This Schedule of Benefits describes your health insurance Policy provided by Hometown Health Providers Insurance Company, Inc. (Hometown Health), an insurance company licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members.

Network. This Policy is an open access Preferred Provider Organization (PPO) that provides access to a large network of Preferred Providers who have contracts with Hometown Health. These contracts allow the Member to receive services at the In-Network Benefit level. The Policy also allows Members to seek services from Non-Preferred Providers, generally at a reduced benefit level (higher cost to the Member), unless the services are rendered as part of an Emergency room visit, or they have been previously approved by Hometown Health to be paid at the In-Network Benefit Level.

Prescription Drug Coverage. Members must utilize the Hometown Health Premier Pharmacy Network. *This Policy does not cover drugs which are purchased from pharmacies that are not part of the Hometown Health Premier Pharmacy Network.* Members must work with their doctors to select drugs that are included in the Hometown Health Essential Health Benefits Prescription Drug List. *This Policy does not cover drugs which are not included in the Hometown Health Essential Health Benefits Prescription Drug List (Hometown Health Individual/Small Group Formulary).*

Pediatric Coverage. This Benefit Plan includes pediatric vision coverage for those members under the age of 19, with a corresponding vision network of Preferred Providers. A list of Preferred Providers for this network and the medical and pharmacy networks are available at www.hometownhealth.com. This Benefit Plan does not include pediatric dental coverage.

Geographic Service Area. This Policy is available only to those individuals and families that live in Carson City or Washoe County. Additional eligibility requirements are detailed in the Hometown Health Individual and Family PPO Evidence of Coverage (EOC).

Minimum Essential Coverage. This Benefit Plan is considered Minimum Essential Coverage as defined by 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.

Additional Requirements. This Schedule of Benefits describes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures. This document is summary in nature. It does not contain all of the Prior Authorization requirements and specific restrictions, exclusions and limitations associated with this Benefit Plan. Refer to the EOC for a more comprehensive list of Prior Authorization requirements and specific cost sharing information, restrictions, exclusions and limitations. In case of conflicts between the EOC and this Schedule of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents. Copies of EOCs, Schedules of Benefits, attachments, Preferred Provider lists and other associated documents are available online at www.hometownhealth.com. We will

provide you with paper copies of these documents without charge upon your request to our customer services department.

Ongoing Regulation. This Schedule of Benefits complies with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, referred together as the Affordable Care Act (ACA). As of the date of the publication of this Schedule of Benefits and the EOC it supports, the United States Department of Health and Human Services and other regulatory agencies had not issued regulations or guidance with respect to many aspects of these laws. We will provide coverage under this Policy in accordance with these laws and in compliance with applicable regulations and guidance as they are issued.

Definitions. Specific terms that may be used throughout this Schedule of Benefits are defined as follows. For additional definitions and information, see the EOC that governs this Schedule of Benefits.

Allowable Amount – The contracted amount for a given service or, if there is not a contracted amount and the service is still covered by this Benefit Plan, the lesser of the Usual and Customary amount or the amount Medicare would pay for the service.

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

Coinsurance – The percentage of the maximum Allowable 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.

Copayment – The specific dollar amount that is due and payable by the Member to a Provider upon receipt of certain 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.

Deductible – The amount that must be paid by a Member each calendar year before Hometown Health pays for certain covered 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 two times 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. One individual family member cannot contribute more than the individual Deductible amount. This is called an Embedded Deductible.

In-Network – The receipt of Covered Services or benefits from a Participating Provider. *Except as otherwise approved by Hometown Health in advance or in the case of approved telemedicine providers, all non-Emergency services received at Providers who are not In-Network Providers will be paid at the non-par Out-of-Network rate.*

Medically Necessary – 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, and that are:

a. 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 with regard to a patient's condition);
b. Clinically appropriate with regard to type, frequency, extent, location, and duration;
c. Not primarily provided for the convenience of the patient, Physician or other Provider of health care;
d. Required to improve a specific health condition of a Member or to preserve his existing state of health;
e. The most clinically appropriate level of health care that may be safely provided to the insured;
f. Effective as proven by scientific evidence, in materially changing health outcomes;
g. Not experimental, investigational, or subject to an exclusion under this Policy;
h. Cost-effective compared to alternative interventions, including no intervention ("cost effective" is not construed to mean lowest cost); and
i. Obtained from a Physician and/or licensed, certified or registered Provider.

