HOMETOWN HEALTH PROVIDERS INSURANCE COMPANY, INC.
SMALL GROUP PPO PLAN
EVIDENCE OF COVERAGE 2014

Hometown Health Providers Insurance Company, Inc. is a not-for-profit corporation licensed by the State of Nevada and organized for the purpose of maintaining and operating hospital, medical and dental service policies. Hometown Health Providers Insurance Company is 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. This Small Group Policy is through an open access Preferred Provider Organization that provides access to its members to a large network of providers who have agreed to contract with Hometown Health Providers Insurance Company, and thus to provide the Member with services that pay at the In-Network Benefit level. The Policy also provides for Members to seek services out of the Preferred network and will pay these a reduced benefit level unless the services are rendered as part of an emergency room visit, or they have been previously approved by Hometown Health Providers Insurance Company to be paid at the In-Network Benefit Level. This plan of benefits is only available in the Geographic Service Areas of Washoe County and Carson, Douglas, Lyon, and Storey counties. A person to be eligible for this Small Group product must work for an employer whose site of business is in one of those two Geographic Service Areas.

This Evidence of Coverage (EOC) describes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures. Refer to your summary of benefits for Policy-specific cost sharing information not described within this EOC.

This EOC has been amended to comply with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. As of the date of the publication of this EOC, 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.

Hometown Health has partnered with two other companies to provide specialty network services provide this policy that includes the Essential Health Benefits mandated by the Affordable Care Act and chosen by the State of Nevada. Vision Service Plan (VSP) is our partner in providing the Pediatric vision network . VSP will provide a list of Preferred Providers for access by the members who have the Pediatric vision benefit. Hometown Health Providers will provide a list of Preferred Providers who will be available for services related to the Pediatric Dental Benefit. Details of the administration of these benefits are available on www.Hometownhealth.com.

Copies of EOCs, summaries of benefits, attachments, and other associated documents are available online at www.hometownhealth.com in the Members section under "View My Benefits." We will provide you with paper copies of these documents without charge upon your request to our Customer Services department.

Small Group PPO Plan Hometown Health Providers Insurance Company Attn: Customer Service 830 Harvard Way Reno, Nevada 89502 Email: Customer_Service@hometownhealth.com	Phone Numbers: · Main: 775-982-3230 · Toll Free: 800-336-0123 · Fax: 775-982-3741 Attention: Customer Services · TTY: 711 (special equipment required) · Español: 775-982-3242

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PART 1. DEFINITIONS

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

Acute means 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.

Billing Cycle means 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 means 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 means 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 means the percentage of covered charges that is due and payable by the Member to a Provider upon receipt of certain covered services. There may be separate coinsurance for pharmacy, pediatric dental, pediatric vision, and medical benefits according to the benefit plan that is in place. Coinsurance is presented in the Summary of Benefits as a percentage of the maximum allowable amount that is due and payable by the Member to a Provider upon receipt of covered services. Coinsurance applies after all deductibles have been paid, unless otherwise stated within the Summary of Benefits or EOC.

When you go out of network, you may be responsible for the difference between our Usual and Customary determined charge and the Provider's billed charges.

Copayment means the specific amount payable by the member to a provider of care at the time of service for certain covered services. Copayments apply after all deductibles have been paid, unless otherwise stated within the Summary of Benefits or EOC. Copayments apply to the out of pocket maximums. There may be separate copayments for pharmacy, pediatric dental, pediatric vision, and medical benefits according to the benefit plan that is in place.

Covered Service means a benefit for services and supplies that we provide or arrange under this Policy that is:

- Medically Necessary or otherwise specifically listed as a benefit in the summary of benefits or EOC;
- 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;
- Prior-authorized by us if preauthorization is required per this document; or

- Not experimental or investigational or otherwise limited or excluded by this EOC, or by amendment to this EOC.

Criminal Act means any action for which a person is convicted of a misdemeanor or felony or any action for which a person is not charged or convicted but for which clinical evidence or a statement in a police report indicates that a law has been broken.

Custodial Care means 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 means the set amount that must be paid by a member before Hometown Health pays for covered services, other than preventive care, or other named copayment specific benefits , before benefits are payable by HTH. There may be separate deductibles for pharmacy, pediatric dental, pediatric vision, and medical benefits according to the benefit plan that is in place, or they may be combined.

A member must satisfy the individual deductible for some benefits and plans before benefits other than those noted earlier in this section are payable, unless the Family has met the family deductible.

A Family deductible is set at two or three times the individual deductible. One individual family member cannot contribute more than 50% of the family deductible amount. The Family deductible continues to be applied to the benefits of other family members until the total Family deductible has been met.

Developmental Care means 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 (restoring fully developed skills that were lost or impaired due to injury or illness).

