a discharge and continuing care plan early in the stay
- Assessing this plan during the stay
- Identifying and referring potential quality of care concerns and patient safety events for additional review

Convenient Care Facility – A facility that provides services for Medically Necessary, non-urgent illness or Injury. Examples of such conditions include diagnostic laboratory services, general health screenings, minor wound treatment and repair, minor illnesses (cold/flu), treatment of minor burns and sprains and blood pressure checks.

Copay – The dollar amount that a member must pay to a provider upon receipt of Covered Services. Copayments apply after all deductibles have been paid, unless otherwise stated within the Schedule of Benefits or EOC. If there is no Deductible for a particular service or the applicable Deductible has been reached, and a Copayment is listed, the Member's Cost Sharing for that service will be that Copayment. Copayments paid by the Member apply to the In-Network Out-of-Pocket Maximums.

Cost Sharing – A general term used to describe the amount of Deductible, Copayment, Coinsurance and other expenses that a Member must pay before Hometown Health pays for Covered Services. Cost Sharing is used to promote the use of lower high cost and higher quality services. Charges associated with the following are the Member's responsibility and do not accumulate toward the Member's Deductible and Out-of-Pocket Maximum:

- Costs for services received from an Out-of-Network Provider in excess of the Allowed Amount;
- Coinsurance for services for which the Member did not receive Prior Authorization when Prior Authorization is required;
- Costs for Prescription Drugs in excess of the Allowed Amount;
- Non-Covered Services and Prescription Drugs;
- Ancillary Charges
- Denied claims; and
- Prescription drugs received from an Out-of-Network Pharmacy unless in an urgent or emergent case by case basis

Covered Service – A benefit for services and supplies that We provide or arrange under this Policy and:

- Is Medically Necessary or otherwise specifically listed as a benefit in the Schedule of Benefits or EOC;
- Is rendered by a licensed, certified, or registered Provider within the state of the place of service and within the scope of the license of the Provider performing the service;
- For which We provide a Prior Authorization if Prior Authorization is required; and
- Is not experimental or investigational or otherwise limited or excluded by this EOC.

Services that are not Covered Services do not count toward Your Deductible or Out-of-Pocket Maximum.

Custodial Care – Health care services or other related services (such as assistance in activities of daily living) that either:

- Do not seek a cure;
- Are provided during periods when Acute care is not required or when the medical condition of a Member is not improving;
- Do not require continued administration by licensed medical personnel; or
- Assist in the activities of daily living.

Deductible – The dollar amount that a Member must pay to Providers for Covered Services each calendar year before Hometown Health pays for services, other than preventive care. There may be separate Deductibles for medical, pharmacy and other benefits according to the Benefit Plan that is in place, or they may be combined. Services subject to the Deductible will be annotated with "CYD" in the Benefit Summary Table. Generally, Copayments or Coinsurance are payable once the Member or family has reached the applicable Deductible. Amounts paid by the Member that are applied to the In-Network Deductible are also applied to the In-Network Out-of-Pocket Maximum.

The family Deductible is set at twice the individual Deductible. Once the family has reached the family Deductible, benefits are payable to all Members of the family regardless of whether the Member has met the individual Deductible. Except for certain HDHPs, one individual family Member cannot contribute more than the individual Deductible amount. This is called an embedded Deductible.

For certain HDHPs, if enrolled as a family, the family must satisfy the family Deductible each calendar year before benefits are payable for any individual family Member. HDHPs cannot cover health plan expenses before Deductibles except for preventive care services. This is called an umbrella Deductible.

See Your Schedule of Benefits for the definition of Deductible that applies to You.

Developmental Care – Services or supplies that:

- Are provided to a Member who has not previously reached the level of intellectual, speech, motor, or physical development normally expected for the Member's age, and such conditions were not a result of an Injury or illness;
- Are primarily provided to assist in the development of those skills described above; and
- Are not rehabilitative in nature (for example, restoring fully developed skills that were lost or impaired due to Injury or illness).

Domiciliary Care – Services or supplies that:

- Primarily provide a protective environment and assistance with basic personal needs for a Member;
- Are primarily provided because the Member's own home arrangements are not appropriate; and
- Are not part of an active treatment plan intended to or reasonably expected to improve the Member's condition of functional ability.

eConsult – A consultation with a specialist from your Primary Care Physician (PCP) in order to receive advice or treatment recommendation for Your care.