Non-Preferred or *Non-Participating (Out-of-Network) Providers* – Providers with whom Hometown Health is not contracted to provide discounted covered healthcare services to its members. Generally, Hometown Health pays a lower, non-preferred benefit level, or does not pay a benefit at all, for services provided by a Non-Preferred Provider, unless the services are rendered as part of an Emergency room visit, or they have been previously approved by Hometown Health. *Because Hometown Health is not contracted with Non-Preferred Providers, the Non-Preferred Provider may balance bill you for the amount charged in excess of the Allowable Amount paid by Hometown Health. Additionally, Non-Preferred Providers may not follow appropriate Prior Authorization procedures which may result in you receiving services that are not covered, not Medically Necessary or are otherwise excluded from coverage under this Benefit Plan .*

Out-of-Network – The receipt of Covered Services or benefits from a Non-Participating Provider resulting in Member cost sharing at higher rate than if the service were received In-Network. *Except as otherwise approved by Hometown Health in advance or in the case of approved telemedicine providers, all non-Emergency services received at Providers who are not In-Network Providers will be paid at the non-par Out-of-Network rate.*

Out-of-Pocket Maximum – The maximum amount of In-Network Deductible, Copayments, and Coinsurance paid by the Member or Family for Covered Services in a Calendar Year. Premiums paid by the Member are not included in the Out-of-Pocket Maximum. In no instance will the Member pay more for covered services than the Individual In-Network Combined Out-of-Pocket Maximum as provided in the Benefit Summary Table. If coverage is extended to qualified dependents and the family In-Network Out-of-Pocket maximum has been paid, no further payment is required for benefits to be paid on the Member's behalf.

Different Out-of-Pocket Maximums apply to individuals and families. Different Out-of-Pocket Maximums apply to services received from In-Network Providers and Out-of-Network Providers. Payments made by Members toward Deductibles and Copayments also count towards the Out-of-Pocket Maximum for In-Network benefits. However, Deductibles and Copayments for Out-of-Network benefits do not apply to the Out-of-Pocket Maximum. When a member seeks care from an Out-of-Network Provider, the difference between the Provider's bill and the Allowable Amount, as determine by Hometown Health, does not count towards the Out-of- Pocket Maximum for the non-preferred benefit.

Preferred or Participating (In-Network) Provider – A Provider who is listed in our current health directory and who is directly or indirectly under contract with Hometown Health to provide Covered Services to Members.

Prior Authorization – A determination made by Hometown Health of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. 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 Schedule of Benefits may be subject to Prior Authorization requirements and concurrent review depending upon the circumstances associated with the services. *If a Prior Authorization is required and you do not obtain the required Prior Authorization, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary.* You may find a full list of services that require Prior Authorization by visiting our website at www.hometownhealth.com. There may be Prior Authorization or pre-treatment requirements for pharmacy, dental, and vision benefits that are provided in this Benefit Plan. Refer to the EOC for more details.

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.

Usual and Customary – The lesser of:

a. A Provider's usual charge for furnishing a treatment, service, or supply; or

b. 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 is comparable in nature and severity.

Pharmacy Benefit Definitions. Specific terms related to pharmacy benefits that may be used throughout this Schedule of Benefits are defined as follows. For additional definitions and information, see the EOC that governs this Schedule of Benefits and the Drug Formulary.

Ancillary Charge – An additional cost-sharing charge borne by the member and calculated as the difference between the contracted reimbursement rate for participating 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-Name Prescription Drug or *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-name and generic prescription 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 for its commercial and Medicare Advantage formularies.

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

Generic Prescription Drug or *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.

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

Non-Formulary Drug – A drug not listed in the Drug Formulary that has either a generic or a brand alternative drug that is listed in the Drug Formulary. There is no coverage for drugs that are not listed in the Hometown Health Drug Formulary.

Non-Participating Pharmacy – A pharmacy with which Hometown Health is not contracted to provide discounted covered prescription drug products to its members.

Participating Retail Pharmacy – A pharmacy with which Hometown Health is contracted to provide discounted prescription drugs to its members.

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.

Special Pharmaceuticals – prescription drugs having one or more of the following characteristics: expensive (typically greater than $200 per dosage unit or per prescription); limited access; complicated treatment regimens; compliance issues; special storage requirements; or manufacturer reporting requirements.

Benefit Summary Table. The following Benefit Summary Table lists the Member's responsibility. This table may not include all eligible benefits. Items marked with "CYD" are subject to the Calendar Year Deductible which resets each January 1.