Domiciliary Care means 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.

Emergency means 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.

Expense means 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 110% of the applicable Medicare reimbursement rate for such service or supply,
- That is more than the maximum allowed amount for a service or supply, or
- That is not a Covered Service under this Policy.

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

Geographic Service Area means that for the purposes of this document and these plans governed by the Affordable Care Act for the Small group PPO Plan, is Washoe County, Nevada or Carson, Douglas, Lyon, or Storey County, Nevada. The employer must have their principal site of business in Washoe County, or Carson, Douglas, Lyon, or Storey County.

Hospital means 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.

Illness or **Injury** means 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.

Licensed Area Hometown Health Providers has a license to provide PPO benefit plans throughout the state of Nevada. This Small Group PPO is only available in the Geographic Service areas of Washoe County, or Carson, Douglas, Lyon, or Storey County.

Medically Necessary means 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;
- 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 ("cost effective" is not construed to mean lowest cost), and
- Obtained from a Physician and/or licensed, certified, or registered Provider.

For purposes of this EOC, 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.

Medical Director means 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 means 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 www.hometownhealth.com

Member means a Subscriber and the Subscriber's eligible dependents covered under the Policy.

Network means the Preferred or Participating Providers that we have contracted with to provide Covered Services.

Out-of-Area Services means services provided outside the Hometown Health's Geographic Service Area, unless the Small group employer has chosen to offer a plan of benefits that includes a National Network

Out-Of-Pocket Maximum means the maximum payment amount for which the Member or

Family is responsible for deductible, copayments, or coinsurance in a plan year for covered services. Out of pocket maximums may be different for pharmacy, medical, pediatric vision and pediatric dental benefits. All out of pocket maximums for these benefits will be aggregated to determine the out of pocket maximum total for that plan year. In no instance will the out of pocket maximum amount for covered services provided at the in-network benefit level that a member pays be greater than the amount stated in the benefit plan, or as allowed by law.

Different Out-of-Pocket coinsurance maximums apply for individuals and families. Different Out-of-Pocket coinsurance maximums apply for In-Network Providers and for Out of Network Providers. Deductibles count towards the Out-of-Pocket maximum for in-network benefits. Deductibles for out of network benefits do not apply to out of pocket maximums. When a member goes outside the network, and seeks care from an out of network provider, the difference between the Provider's bill and the usual and customary allowable as determine by Hometown Health, does not count towards the out of pocket maximum for the non-preferred benefit.

Outpatient Observation means–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.

Preferred or **Participating Provider** means a Physician, organization or association of Physicians, Hospital, skilled nursing facility, any organization licensed by a state to render home health services, or any other licensed institution or Professional who is listed in our current health directory and who is directly or indirectly under contract with us to provide Covered Services to Members. A Participating Provider provides services within our Network.

Unless your employer has purchased national Network coverage from us and/or purchased additional coverage inside Nevada, Participating Providers are only located in the Licensed Area or out-of-state within 50 miles from the Licensed Area. Unless a Provider is a Participating Provider, services are rendered for a life threatening emergency, or we have issued a prior-authorization for an in-network service, we will cover services by a non-Participating Provider at the non preferred benefit level of the Policy.

Unless a Provider is a Participating Provider, services are rendered for a life threatening emergency, or we have issued a prior-authorization for an in-network service, we will cover services by a non-Participating Provider at the non preferred benefit level of the Policy.

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

A Participating Provider's agreement with us or the association of a particular Professional with a Participating Provider may terminate, and, in such a case, a Member will be required to use another Participating Provider in order to receive in-network benefits. Not all Physicians, organizations or associations of Physicians, Hospitals, skilled nursing facilities, organizations licensed by the state to render home health services, or other licensed institutions or health Professionals who have contracts with us are Participating Providers for the purposes of this particular product We do not guarantee the continued availability of any particular Participating Provider. Participating Providers cannot determine whether a service is a Covered Service under this Policy or on behalf of us.

Physician means a licensed doctor of medicine, osteopathy, dentistry, or podiatry.

Policy means the Group Subscription Agreement, this Evidence of Coverage (EOC), the policy-specific summary of benefits, or amendments.

Premium means a periodic payment, typically monthly, paid to us for this Policy.

Primary Care Physician (PCP) means a Physician who is Participating 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 means our determination of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. All benefits listed in this Summary of Benefits may be subject to Prior Authorization requirements and concurrent review depending upon the circumstances associated with the services. Refer to your plan-specific summary 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 www.hometownhealth.com. There may be Prior Authorization or pre-treatment requirements for pharmacy, dental, and vision benefits that are provided in this plan.

Professional means 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 means a Professional who delivers health care services or an institution that supervises the rendering of such care.