Emergency – A medical condition manifesting itself by symptoms of sufficient severity (including severe pain) that a Member, as a prudent layperson with an average knowledge of health and medicine, could reasonably believe that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the Member;
- Serious jeopardy to the health of an unborn child;
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

Evidence of Coverage (EOC) – This document which describes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures for Your health insurance Policy.

Expense – The cost incurred for a Covered Service or supply. An Expense is considered incurred on the date that a service or supply is received. A covered Expense does not include any charge:

- For a service or supply that is determined to not be Medically Necessary by Hometown Health;
- To the extent that the charge for a service or supply exceeds the lesser of the Usual and Customary charge or the applicable Medicare reimbursement rate for such service or supply;
- That is more than the Allowed Amount for the service or supply; or
- That is not a Covered Service under this Policy.

Food and Drug Administration (FDA) Approved – Drugs, medications, and biological agents that have been approved by the FDA and listed in the United States Pharmacopoeia, the American MA Drug Evaluations, or the American Hospital Formulary.

Gestational Carrier or Surrogate – An adult woman who is not the intended parent and enters into a gestational agreement, as defined by applicable law, to bear a child conceived using the gametes of other persons and not her own.

High Deductible Health Plan (HDHP) – A plan as described in IRS Publication 969 and IRS Revenue Procedure 2018-30, or its successor, in which the plan cannot pay for any benefits, except for preventive care benefits prior to the individual and family meeting the minimum Deductible limit as defined by the IRS (additional requirements apply). As such, taxpayers enrolled in this Benefit Plan may be eligible to make pre-tax contributions to their qualified Health Savings Account (HSA). If Your plan has "HSA" in its name, the plan qualifies as an HDHP under all IRS requirements. Contact Your tax Professional for more details.

Hospital – A legally operated facility defined as an Acute care or Tertiary Care Hospital that is licensed by the state and may be approved by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission or JCAHO), the American Osteopathic Association (AOA) or by Medicare.

ICHRA – An account-based healthcare plan that allows employers to reimburse employees for individual health insurance premiums and qualified medical expenses tax free.

Illness or ***Injury*** – A disorder or disease of the body or mind or an accidental bodily wound. All illnesses due to the same cause or to a related cause are considered one illness.

Infusion Therapy – Includes home infusion therapy. Does not include the cost of special pharmaceuticals used

in infusion therapy.

In-Network - The receipt of Covered Services or benefits from a Provider who is listed in Our current Provider directory and who is directly or indirectly under contract with Hometown Health to provide Covered Services to Members. These Providers are sometimes referred to as Preferred or Participating Providers.

Except for Emergency room visits or as otherwise approved by Hometown Health in advance all services received from Providers who are not In-Network Providers will not be covered.

An In-Network Provider's agreement with Us or the association of a particular Professional with an In-Network Provider may terminate, and, in such a case, a Member will be required to use another In-Network Provider to receive In-Network benefits. Not all Providers who have contracts with Us are In-Network Providers for the purposes of this particular product. We do not guarantee the continued availability of any particular Provider. In-Network Providers cannot determine whether a service is a Covered Service under this Policy or on Our behalf.

You can find Our current Provider directory on Our web site at hometownhealth.com under the Provider Directory link or You can request one by contacting Our customer service department.

As a Member of Hometown Health, Your plan has a Network of healthcare providers available to You. If the health care services are not available within the Network, then Your Provider must contact Our Utilization Management department to request a review for an Out-of-Network Provider. Our determination will be sent to You and Your Provider and will specify the approved procedure and servicing Provider.

Licensed Area – The geographic area in which Hometown Health can provide health insurance. The Licensed Area generally defines the geographic area in which In-Network Providers are located, though not all Providers within the Licensed Area are In-Network Providers and In-Network Providers may be located outside the Licensed Area. The Licensed Area may be larger than the Geographic Service Area for a specific Benefit Plan. Hometown Health has a license to provide Benefit Plans throughout the State of Nevada.