Benefit Summary Table		
	Member Responsibility	
Benefit Category	In-Network	Out-of-Network
Calendar Year Deductibles and Out-of-Pocket Maximums		
Individual Combined Medical & Pharmacy Deductible	N/A	$7,000
Family Combined Medical & Pharmacy Deductible	N/A	$14,000
Individual Medical Deductible	$2,500	N/A
Family Medical Deductible	$5,000	N/A
Individual Pharmacy Deductible	$1,000	N/A
Family Pharmacy Deductible	$2,000	N/A
Individual Combined Out-of-Pocket Maximum	$5,000	$10,000
Family Combined Out-of-Pocket Maximum	$10,000	$20,000
Out-of-Pocket Maximums are applied differently for In-Network and Out-of-Network benefit levels. In no case will a member pay more for In-Network Medical and Pharmacy services than the In-Network Combined Out-of-Pocket Maximum.		
Physician Office Visits		
Primary care (PCP) *(no charge for the first 2 in-network PCP visits each Calendar Year)*	$40	CYD then 50%
Primary care - wellness visit ACA covered	$0	CYD then 50%
Obstetrics and gynecology for ACA services	$0	CYD then 50%
Specialist care	$80	CYD then 50%
All necessary wellness visits are covered for children less than two years of age. One wellness visit per Calendar Year is covered for members older than two or as frequently as mandated by ACA. PCP and specialist visits include telemedicine only available through select in-network providers.		
Preventive Screenings		
Mammography screening	$0	CYD then 50%
Papanicolaou (Pap) test	$0	CYD then 50%
Prostate Specific Antigen (PSA) screen	$0	CYD then 50%
Colorectal screening	$0	CYD then 50%
Counseling for sexually transmitted infections (STI) HIV counseling and testing	$0	CYD then 50%
Breastfeeding support, supplies and counseling	$0	CYD then 50%
Screening for interpersonal and domestic violence	$0	CYD then 50%
Contraceptives and Counseling for FDA approved in office including injections, implants, and contraceptive devices not covered under pharmacy benefits	$0	CYD then 50%
Screening for Gestational Diabetes	$0	CYD then 50%
High-risk human papillomavirus (HPV) testing	$0	CYD then 50%
Hospital Facility Services		
Acute care hospital admission	$1,000	CYD then 50%
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	CYD then 30%	CYD then 50%
Skilled nursing facility *(limited to 100 days per Calendar Year)*	CYD then 30%	CYD then 50%
Rehabilitation facility *(limited to 60 days per Calendar Year)*	CYD then 30%	CYD then 50%

Benefit Summary Table		
	Member Responsibility	
Benefit Category	In-Network	Out-of-Network
All Hospital Facility Services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network inpatient hospital and facility admissions. In emergencies in which a member is admitted to a hospital for an inpatient stay, to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so.		
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services. Maternity care is covered except as noted in the Infertility section of covered services in the Evidence of Coverage.		
Urgent Care and Emergency Services		
Urgent Care Center Services	CYD then 30%	CYD then 50%
Emergency Room Services	CYD then 30%	CYD then 30%
Ambulance (ground)	CYD then 30%	CYD then 50%
Ambulance (air and water)	CYD then 30%	CYD then 50%
Imaging and Diagnostic Testing		
Specialty Imaging and Diagnostic Services such as Computer Tomography (CT, CTA) scan Positron Emission Tomography (PET) scan Magnetic Resonance Imaging (MRI/MRA) Nuclear Medicine Angiograms and Myelograms *Prior Authorization required. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary.*	CYD then 30%	CYD then 50%
X-ray	CYD then 30%	CYD then 50%
Diagnostic mammography	CYD then 30%	CYD then 50%
All other imaging and diagnostic services	CYD then 30%	CYD then 50%
Services provided in a primary care physician office *(except Specialty Imaging and Diagnostic Services)*	$40	CYD then 50%
Services provided in a specialty care physician office *(except Specialty Imaging and Diagnostic Services)*	$80	CYD then 50%
Laboratory Services		
General laboratory services *(unless covered under ACA preventive guidelines)*	CYD then 30%	CYD then 50%
Outpatient Therapy and Rehabilitation Services		
Speech therapy *(See limits below)*	$40	CYD then 50%
Occupational therapy *(See limits below)*	$40	CYD then 50%
Physical therapy *(See limits below)*	$40	CYD then 50%