Specialist means a Professional who provides medical care in a specific branch of medicine generally referable to a particular bodily system or area.

Subrogation means a legal process whereby Hometown Health may seek reimbursement from a third party that is legally liable for a claim or a portion thereof.

Subscriber means 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.

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

Usual and Customary means the lesser of:

- A Provider's usual charge for furnishing a treatment, service, or supply;
- The charge we determine to be the general rate charged by others who render or furnish such treatment, service, or supply to person who reside in the same geographic area and whose condition is comparable in nature and severity; or
- What Medicare would pay for such treatment, service, or supply.

We, us, our, or **Hometown Health** means Hometown Health Providers Insurance Company, Inc.

You, your, or **Member** means a person who meets all applicable eligibility requirements of this EOC and whose enrollment form we have accepted.

PART 2 NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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 Hometown Health Customer Services at 775-982-3230 or 800-336-0123.

A. Who Will Follow This Notice

This notice describes the practices of Hometown Health Plan, Inc., and Hometown Health Providers Insurance Company (collectively referred to as "Hometown Health") and their respective employees.

B. Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting your medical information, including nonpublic personal financial information relating 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 Providers providing healthcare services to our Members may have different policies or notices regarding their uses and disclosures of your medical information.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

1. make sure that medical information that identifies you is kept private;
2. give you this notice of our legal duties and privacy practices with respect to medical information about you; and
3. follow the terms of the notice that is currently in effect.

C. Information About Our Members

In the course of providing healthcare benefits, we may receive the following information about you:

1. Information provided by you on applications, forms, surveys and our Web site, such as your name, address, date of birth, Social Security number, gender, marital status and dependents.
2. Information about your transactions and experiences with our health plan and our affiliates, such as: services purchased, account balances, payment history, claims history, Policy coverage, and Premiums.
3. Information from consumer or medical reporting agencies, medical providers or third parties, such as medical information and demographic information.

D. How We Protect Your Medical Information

At Hometown Health, we restrict access to your medical information to those employees who need it to provide services to you and your dependents. We maintain physical, electronic, and procedural safeguards to protect your medical information against unauthorized access and use. For example, access to our facilities is limited to authorized personnel, and we protect information we maintain electronically through the use of a variety of technical tools. We have also established a Privacy Office, which has overall responsibility for developing, educating company personnel about, and overseeing the implementation of policies and procedures to safeguard medical information against inappropriate access, use, and disclosure, consistent with applicable law.

E. How We May Use and Disclose Medical Information About You

Hometown Health will not disclose your medical information to anyone, except with your authorization or otherwise as permitted by law. For some activities, we must have your written authorization to use or disclose your medical information. The law, however, permits Hometown Health to use or disclose your medical information for the following purposes without your authorization:

1. **For Payment**. We may use and disclose your medical information in order to pay for your medical benefits under our health plan. These activities may include making benefit determinations and paying claims.
2. **For Healthcare Operations**. We may use and disclose medical information about you 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. Here are some examples of the ways that we use your medical information for our healthcare operations:
    a. Quarterly newsletters that offer Members information on various healthcare issues such as asthma, diabetes, and breast cancer.
    b. Administration of Hometown Healthbenefit plans or contracts, which, where applicable, may involve claims management; utilization review and management; data and information systems management; medical necessity review; coordination of care, benefits and services; response to Member inquiries or requests for services; conduct of grievances, appeals and external review programs; benefits and program analysis and reporting; risk management; detection and investigation of fraud and other unlawful conduct; auditing; underwriting and ratemaking; and other activities described below.
    c. Operation of disease and case management programs in plans that offer these 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.
    d. Quality assessment and improvement activities, such as peer review and credentialing of Participating Providers; program development; and accreditation by independent organizations, where applicable.
    e. Transitioning of policies or contracts from and to other health plans.

f. We may disclose your medical information to another entity that has a relationship with you and is subject to the federal privacy laws, for their healthcare operations relating to quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.

3. **To Your Family and Friends**. We may disclose your medical 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 disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

4. **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.

5. **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, however, would only be to someone able to help prevent the threat.

F. Special Situations

1. Military and Veterans

   If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

2. Public Health Risks

   We may disclose medical information about you for public health activities. These activities generally include the following:

   a. To prevent or control disease, injury or disability;

   b. To report births and deaths;

   c. To report the abuse or neglect of children, elders and dependent adults;

   d. To report reactions to medications or problems with products;

   e. To notify people of recalls of products they may be using;

   f. 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

   g. 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 this disclosure if you agree or when required or authorized by law.

3. Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, 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.