Medically Necessary (Medical Necessity) – Health care services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an illness, Injury or disease, or any symptoms thereof, that are:

- Provided in accordance with generally accepted standards of medical practice (for purposes of this document, the phrase "generally accepted standards of medical practice" is defined as standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, endorsed through national Physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas withregard to a patient's condition);
- Clinically appropriate with regard to type, frequency, extent, location, and duration;
- Not primarily provided for the convenience of the patient, Physician or other Provider of health care;
- Required to improve a specific health condition of a Member or to preserve his existing state of health;
- The most clinically appropriate level of health care that may be safely provided to the insured;
- Effective as proven by scientific evidence, in materially changing health outcomes;
- Not experimental, investigational, or subject to an exclusion under this Policy;
- Cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting ("cost effective" does not mean lowest cost). It does mean that as to the diagnosis or treatment of the Member's illness, Injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate; and
- Obtained from a Physician and/or licensed, certified, or registered Provider.

A determination that a service is Medically Necessary is not an authorization to receive that service from an Out-of-Network Provider.

Medical Director – A Physician licensed by the State of Nevada that We employ or contract with to monitor and review the utilization and quality of health services that We provide to Members.

Medical Pharmacy – Drugs, pharmaceuticals, immunizations, or biologics whose distribution, administration or supply of pharmaceuticals is generally in a healthcare facility, Physician's office, and not in a retail pharmacy setting. A complete list of pharmaceuticals that are covered under the Medical Pharmacy benefit is available at hometownhealth.com.

Member – A Subscriber or the Subscriber's eligible dependents covered under the Policy.

Network – All of the In-Network Providers with which We have contracted to provide Covered Services.

Office Visit – An office or outpatient visit consists of counseling and/or coordination of care with a Physician, a qualified health care Professional, or an agency consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Open Enrollment Period – The period of time between November 1 and December 15 during which You may enroll in any individual and family Hometown Health plan for which You are eligible.

Out-of-Area – Outside of Your specific plans Geographic Service Area.

Out-of-Network – When you do not use In-Network Provider or get care as part of an Authorized Referral, Covered Services are covered at the Out-of-Network level.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the plan's Maximum Allowed Amount, except for Emergency Care received in the United States, and certain non-Emergency Covered services that you receive from an Out-of-Network provider while you are receiving services from an In-Network facility;

2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless your claim involves a Surprise Billing Claim;

3. You will have to pay for services that are not Medically Necessary;

4. You will have to pay for non-Covered Services;

5. You may have to file claims;

6. You must make sure any necessary Precertification is done

Out-of-Pocket Maximum – The most a Member or Family will pay for Covered Services in a calendar year.

Copayments, Coinsurance and Deductibles paid by Members count towards the Out-of-Pocket Maximum.

The Out-of-Pocket Maximum does not include Premiums, expenses associated with non-Covered Services or denied claims, Ancillary Charges and amounts that Out-of-Network Providers bill and are payable that are greater than the Allowed Amount.

If coverage is extended to qualified dependents and the family Out-of-Pocket Maximum has been paid, no further payment is required to be paid on the Member's behalf for Covered Services.

Outpatient Observation – A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before medical staff members can decide whether a patient needs additional treatment as an inpatient or can be discharged from the Hospital, generally limited to a maximum of 48 hours.

Partial Hospitalization – The continuous treatment for at least four hours but not more than 12 hours in any period of 24 consecutive hours. Partial hospitalization services can be performed in a Hospital or treatment center facility.

Physician – A licensed doctor of medicine, osteopathy, dentistry, or podiatry.

Policy – This Evidence of Coverage (EOC), the Schedule of Benefits, riders, the individual application, questionnaires, applicable attachments if any and Your on-line signature accepting coverage.

Premium – A periodic payment, typically monthly, paid to Us for this Policy.

Primary Care Physician (PCP) – A Physician in the fields of Family Practice, Internal Medicine or Pediatrics who is an In-Network Provider and who a Member designates (or who We designate on behalf of a Member) to arrange and coordinate all aspects of such Member's care.

Prior Authorization – Approval from Hometown Health that may be required before You get a service or fill a prescription. We use utilization management and quality assurance protocols to ensure the service being requested is Medically Necessary and covered. Prior Authorizations protect You from expenses that result from receiving services that are not covered, not Medically Necessary or are otherwise excluded from coverage under this plan. All benefits listed in this EOC and Your Schedule of Benefits may be subject to Prior Authorization requirements and concurrent review depending upon the circumstances associated with the services.