Benefit Summary Table		
	Member Responsibility	
Benefit Category	In-Network	Out-of-Network
Coverage for Medically Necessary speech therapy, occupational therapy and physical therapy are limited to 60 visits for all three therapy types combined, separately for both habilitative and rehabilitative services, per Calendar Year. Visit maximums are for both In-Network and Out-of-Network visits combined, and for outpatient facility/provider visits combined.		
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 60 visits per Calendar Year all modalities combined.)*	CYD then 30%	CYD then 50%
Wound therapy in an outpatient hospital or outpatient facility setting *(For wound therapy in an office based setting, see the Physician Office Visits section of this Benefit Summary Table.)*	CYD then 30%	CYD then 50%
Chemotherapy in an outpatient hospital, outpatient facility or office based	CYD then 30%	CYD then 50%
Radiation therapy in an outpatient hospital, outpatient facility or office based	CYD then 30%	CYD then 50%
Infusion therapy *(Includes home infusion therapy. Does not include the cost of special pharmaceuticals used in infusion therapy. For cost of the special pharmaceuticals used in infusion therapy, see the special pharmaceuticals benefit in the Medical Pharmacy and Immunizations section or the Pharmacy Benefits section as appropriate.)*	CYD then 30%	CYD then 50%
Port Wine Stain Removal	CYD then 30%	CYD then 50%
Rehabilitation services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary.		
Surgical Services		
Performed in primary care physician's office	CYD then 30%	CYD then 50%
Performed in specialty care physician's office	CYD then 30%	CYD then 50%
Performed in outpatient facility	CYD then 30%	CYD then 50%
Performed in same-day-surgery facility	CYD then 30%	CYD then 50%
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime.)*	$1,000	CYD then 50%
Diagnostic and/or therapeutic endoscopy	CYD then 30%	CYD then 50%
All surgical services require Prior Authorization. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network facility surgical services.		
Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME) *(Limited to one purchase of specific item of DME, including repair and replacement every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of Durable Medical Equipment in excess of $150, including oxygen and oxygen-related equipment, require Prior Authorization.)*	CYD then 30%	CYD then 50%
Hearing Aids *(Limited to one hearing aid per ear every 3 years; Single purchase; repair and replacement, every 3 years.)*	CYD then 30%	CYD then 50%

Benefit Summary Table		
	Member Responsibility	
Benefit Category	In-Network	Out-of-Network
Orthopedic and prosthetic devices *(Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years. Orthopedic or prosthetic devices require Prior Authorization.)*	CYD then 30%	CYD then 50%
Ostomy supplies *(Limited to 30 days worth of therapeutic supplies per month.*	CYD then 30%	CYD then 50%
Special Food Products *(Limited to a maximum benefit of three (3) sets of thirty (30) days of therapeutic supplies per Calendar Year . Special food products require Prior Authorization.)*	CYD then 30%	CYD then 50%
If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary.		
Alcohol and Substance-Abuse Treatment		
Inpatient treatment	$1,000	CYD then 50%
Outpatient treatment – specialist	$40	CYD then 50%
Withdrawal treatment – inpatient	$1,000	CYD then 50%
Withdrawal treatment – outpatient	$40	CYD then 50%
Inpatient and outpatient programs for alcohol and substance abuse treatment require Prior Authorization. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary. A lcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require Prior Authorization. This Benefit Plan provides all mental health and substance abuse benefits in accordance with the Mental Health Parity and Addiction Equity Act of 2008.		
Mental Health		
Inpatient Medically Necessary services for mental health disorders	$1,000	CYD then 50%
Outpatient and office visits	$40	CYD then 50%
Applied Behavioral Therapy for the treatment of Autism *(Limited to 60 visits not to exceed 258 hours of therapy for habilitation and 60 visits not to exceed 258 hours of therapy for rehabilitation per Calendar Year.)*	$40	CYD then 50%
<u>All</u> outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network facility mental health services. Mental health office visits that are not part of a mental health treatment program do not require Prior Authorization. This Benefit Plan provides all mental health and substance abuse benefits in accordance with the Mental Health Parity and Addiction Equity Act of 2008.		
Other Medical Services		
Chiropractic and spinal manipulation services *(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime)*	CYD then 30%	CYD then 50%