4. Lawsuits and Disputes

   If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

5. Law Enforcement

   We may release medical information if asked to do so by a law enforcement official:

   a. In response to a court order, subpoena, warrant, summons or similar process;

   b. To identify or locate a suspect, fugitive, material witness or missing person;

   c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

   d. About a death we believe may be the result of criminal conduct; or

   e. In Emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

6. Disaster Relief

   We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

7. National Security and Intelligence Activities

   We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

8. Protective Services for the President and Others

   We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

9. Inmates

   If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary:

   a. for the institution to provide you with healthcare;

   b. to protect your health and safety or the health and safety of others; or

   c. for the safety and security of the correctional institution.

G. Medical Information of Former Members of Hometown Health

Hometown Health does not destroy the medical 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 practices and procedures that protect that information against inappropriate use or disclosure, however, apply regardless of the status of any individual Member.

H. Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

1. Right to Inspect and Copy

    a. You have the right to inspect and copy medical information that may be used to make decisions about your healthcare benefits. Usually, this includes benefits, eligibility and claims records, but may not include some mental health information.

    b. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 89502. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

    c. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare Professional chosen by the health plan will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

2. Right to Amend

    If you feel that medical 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 Hometown Health.

    To request an amendment, your request must be made in writing and submitted to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 89502. In addition, you must provide 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. In addition, we may deny your request if you ask us to amend information that:

    a. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

    b. Is not part of the medical information kept by or for the Hometown Health;

    c. Is not part of the information that you would be permitted to inspect and copy; or

    d. Is accurate and complete.

3. Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than:

a. our own uses for treatment, payment and healthcare operations, as those functions are described above,

b. to you based upon your authorization and

c. for certain government functions.

To request this list or accounting of disclosures, you must submit your request in writing to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 89502. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose claims information indicating that you have had a surgery.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with Emergency treatment.

To request restrictions, you must make your request in writing to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 89502. In your request, you must tell us:

a. what information you want to limit;

b. whether you want to limit our use, disclosure or both; and

c. to whom you want the limits to apply (for example, disclosures to your spouse).

5. Right to Request Confidential Communications

You have the right to request that we communicate with you about healthcare matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 80502. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. 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 copy of this notice at our Web site, hometownhealth.com.

To obtain a paper copy of this notice, please contact Customer Services at 775-982-3230or 800-336-0123.

I. Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical 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 on the Hometown Health website at www.hometownhealth.com. The notice will contain on the first page, in the top right-hand comer, the effective date. In addition, each time you enroll in a Hometown Health health plan, we will offer you a copy of the current notice in effect. We also may publish the current notice in our newsletter on at least an annual basis.

J. Complaints

If you believe your privacy rights have been violated, you may file a complaint with Hometown Health or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Hometown Health, contact Hometown Health Customer Service at 775-982-3230 or 800-336-0123. We will provide you with the address to file a complaint with the U.S. Department of Health and Human Services upon request. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

K. Other Uses of Medical Information

Other uses and disclosures of medical 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 medical 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 medical 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.

PART 3 SCHEDULE OF BENEFITS

Except as otherwise provided in an accompanying schedule of benefits, if you incur expenses for Covered Services, we will pay that expense less the applicable Deductible, Copayments, and/or Coinsurance, subject to the terms of this EOC. The specific Deductible, Copayments, and Coinsurance amounts are shown in your Policy-specific summary 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 a Participating 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. The Schedule of Benefits should be read in conjunction with Part 4 (Limits and Exclusions) and your Policy-specific summary of benefits. Your Policy-specific summary 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 and outpatient).

   Medically Necessary inpatient and outpatient alcohol and substance abuse services will be provided under the terms as noted in the summary 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.

2. Allergy testing and treatment.

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

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3. Blood services for surgery

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

4. Chemotherapy

   Chemotherapy and other drug therapies that are Medically Necessary to treat cancers and other diseases and conditions are Covered Services.

5. Clinical trials

   The routine medical treatment costs, including all items and services that are otherwise generally available to our Members, received as part of a clinical trial or study, may be covered. A clinical trial is the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases. Costs incurred are covered if:

   a. The medical treatment is provided in a Phase I, Phase II, Phase III, or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III, or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

   b. The clinical trial or study is:

      i. Approved by an agency of the National Institutes of Health as set forth in applicable law;

      ii. Approved by a cooperative group, a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health;

      iii. FDA-Approved as an application for a new investigational drug;

      iv. Approved by the United States Department of Veterans Affairs; or

      v. Approved by the United States Department of Defense.

   c. In the case of:

      i. A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

      ii. A Phase II, Phase III, or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a Provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

   d. 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;

   e. 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;

   f. The clinical trial or study is conducted in Nevada;

   g. 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

h. 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 eligible to participate in the clinical 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:

a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical, or medical industry;

b. Coverage for a drug or device described above that is paid for by the manufacturer, distributor, or Provider of the drug or device;

c. Health care services that are specifically excluded from coverage in this EOC, regardless of whether such services are provided under the clinical trial or study;

d. 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;

e. 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;

f. Any expenses incurred by a person who accompanies you during the clinical trial or study;

g. Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of you; and

h. Any costs for the management of research relating to the clinical trial or study.