- *HMO plan: Prior Authorization is required and if not obtained, the service may not be covered, even if the service is Medically Necessary.*
- *EPO plan: Prior Authorization is required and if not obtained, the service may not be covered, even if the service is Medically Necessary.*
- *PPO plan: Prior Authorization is required and if not obtained, You may be subject to a 50% reduction in benefits, even if the service is Medically Necessary.*

There may be Prior Authorization or pre-treatment requirements for pharmacy, dental, and vision benefits. Refer to Your plan-specific Schedule of Benefits for services that require Prior Authorization. You may find a full list of services that require Prior Authorization by visiting Our website at hometownhealth.com or contact Customer Service at 1-800-336-0123 for more information.

Professional – A Physician or other health care Professional, including a pharmacist, Physician's assistant, nurse practitioner, or autism behavioral interventionist, who is licensed, certified, or otherwise authorized by the state to provide health care services consistent with state law.

Provider – A Physician, Professional, organization or association of physicians, Hospital, skilled nursing facility, any organization licensed by a state to render home health services, or any other licensed health care institution or health care Professional.

Qualifying Life Event – An event in Your life, such as birth or marriage, which allows You to enroll or change health insurance coverage.

Remote Monitoring – *R*emote patient monitoring, including the collection, storage, and evaluation of health information through live monitoring via devices that transmit information from the home or care facility to Your provider.***Specialist or Specialty Care Physician*** – A Professional who provides medical care in a specific branch of medicine generally referable to a particular bodily system or area.

Subscriber – A person who meets all applicable eligibility requirements of this EOC, whose enrollment form has been accepted by Hometown Health and in whose name the membership is established. For group plans, the Subscriber is generally the employee. For individual and family plans, the Subscriber is the Policy holder.

Schedule of Benefits – The document that describes the Cost Sharing and some of Your rights and restrictions for Your health insurance Policy provided by Hometown Health. The Schedule of Benefits is a supplement to this EOC. In case of conflicts between this EOC and Your Schedule of Benefits, this EOC shall be the document that determines the benefits or interpretation of those documents.

Sickle Cell Disease and Its Variants - An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood vessels. May include sickle cell disease, or one or more variants or a combination thereof.

Telehealth or Telemedicine – The delivery of services from a Provider to a Member, while the patient is at the originating site and the provider for telehealth is at a distant site through the use of information and audio-visual communication technology, not including facsimile or electronic mail.

Tertiary Care – The highest or most complex level of care for the treatment of a particular medical condition and not generally available in a community Hospital. Tertiary care is specialized consultative care, usually on referral from primary or secondary medical care personnel, by Specialists working in a center that has personnel and facilities for special investigation and treatment.

Urgent Care – Medically Necessary services for a condition that requires prompt medical attention but is not an Emergency.

Urgent Care Center services received from Out-of-Network Providers will be covered at the Cost Sharing amount described in Your Schedule of Benefits. *Because Hometown Health is not contracted with Out-of-Network Providers, the Out-of-Network Provider may balance bill You for the amount charged in excess of the Allowed Amount paid by Hometown Health.*

Usual and Customary – The lesser of:

- A Provider's usual charge for furnishing a treatment, service, or supply; or
- The amount Hometown Health determines to be the general rate paid to others who render or furnish such treatment, service, or supply to individuals who reside in the same geographic area and whose conditions are comparable in nature and severity.

Virtual Visit – An Urgent Care Telehealth visit delivered via the Member's audio and video enabled device.

We, Us, Our, or Hometown Health – Hometown Health Plan, Inc.

Wrap Network – An extended network of providers where health plan members can access care if they are in a different location or if they require care from a specialist that is not in the plan's primary network.

You, Your, or Member – A person who meets all applicable eligibility requirements of this EOC and whose enrollment form We have accepted.

B. PHARMACY BENEFIT DEFINITIONS

Specific terms related to pharmacy benefits that may be used throughout his EOC and to the applicable Schedule of Benefits are defined as follows.

Ancillary Charge – An additional charge borne by the Member and calculated as the difference between the contracted reimbursement rate for In-Network pharmacies for the medication dispensed and the Generic Drug product equivalent. Ancillary Charges do not apply toward Your Deductible or Out-of-Pocket Maximum.