Benefit Summary Table		
	Member Responsibility	
Benefit Category	In-Network	Out-of-Network
Alternative/Complementary Medicine - Services or supplies related to alternative or complementary medicine including, acupuncture, Holistic Medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and bio and neuro feedback *(Limited to $1,000 maximum benefit per Calendar Year)*	CYD then 30%	CYD then 50%
Home health care *(Limited to 30 visits per Calendar Year ; May provide for private duty nursing in the home; Requires Prior Authorization for in-network benefits to be considered.)*	CYD then 30%	CYD then 50%
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. *(Limited to one diagnostic evaluation for infertility every Calendar Year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the EOC . These limits and exclusions apply to both office based and non-office based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in this Benefit Summary Table.)*	$80	CYD then 50%
Temporomandibular Joint (TMJ) Disorder Services *(TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to 1 surgery per Calendar Year and 2 surgeries in a lifetime. The full scope of TMJ benefit coverage is detailed in the EOC.)* Office based services All other services	 $80 CYD then 30%	 CYD then 50% CYD then 50%
Hospice Services are covered for Members with a life expectancy of 6 months or 185 days or less as certified by his or her Provider *(Limited to a lifetime benefit maximum of 185 days)* : a. Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week. b. Outpatient counseling of the Member and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific Policy). 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.		

Benefit Summary Table		
	Member Responsibility	
Benefit Category	In-Network	Out-of-Network
c. Respite care providing nursing care for a maximum of 8 inpatient respite care days per Calendar Year and 37 hours per Calendar Year for outpatient respite care services. Inpatient respite care will be provided only when we determine that home respite care is not appropriate or practical.		
Office based services	$80	CYD then 50%
All other services	CYD then $0	CYD then 50%
Medical Pharmacy and Immunizations		
Special pharmaceuticals	CYD then 30%	CYD then 50%
Preventive immunizations *(as described in the Preventive Services sec tion of the EOC)*	$0	CYD then 50%
Other covered immunizations	CYD then 30%	CYD then 50%
All other medical pharmacy	CYD then 30%	CYD then 50%
Some medications, injection and infusion drugs require Prior Authorization. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary.		
Pharmacy Benefits		
Preventive Medication *(See Other Pharmacy Information below)*	$0	N/A
Generic Drugs	$20	N/A
Preferred Brand Drugs	$50	N/A
Non-Preferred Brand Drugs *(Must pay the designated Copayment and Coinsurance, not to exceed the drug cost)*	$50 and 50%	N/A
Special Pharmaceuticals *(Special pharmaceuticals require Prior Authorization. Most special pharmaceuticals must be obtained through a specialty pharmacy designated by Hometown Health and are limited to a 30-day supply per fill)*	CYD then 30%	N/A
Diabetic Supplies - Preferred Brand *(See Other Pharmacy Information below)*	$50	N/A
Diabetic Supplies - Non-Preferred Brand *(See Other Pharmacy Information*	$50 and 50%	N/A
Pediatric Vision		
Well Vision Exam *(Complete eye exam covered in full once per Calendar Year. One low vision exam is covered every 5 years)*	$0	30%
Lenses *(Limited to once per Calendar Year . Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full. Polycarbonate, plastic, or glass covered in full. Scratch and UV resistant covered in full.)*	$0	30%
Frame *(From Pediatric Exchange Collection covered in full.)*	$0	30%
Elective Contact Lenses and materials are covered in full, in lieu of eyeglasses, with the following service limitations: Standard (one pair per Calendar Year) = 1 lens/eye (2 lenses) Monthly (6 month supply) = 6 lenses/eye (12 lenses) Bi-weekly (3 months supply) =6 lenses/eye (12 lenses) Dailies (1 month supply) = 30 lenses/eye (60 lenses)	$0	30%

Benefit Summary Table		
	Member Responsibility	
Benefit Category	In-Network	Out-of-Network
Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction.		
Pediatric Dental		
This plan does not cover pediatric dental services.		

Other Benefit Information

Certain services require the member to receive Prior Authorization from Hometown Health prior to receiving the service. If you do not obtain the required Prior Authorization for the service, you will be subject to a 50% reduction in benefits, even if the service is Medically Necessary. Refer to the Utilization Management Program, Certification and Prior Authorization sections in the EOC for a more comprehensive list of services requiring Prior Authorization.

Notwithstanding anything in this Schedule of Benefits to the contrary, Hometown Health will provide:

1. Emergency services (as defined in the EOC):
    a. Without requiring a Prior Authorization, even if the Emergency services are provided out-of-network, without regard to whether the provider furnishing the Emergency services is a participating provider;
    b. 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 preferred providers;
    c. If the Emergency services are provided out-of-network, by complying with the cost sharing requirements promulgated pursuant to the Affordable Care Act; and
    d. Without regard to any other term or condition of the coverage, other than the exclusion of or coordination of benefits, an affiliation or waiting period permitted under applicable federal law, or applicable cost sharing; and
2. Preventive services described in the Public Health Service Act, Section 2713(a) (as amended by the ACA) without any cost sharing requirements.
3. Genetic disease testing services under the conditions provided in the EOC and as required pursuant to state and federal law.