6. 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.

7. 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, of 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 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.

8. **Gastric restrictive services (Bariatric)**

   Covered services include prior-authorized Medically Necessary surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese with associated Illnesses, including but not limited to:

   Cardiac disease,

   Sleep apnea,

   Diabetes,

   Hypertension,

   Disorders of the pituitary gland and its hypothalamic control,

   Disorders of the adrenal glands, or

   Cushing's syndrome

   Benefits for gastric restrictive services are subject to preauthorization requirements and are limited to the following benefit maximums: One gastric restrictive or bariatric 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.

9. 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 mental retardation, 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 for the individual;

The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and

One of the following conditions is met:

The Member demonstrates signs/symptoms of a genetically-linked heritable disease, or

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 covered with regard to 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.

10. 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.

11. Infertility services

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 has benefits under a Hometown Health 2014 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. This is 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; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval;

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; and

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.

12. Mastectomy reconstructive surgery

    Breast reconstructive surgery and the internal or external prosthetic devices is 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:

    a. All stages of reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical structure;

    c. Prostheses; and

    d. Physical complications for all stages of mastectomy, including lymphedemas.

    If reconstructive surgery is begun 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 is begun 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.

13. Care of newborns

    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 subject to the eligibility requirements as defined in this EOC.

    Notwithstanding anything in this EOC to the contrary, a Member does not need prior authorization from us or from any other person in order 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 participating Professionals who specialize in obstetrics or gynecology, go to www.hometownhealth.com or contact our customer services.

    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 a Participating Provider.

    Services that are not covered include:

    e. Non-newborn circumcisions after eight weeks of age unless Medically Necessary and prior-authorized by us.

14. Medical care

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

a. Office visits and consultations;

b. Hospital and skilled nursing facility services;

c. Ambulatory surgical center services;

d. Home health care services;

2. e. Surgery

f. Other Professional services.

15. Mental health services

Medically Necessary mental health services 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 summary of benefits.

16. Oral surgery, dental services, and Temporomandibular Joint Disorder

Medically Necessary oral surgery procedures are covered (inpatient or outpatient) related to the following situations. These benefits are available to all covered members and not specifically limited to those members who are eligible for the Pediatric Dental Essential Health Benefits.

a. Accidental Injury to the jaw bones or surrounding tissues when the Injury occurs and the repair takes place while a Member. Services must commence within 90 days after the accidental Injury. (Services that commence after 90 days are not covered.);

b. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth;

c. 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;

d. Repair and restoration of sound and natural teeth from injuries that arise from non-gustatory trauma

e. Extraction of teeth when related to radiation therapy or in advance of an organ transplant (other than a corneal transplant);

f. Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures;

Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. TMJ surgeries are covered under the medical benefits based on medical necessity and are limited to an annual maximum of one surgery and a lifetime maximum of 2 surgeries.

g. 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.

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:

h. 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;

i. 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;

j. 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; or

k. Other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals).

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

l. Devices that are required to substitute for the missing or non-functioning body part or organ;

m. Devices provided in connection to an Illness or Injury that occurred subsequent to your effective date of coverage;

n. Adjustment of initial prosthetic device; and

o. The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.

p. Repair and replacement of prosthetic devices is not covered except in limited situations involving mastectomy reconstructive surgery.

18. 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.

19. Partial Hospitalization Services

Partial hospitalization services are covered for mental illness and substance abuse according to the benefits listed in the summary of benefits that accompany this Evidence of Coverage. 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 and will be applied against the member's maximum inpatient benefit.

20. 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:

a. 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.

b. Routine foot care

21. Preventive Services

Covered preventive services include but are not limited to:

a. Periodic physical examinations and routine immunizations;

b. Routine gynecologic examination (one per plan year), including annual cytologic screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination;

c. Screening mammograms including an initial baseline mammogram for female

Members 35–39 and annually for women 40 years of age or older;

d. Well-baby care, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies;

e. Prostate and colorectal cancer screening 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.

f. Influenza, pneumovax, haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, and tetanus immunizations; and

g. Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.

Notwithstanding anything to the contrary in this EOC, Non-Grandfathered Plans will cover the following services without any Member cost-sharing requirements if such services are provided by a Participating Provider:

a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, provided that, with regard to breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Services Task Force will be the most current other than those issued in or around November 2009;

b. Immunizations that 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;

c. 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

d. 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.

e. For additional information see http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/guide-clinical-preventive-services.pdf

22. Radiation therapy

Medically Necessary Professional services related to radiation therapy are covered.