Brand Drug – A Prescription Drug, including insulin, typically protected under patent by the drug's original manufacturer or developer with a proprietary trademarked name.

Diabetic Services – Products for the management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies and appliances for the treatment of diabetes.

Drug Formulary – A comprehensive list of Brand and Generic Drugs, approved by the U.S. Food and Drug Administration (FDA), covered under this Benefit Plan. The medications covered under this formulary may be substantially different from other Hometown Health drug formularies.

Formulary Drug – A Brand Drug or Generic Drug included in the Drug Formulary.

Generic Drug – A Prescription Drug, whether identified by its chemical, proprietary or nonproprietary name, that is accepted by the FDA as therapeutically equivalent and interchangeable with a drug having an identical amount of the same active ingredient(s) in the same proportions, that have the same information printed on the label and that perform in the same manner as the trademarked, brand-name version of the drug

Injectable Drug – A Prescription Drug dispensed from a pharmacy (including combination therapy kits) that are injected directly into the body by the Member or the Member's Physician.

Maintenance Medication – Prescriptions Drugs commonly used to treat conditions that are considered Chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of Maintenance Medications are those drugs used to treat high blood pressure, heart disease, asthma, and diabetes.

Maximum Allowed Amount – The lowest available cost to Hometown Health for a Generic Drug, a Prescription Drug product or a Brand Drug without a Generic Drug equivalent available at the time a prescription is filled.

Non-Formulary Drug – A drug not listed in the Drug Formulary. There is no coverage for drugs that are not listed in the Drug Formulary.

Out-of-Network Pharmacy – A Pharmacy with which Hometown Health is not contracted to provide discounted covered Prescription Drug products to its members.

In-Network Retail Pharmacy – A pharmacy with which Hometown Health, or PBM is contracted to provide discounted Prescription Drugs to its members.

Pharmacy Benefit Manager (PBM) – A company with which Hometown Health is contracted to manage the Prescription Drug benefits provided in Your Policy.

Prescription Drug – A medication, product or device approved by the FDA and dispensed under state or federal law pursuant to a prescription order (script) or refill.

Step Therapy – A treatment process that requires the use of lower cost drugs first (generally within a specific therapeutic class of drugs) when multiple treatment options exist for a particular medical condition, before Hometown Health authorizes the use of higher cost Formulary Drugs.

Specialty Pharmaceuticals – Prescription Drugs having one or more of the following characteristics: expensive (typically greater than $600 per dosage unit or per prescription); limited access; complicated treatment regimens; compliance issues; special storage requirements; or manufacturer reporting requirements.

NOTICE OF PROTECTION PROVIDED BY NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Effective On or Before July 1, 2022

This notice provides a **brief summary** regarding the protections provided to policyholders by the Nevada Life and Health Insurance Guaranty Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies and health maintenance organizations licensed in Nevada to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is limited and is *not* a substitute for consumers' care in selecting insurers. **Your policy or contract may not be covered, and if covered, there are substantial coverage limitations and exclusions. Further, coverage is dependent on continued residence in Nevada.** Below is a brief summary of the coverages, exclusions, and limits provided by the Association. This summary does not cover all provisions of the law, and the law may change.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in Nevada at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in Nevada.

Amounts of Coverage

For any one life, per company, the coverage protections provided by the Association shall not exceed:

- **Life Insurance**
  - Death benefits: $300,000
  - Cash surrender or withdrawal values: $100,000

- **Annuities and Structured Settlement Annuities**
  - Present value of annuity benefits and structured settlement annuities, including cash surrenders or withdrawal values: $250,000
  - Participants in a government retirement plan covered by an unallocated annuity as described by NRS 686.C.035: $250,000.