After the member has paid the Out-of-Pocket Maximum, Hometown Health will pay 100 percent of the charges for covered services up to the Allowable Amount.

Only amounts paid by members for covered services apply toward the Deducible and Out-of-Pocket Maximum.

Unless a Provider is a Participating Provider, services are rendered for an Emergency, or Hometown Health issues a prior-authorization for an in-network service, Hometown Health will cover services by a non-Participating Provider at the non-preferred benefit level of the Policy, if a non-preferred benefit is available. Members may elect to seek services from non-preferred healthcare providers provided the member pays the additional Out-of-Network Deductible and Coinsurance amounts and any additional charges over the Allowable Amount for the service provided. Members also may be required to obtain Prior Authorization before seeking services from non-preferred providers.

Copayments for services not shown in the Benefit Summary Table may be determined by the location in which services are provided (such as Emergency rooms, urgent care centers or physicians' offices). The Copayment or Coinsurance amounts listed in the Benefit Summary Table are applicable for covered services and prescription drugs received as described in the EOC and this Schedule of Benefits. Charges associated with the following are the Member's responsibility and do not accumulate toward the Member's Deductible and Out-of-Pocket Maximum:

1. Costs for services in excess of the Allowable Amount for services received from Non-Preferred Provider;
2. Services for which the member did not receive Prior Authorization when Prior Authorization is required;
3. Costs for prescription drugs in excess of the Allowable Amount;
4. Non-covered services;

5. Non-covered prescription drugs;
6. Ancillary charges;
7. Denied claims; and
8. Prescription drugs received from a nonparticipating pharmacy.

Other Pharmacy Information

The Hometown Health Pharmacy and Therapeutics Committee developed the Drug Formulary. This committee, which is comprised of physicians from various medical specialties, reviews medications in all therapeutic categories and selects the agent(s) in each class that meet its criteria for safety, effectiveness, and cost. The Pharmacy and Therapeutics Committee meets twice a year to review new and existing medications to ensure that the Drug Formulary remains responsive to the needs of Hometown Health members and healthcare service providers. A copy of the Drug Formulary is available upon request by the member or may be accessed at the Hometown Health website (www.hometownhealth.com). Information regarding the Drug Formulary can be obtained by contacting Hometown Health at 775-982-3232 or 800-336-0123. Inclusion of a drug in the Drug Formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition. The Drug Formulary is subject to change at the sole discretion of Hometown Health.

The medications covered under this formulary may be substantially different from other Hometown Health drug formularies for its commercial and Medicare Advantage formularies.

For certain outpatient prescription drugs, a prescribing physician must contact Hometown Health or the PBM to request and obtain coverage for such drugs. Hometown Health or the PBM will respond to the physician by telephone or other telecommunication device once Prior Authorization has been determined. The list of prescription drugs requiring Prior Authorization is subject to change by Hometown Health. An updated copy of the list of prescription drugs requiring Prior Authorization shall be available upon request by the member or may be accessed at the Hometown Health website, at www.hometownhealth.com. If Prior Authorization is not obtained, the member must pay the participating retail pharmacy directly and 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 Hometown Health. 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 for the member's medical condition. If the claim is approved, Hometown Health will directly reimburse the member the cost of the prescription drug, less the applicable Copayments or Coinsurance specified in this Schedule of Benefits.

Many of these medications are biotech medications, using DNA recombinant technology (genetic replication) as opposed to chemical processes. Special pharmaceuticals may be delivered in any setting and may include injectable drugs or medications given by other routes of administration, or oral medications.

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

Preventive Medications – There will be no co-pay for the following medications recommended by The Preventative Services Task Force (USPSTF) upon the physician's order only at a participating retail pharmacy.

1. Aspirin to prevent cardiovascular diseases (CVD): 45 years and older; quantity limit 1/day; generic only; OTC (requires a prescription).