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23. Rehabilitative and habilitative therapy

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

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.

23. Skin lesions

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

24. Medical Pharmacy

    This benefit includes the distribution, administration, and/or supply of pharmaceuticals and immunizations, frequently in conjunction with other services, that are provided at a Medical Pharmacy. This benefit does not include other types of pharmaceuticals, which may be covered as described elsewhere in this EOC or in a separately purchased Pharmacy rider.

    Medically Necessary immunizations, biologics, injectables, or other special pharmaceuticals, and contraceptive diaphragms (one device per a 12-month period, unless otherwise prescribed by a participating Physician) distributed, administered, or supplied by a Medical Pharmacy (except as described below) are covered.

    Special pharmaceuticals, which include injectables, oral medications, and medications given by other routes of delivery, may be delivered in any setting. Special pharmaceuticals are pharmaceuticals that typically have a cost greater than $200 per dosage unit or per prescription. We maintain and update on an ongoing basis a list of special drugs classified as special pharmaceuticals, which may be found on our website at www.hometownhealth.com. Immunizations related to foreign travel or employment are excluded.

25. Spinal manipulation (non-surgical)

    Coverage is provided for up to 20 visits per year, or 100 visits per lifetime 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.

26. Transplant services

Medically Necessary organ transplants at a contracted or Hometown Health approved facilities are covered at the preferred benefit level when you are the organ recipient in the following cases:

a. Bone marrow

b. Cornea

c. Heart

d. Heart and lung

e. Intestinal and liver

f. Kidney

g. Liver

h. Lung

i. Pancreas

j. Pancreas and kidney

k. Stem cell.

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 are limited to:

a. Tests necessary to identify an organ donor

b. The reasonable expense of acquiring the donor organ, one procurement per transplant benefit period Transplant benefit Period is defined as beginning on the date the Insured 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 covered under a plan sponsored by Hometoen health Providers Insurance Company, , or other Hometown Health benefit plan subject to Nevada's Essential Health Benefits.

c. 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;

d. Storage costs of an organ, but only as part of an authorized treatment protocol; and

e. Follow-up care

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

a. Services provided at a facility that we do not designate;

b. Services provided to an organ donor;

c. Services provided in connection with purchasing or selling organs;

d. Transplants utilizing any animal organs;

e. Any transportation of the donor (as opposed to transportation of the donor organ only);

f. Any expenses associated with an organ transplant where an alternative remedy is available

g. Artificial heart implantation;

h. Services for which government funding or other insurance coverage is available;

i. 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; and

j. 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, except as described above.

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:

a. Services for medical conditions treated in an Acute care Hospital inpatient environment;

b. Semi-private room and board (private room when Medically Necessary);

c. General nursing care facilities, services, and supplies on an inpatient basis;

d. 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);

e. Surgical procedures, including the services of a surgeon or Specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care;

f. 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, skilled nursing facility, or other facility approved by us (limited to60 days per plan year);

Inpatient services to treat mental illness conditions are subject to medical policy and medical necessity. Inpatient treatment for substance abuse conditions is limited to a maximum number of days as listed on the *Summary of Benefits* per member's benefit year. 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 Summary of Benefits. Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center.

Prior Authorizations The member should contact Hometown Health's behavioral health administrator or Hometown Health to determine medical necessity, appropriate treatment level and appropriate setting. Inpatient services are subject to preauthorization notification guidelines to avoid potential penalties related to non-notification of services.

Hometown Health's behavioral health administrator must be notified for all emergency admissions by the next business day unless the member is unable to do so.

Medically Necessary care at a skilled nursing facility (limited to 100 days per plan year) for non-Custodial Care is covered. A skilled nursing facility is a facility that is duly licensed by the state of Nevada 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. Hometown Health uses a similar definition. Prior care in a Hospital is not required before being eligible for coverage for care in a skilled nursing facility.

2. 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 summary of benefits for each plan, particularly with regard to mental health and substance abuse services.

Outpatient services include, but are not limited to:

a. Services for medical conditions treated in an Acute care Hospital outpatient environment;

b. Semi-private room and board (private room when Medically Necessary) if patient is in observation status;

c. General nursing care facilities, services, and supplies on an outpatient basis;

d. Diagnostic services that are provided in a facility, whether such facility is a Hospital or a freestanding facility;

e. Surgical procedures, including the services of a surgeon or Specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care;

f. Outpatient, short-term rehabilitative services;

g. Outpatient alcohol and substance abuse rehabilitation services in a Hospital,

Hospital residential treatment facility, or day treatment program; and

h. Outpatient mental health services.