- **Health Insurance**
  - Disability Income and long-term care insurance, including net cash surrendervalues: $300,000
  - Health Benefit Plan: $500,000
  - Health insurance, other than disability income, long-term care insurance or Health Benefit Plan: $100,000

Please note that the maximum protection provided by the Association to an individual for all life insurance, annuities, and structured settlement annuities with one insurer is $300,000; or for all life insurance, annuities, structured settlement annuities, and benefits for health benefit plans with one insurer, $500,000, regardless of the number of policies or contracts covering the individual.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The following policies and persons are examples of those excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Nevada when it issued the policy or contract
- A policy or contract issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or an organization that is only licensed to issue charitable gift annuities
- Persons provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual except for annuities owned by a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields exceed an average rate

NOTICES

Member insurers or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. The member insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or coverage offered by a health maintenance organization. You may file a complaint with the Nevada Insurance Commissioner if you believe any provision of the Nevada Life and Health Insurance Guarantee Association law has been violated. To learn more about coverage provided by the Association, please visit the Association's website at www.nvlifega.org, or contact either of the following:

Nevada Life and Health Insurance
Guaranty Association
2377 Gold Meadow Way, Suite 100
Gold River, CA 95670

Nevada Division Insurance
Department of Business and Industry
1818 E. College Pkwy., Suite 103
Carson City, NV 89706

When selecting an insurer, you should not rely on Association coverage. If there is any inconsistency between this notice and Nevada law, Nevada law will control.

Right and Responsibilities

As a member, you have a right:

To be treated in a manner that respects your privacy and dignity as a person and to receive assistance in a prompt, courteous and responsible manner.

To affordable, comprehensive care that provides the value you expect and contributes to your peace of mind, which is essential to good health.

To a choice of physicians who meet high standards of professional training and experience, because informed choices and the freedom to select physicians are essential to building active partnerships between members and doctors.

To be informed about how to obtain a referral for specialty care and how to obtain after-hours and emergency care inside and outside of your local area.

To be provided with information about the providers who deliver your health care and about your health-care benefits. You need to know any exclusions and limitations associated with the plan and any charges for which you will be held responsible.

To be informed by your physician of your diagnosis, prognosis and plan of treatment in terms you understand and to know that all health-care professionals will be held accountable for the quality of services they provide and for the satisfaction of members.

To be informed by your physician about any treatment you may receive. You have a right to participate in the plan for your care. Your provider will request your consent for all treatment, unless there is an emergency and your life and health are in serious danger.

To confidential handling of all communications and medical information maintained at Hometown Health Plan, as provided by law and professional medical ethics.

To complete and easily understood information about the costs of your coverage or any changes that may affect your coverage.

To refuse treatment and be advised of the probable consequences of your decision by your treating physician. We encourage you to discuss your options with your Primary Care Physician (PCP). He or she will advise you and discuss alternative treatment plans with you, but you will have the final decision.

To select a Primary Care Physician from a listing of participating providers, change your Primary Care Physician for any reason and be informed about how provider incentives or restrictions might influence practice patterns.

To have your medical records transferred promptly to a new provider within or outside the network, to ensure continuity of your care.

To express a concern or grievance about Hometown Health Plan and the care you have received and to receive a response in a timely manner.

To keep scheduled appointments and notify the physician's office promptly if you will be unable to keep an appointment and to pay all charges, if any, for missed appointments and services not covered.

To participate actively in decisions about your health care and cooperate fully on mutually accepted courses of treatment.

To follow the advice of your Primary Care Physician and consider the likely consequences when you refuse to comply. We encourage you to ask questions of your physician until you fully understand the care you are receiving.

To provide honest and complete information to those providing care.

To know what medication you are taking, why you are taking it and the proper way to take it.

To express your opinions, concerns or complaints in a constructive manner to the appropriate people within Hometown Health Plan or the provider network.

To make premium payments on time if they are not paid directly by your employer.

To be treated with respect and recognition of their dignity and their right to privacy.

To a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

To make recommendations regarding the organization’s member rights and responsibilities policy.

To receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

To participate with practitioners in making decisions about their health care.

To voice complaints or appeals about the organization or the care it provides.

A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

All participants are responsible for learning how Hometown Health Plan works by carefully studying and referring to your benefit documents. Please call our Customer

Services Department at 775-982-3232 or 800-336-0123 if you have questions about the plan. If you are hearing impaired, dial our TDD number, 775-982-3240.

Our Philosophy of Care

We represent a philosophy of health care that emphasizes active partnerships between members and their physicians. We believe members should have the right care, at the right time, in the right setting. We believe working with people to keep them healthy is as important as making them well.

We value prevention as a key component of comprehensive care - reducing the risks of illness and helping to treat small problems before they can become more severe. We are committed to high standards of quality, service and professional ethics and to the principle that members come first.