2. Sodium fluoride products (not in combination): 5 years old and younger, whose primary water source is deficient in fluoride; tablet 0.5mg, chewable tablet 0.25mg-05mg, solution
3. Folic Acid for all women planning or capable of pregnancy: Age limit 55 years old or younger; (not in combination); 0.4mg and 0.8mg; quantity limit 1/day; OTC (requires a prescription)
4. Iron Supplements for asymptomatic children aged 6 to 12 months who are increased risk for iron deficiency anemia: Age limit 0-1 year; prescription or OTC (requires a prescription); iron suspension, ferrous sulfate elixir, syrup and solution
5. Tobacco Cessation – The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products: Limit of 2 cycles (12 weeks per cycle) per Calendar Year; OTC generics only; generic Zyban only; Rx or OTC (requires a prescription); Nicotrol Inhaler and Nasal Spray; Nicotine polacrilex gum or lozenge; Nicotine TD patch 24hr kits; Bupropion HCl SR tabs; Varenicline (Chantix) tablets
6. Immunizations: Vaccines: The following vaccines are covered if provided by a Certified Immunizing pharmacist: Influenza, Hepatitis A & B; Human Papillomavirus inactivated; Poliovirus; Rubella; Meningococcal, Pneumococcal; Rotavirus; Tetanus Diptheria, Pertussis, Varicella, Zoster. These may be administered or dispensed at the pharmacy, but are part of the preventive services covered in the benefits outlined under the Evidence of Coverage.

Contraceptive products – Prescription contraceptive products for women are covered prescription drug products upon the participating physician's order only at a participating retail pharmacy:

1. Oral contraceptives;
2. Diaphragms: One per 365 consecutive day period;
3. Injectable contraceptives: The prescription provider's Copayment applies for each vial;
4. Contraceptive patches;
5. Contraceptive ring; and
6. Norplant and IUDs are covered when obtained from a participating physician.

The participating 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 a participating physician.

The dispensing of each type will require a separate prescription. Oral-contraceptive prescription quantities are limited to one 21-day cycle supply or one 28-day cycle supply per month. Formulary generic drugs and brand drugs that do not have a generic equivalent (single source brand) will have no Copayment for the member. Brand drugs that have a generic equivalent (multi-source brand) under a generic benefit will require the member to pay the difference between the brand drug and the generic, as is the case with other multi-source brands. Non-formulary drug co-pays will be applied to Non-Formulary contraceptive drugs.

Diabetic supplies – Diabetic Supplies include insulin, insulin syringes with needles, glucose blood-testing strips, glucose urine-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 participating retail. The member must pay applicable Copayments or Coinsurance. Original and refill prescriptions are limited to a 90-day supply at a participating retail pharmacy unless otherwise limited by Hometown Health or the drug manufacturer. A 30-day filled prescription is required prior to a 90-day filled prescription.

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 HRT prescription drugs require Prior Authorization.

Orally Administered Chemotherapy – Orally Administered Chemotherapy will be paid at the Preferred Brand Drug rate. The cost to the Member for Orally Administered Chemotherapy will not to exceed $100 per prescription.

Exclusions

The remainder of this Schedule of Benefits lists the general medical, pharmacy, pediatric vision and pediatric dental (if offered) benefit exclusions of this Policy. Benefits listed as excluded will not be covered by Hometown Health 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 this Schedule of Benefits and the EOC. For a complete listing and narrative of exclusions and limitations, please refer to the EOC.

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, pediatric vision or pediatric dental (if offered) benefits that may be included in this Benefit Plan if explicitly indicated that the benefit is covered.

1. Services not Medically Necessary or 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 that arises out of or in the course of any employment for pay or profit 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 or reports are excluded.
6. Any loss, expenses, or charges resulting from the Member's participation in a riot or Criminal Act are excluded.
7. Any loss related to an act of war, insurrection, or terrorism are excluded.
8. Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation, work-hardening programs, job related training requirements and employment training and counseling, including services rendered 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. 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.

11. 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.
12. Routine examinations, care or treatment primarily for insurance, immigration, travel, licensing, school sports, adoption and employment purposes, and other third-party physicals are excluded.
13. Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, 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. Laboratory and other diagnostic testing provided in connection with this exclusion are also excluded.
14. Termination of pregnancy is excluded, other than medically indicated abortions necessary to save the life of the mother.
15. Any services received outside the United States are excluded unless deemed to be urgent or Emergency care.
16. Travel expenses, accommodations and travel insurance are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.
17. Costs related to room and board for family members are excluded.
18. 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.
19. 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.
20. 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;
    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 the 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 additionally not covered under this Policy;
    c. Treatment or services related to complications, insertion, removal or revision of breast implants unless provided post mastectomy;
    d. Implants that do not improve physical function;

e. Treatment for the removal, ablation, injection, or destruction of varicose veins;
f. Cosmetic surgery to treat or prevent mental health or psychological conditions or consequences or socially avoidant behavior;
g. 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;
h. Complications related to excluded cosmetic surgery or procedure; and
i. Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function.