Also covered are Medically Necessary outpatient habilitative and rehabilitative services for:

a. Short-term speech, physical, and occupational rehabilitative therapy for Acute conditions that are subject to significant clinical improvement over a 90-day period from the date outpatient therapy commences (limited to 60 visits combined for speech, physical, and occupational therapy per plan year) and

b. Services for cardiac rehabilitation and pulmonary rehabilitation (limited to 40 visits/sessions per plan year for each type of therapy).

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:

a. 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;

b. Private duty nursing and private rooms in an inpatient setting;

c. Personal, beautification, or comfort items for use while in a Hospital or skilled nursing facility; and

d. Services related to psychosocial rehabilitation or care received as a custodial inpatient.

C. Emergency Services

Medically Necessary medical and/or Hospital services are covered in the case of an Emergency.

If you have an Emergency:

a. **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.

b. **As soon as possible, make sure that we are told about your emergency as set forth below.** We need to follow up on your emergency care.

Services must be provided at a contracted facility unless the time requirement to reach one of our Providers would result in a significant risk of permanent health damage. Outside the Geographic Service Area, services furnished by a Physician, oral surgeon, or Hospital or emergency facility personnel for Covered Services are covered during the Emergency.

Emergency medical and Hospital services (inside or outside our Geographic Service Area) are limited to situations that require immediate and unexpected treatment. You should notify our customer services department as soon as possible following receiving Emergency services. If you are outside our Geographic Service Area at the time of your

Emergency, you should notify our customer services department as soon as possible upon your return to our Geographic Service Area to avoid a denial of your claim.

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

a. Without the need for any prior authorization determination whether the health care Provider furnishing such Emergency services is a Participating Provider with respect to such services;

b. Without regard to whether the Provider furnishing the Emergency services is a Participating Provider with respect to the services;

c. 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 Participating Providers;

d. If the Emergency services are provided out of Network, without the cost-sharing requirement expressed as a Copayment amount or Coinsurance rate imposed with respect to a participant or beneficiary for the services exceeding the cost-sharing requirements imposed if the services were provided in-Network; and

e. Without regard to any other terms or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, as permitted by law, or applicable cost-sharing).

Medical care and notification

Medically Necessary Emergency medical care is available through participating Physicians seven days a week, 24 hours a day.

Medically Necessary Emergency services out of our Geographic Service Area will be covered. Out-of-area Emergency services are provided only if we are notified before the receipt of those services or as soon as possible after such Emergency services, but no more than 24 hours after onset of the Emergency, except as provided in this section.

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 our customer services department to provide us with information about the event and relevant circumstances.

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 a non-Network facility is limited to care required before you can, without harmful or injurious consequences, return to our Geographic Service Area and receive care from Participating Providers as determined by us. Benefits for continuing or follow-up treatment(s) are otherwise covered only in our Geographic Service Area from Participating Providers, subject to all provisions of this EOC. Routine or non-Emergency follow-up care at a non-Participating Provider emergency room facility is not covered.

D. Urgent Care Services

Medical care and notification

Medically Necessary medical care on an Urgent Care basis is available through participating Physicians seven days a week. Medically Necessary out-of-area Urgent Care services are also covered.

Out-of-area elective or specialized care required due to circumstances that could reasonably have been foreseen prior to departure from our Geographic Service Area is only covered as set forth in your Policy-specific summary of benefits.

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 Participating Providers as determined by us. Routine follow-up care is not a covered Urgent Care service. You should notify our customer services department upon your return to our Geographic Service Area to avoid a denial of your claim.

Limitations

Urgent Care services obtained at a Hospital emergency facility may have a maximum benefit limit and/or a higher Copayment. Please refer to your summary of benefits.

All Urgent Care services obtained while in our Geographic Service Area must be through a contracted Urgent Care Provider. Urgent Care services obtained from a non-contracted, in-Geographic Service Area Provider will only be covered in accordance with your specific Policy.

E. Other Services and Supplies

Ambulance services

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

a. Provided in an Emergency or

b. Provided in a non-Emergency setting when prior-authorized by us.

Durable medical equipment

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:

a. Can withstand repeated use,

b. Is not disposable,

c. Is appropriate for use in the home, and

d. Is not useful in the absence of an Illness or Injury.

e. Is prescribed by a physician

f. Is not primarily for convenience or comfort, but serves a medical purpose

Durable medical equipment includes, but is not limited to:

a. Oxygen equipment (all oxygen and oxygen related equipment, except for oxygen while traveling on an airline),

b. Wheelchairs,

c. Hospital beds,

d. Glucose monitors (which may be covered under athe pharmacy benefits), and

e. 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).

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.

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:

a. Personal care, Custodial Care, Domiciliary Care, or homemaker services;

b. In-home services provided by certified nurse aides or home health aides;

c. 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 or in a separately purchased Pharmacy rider.