21. Cosmetics are excluded.
22. 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.
23. 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.
24. 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 except as otherwise specified in this Schedule of Benefits and your Evidence of Coverage.
25. Charges related to the acquisition or use of marijuana are excluded, even if used for medicinal purposes.
26. Except as otherwise provided in the EOC, drug, 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.
27. 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.
28. Any off-labeled use of growth hormone is excluded.
29. Coverage for human growth hormone or equivalent is excluded unless specifically covered and described within the EOC.
30. Cryopreservation or storage charges for collection and storage of biologic materials, including umbilical cord blood, for artificial reproduction or any other purpose are excluded.
31. Platelet rich plasma and stem cell related musculoskeletal injections are excluded.
32. 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 at our discretion:

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.

Coverage for clinical trials may still be covered even if the procedure or treatment is otherwise experimental or investigational. Refer to the Clinical Trials section of the EOC for more information.

33. 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 succussion; prolotherapy, magnetically energized geometric patterns, replacement of metal dental fillings, laetrile, and gerovital.
34. 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 Schedule of Benefits and the EOC.
35. 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.
36. 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.
37. Barrier-free and other home modifications are excluded.
38. Services provided by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists are excluded, even if recommended by a Professional to treat a medical condition.

39. Care or treatment of marital or family problems, occupational, religious, or other social maladjustments, behavior disorders, situational reactions, and hypnotherapy is excluded.
40. Stress reduction therapy or cognitive behavior therapy for sleep disorders is excluded.
41. Religious or spiritual counseling is excluded.
42. Orthotic braces that straighten or change the shape of a body part are excluded.
43. Cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome.
44. 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, periphal 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.
45. Services designed to treat infertility conditions.

    Medically Necessary services to diagnose problems of infertility are covered for one workup per year up to 3 evaluations per lifetime. Up to six 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 Hometown Health 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:

    a. 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 includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy;
    b. 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, maternity services related to a Member serving in the capacity of a surrogate mother, sperm donor for profit or prescription (infertility) drugs, GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are excluded.
    c. Any services related to a Member serving in the capacity of a surrogate mother, including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the Member's ability to become pregnant or to carry a pregnancy to term, or maternity services are excluded.

d. 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.

Pharmacy Benefit Exclusions

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

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 Hometown Health are excluded.
4. Any refill in excess of the amount specified by the prescription order is excluded. Before recognizing charges, Hometown Health may require a new prescription or evidence as to need if a prescription or refill 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 Participating Retail Pharmacy are excluded except as Medically Necessary for treatment of an Emergency or urgent care condition.
10. Drugs listed on the Formulary Exclusions List or those designated as Non-Formulary 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 Law to Investigation use” are excluded.
14. Drugs either not approved by the FDA as “safe and effective” as of the date this Benefit Plan was issued 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 of the drug (off label prescribed drugs) are excluded.

16. Fertility drugs, drugs for gene therapy, nicotine patches and gum, oxygen, 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 are supplied by Hometown Health's preferred vendor for the medication.
18. Immunization or immunological agents, including but not limited to biological sera, blood, blood plasma 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 Hometown Health 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 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 a Participating 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 are excluded except as otherwise provided herein or in the 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 30-day supply are excluded. Prescriptions requiring quantities in excess of the above amount shall be completed on a refill basis except as otherwise provided in the Drug Formulary.
31. Replacement of lost, stolen, spoiled, expired, spilled or otherwise mishandled medication is excluded.

32. Prescription orders filled before the effective date or after the termination date of the coverage provided by this Benefit Plan are excluded.
33. Test agents and devices, excluding diabetic test agents are excluded.

Additional Pharmacy Limitations

1. A Participating 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 a Participating Retail Pharmacy.
3. 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 Hometown Health, and the member will be responsible for the entire cost of the prescription.
4. 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, Hometown Health will only reimburse the Member the amount that Hometown Health would have paid if the prescription drug were purchased using the Policy. Because Hometown Health has access to contract discounts, the amount that Hometown Health 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.
5. Hometown Health 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.
6. Hometown Health 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.
7. The contracted reimbursement rate for participating pharmacies does not include amounts that Hometown Health may receive under a rebate programs offered at the sole discretion of individual pharmaceutical manufacturers.

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, pharmacy or pediatric dental (if offered) 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.

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 Provider's 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.

For more information go to

www.HometownHealth.com