Hospice services

The following hospice care services are covered for Members with a life expectancy of six 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 eight 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:

i. A psychiatrist,

ii. A psychologist, or

iii. A 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.

a. Respite care providing nursing care for a maximum of 8 inpatient respite care days per plan year and 37 hours per plan 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.

Medically necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits describe above.

Kidney dialysis services

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

Lab and diagnostic services

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

a. Diagnostic x-rays;

b. Fluoroscopy;

c. Electrocardiograms; and

d. Laboratory tests.

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

Pharmacy Benefit Definitions:

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

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.

Brand-name prescription 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 Prescription Drug Rider.

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 775-982-3230 or 855-652-4001. 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.

Formulary drug – a brand or generic drug included in the Drug Formulary

Generic prescription 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; that perform in the same manner as the trademarked, brand-name version of the drug

Injectable drugs – a prescription drugs 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 drugs – drugs not listed in the Drug Formulary There is no coverage for drugs that are not listed in the Hometown Health Individual and Family Plan and Small Group Formulary. Appeal processes for coverage of non-formulary drugs are detailed in the EOC that governs this plan.

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 medications that are not listed in this Drug Formulary.

Non-participating pharmacy – a pharmacy with which Hometown Health has not contracted to provide discounted covered prescription drug products to its members

Participating retail pharmacy – a pharmacy with which Hometown Health has 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

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 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 Prescription Drug Rider.

Prior Authorization- our determination of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. All benefits listed in this Summary of Benefits may be subject to Prior Authorization

requirements and concurrent review depending upon the circumstances associated with the services. Refer to your plan-specific summary of benefits for services that require Prior Authorization. You may find a full list of drugs that require Prior Authorization by visiting our website at www.hometownhealth.com,and accessing My Hometown Benefits for specific details on the formulary requirements for the small group plan.Plan.

Step Therapy- Hometown Health may make an expectation that where multiple options exist for treatment of a particular medical condition within a specific therapeutic class of drugs, that generic or less costly brand alternatives be utilized first before some formulary drugs are authorized for coverage**.**

Special pharmaceuticals – prescription drugs having one or more of the following characteristics: expensive (typically greater than $300 per dosage unit or per prescription); limited access; complicated treatment regimens; compliance issues; special storage requirements; or manufacturer reporting requirements

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 t of special drugs classified as special pharmaceuticals is subject to change at the sole discretion of Hometown Health

Covered Services under the Pharmacy Benefit

Hometown Health has developed a list of Prescription Drugs that will be covered under this Small Group Plan of benefits. This list of drugs is called a Drug Formulary and 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 formulary requirements as established for the Essential Health Benefits Package for the State of Nevada. This formulary may be substantially different from other Hometown Health Formularies and may have different requirements for Prior Authorization and Step Therapy. There is no coverage for medications that are not listed on this Drug Formulary. Hometown Health will not pay for any drugs that are not listed on this formulary, and the costs of those medications will not be counted toward your In-Network or Out-of Network Out-of Pocket Maximum Costs.

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

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. Note: A 30-day filled prescription is required prior to a 90-day filled prescription.

Other Pharmacy Benefits

A. 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: Annual limit of 2 cycles (12 weeks per cycle); 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 Diphtheria, 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.

B. 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
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.

C. 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.

D. Diabetic supplies – The following 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 as described in the copayments section below.

1. Diabetic needles and syringes
2. Test strips for glucose monitoring and/or visual reading
3. Diabetic test agents
4. Lancets and lancing devices

E. 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.

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.

This benefit includes the Essential Health Benefits that have been mandated by the Affordable Care Act.

The benefits available under the Pediatric Vision Plan include an eye exam each plan year, lenses each plan year, and frames from a formulary selection of pediatric frames, one each plan year. These are provided at no cost to the member. In lieu of eyeglasses, a contact lenses eye exam is covered once per plan year with a choice by the member of:

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

This benefit is serviced by Vision Services Plan (VSP) who can be reached at (800) 877-7195 for Customer Service and coverage questions.

Covered Services under the Pediatric Dental Essential Health Benefits

The Small Group Plan that you have purchased may include Pediatric Dental Essential Health Benefits. Your Summary of Benefits document includes information about this coverage if it is in the benefit plan that you have purchased. 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.

This dental plan provides coverage for preventive services including cleanings, fluoride treatments, sealants, space maintainers, and oral hygiene instruction. Diagnostic and therapeutic services provided include dental examinations by dentists, screening exams by dental hygienists, xrays, fillings and tooth treatments and restorations as necessary. It also provides oral surgery, endodontics, orthodontia, treatment of fractures and other dentally necessary conditions. A detailed list of covered benefits and the benefit schedule is in the Summary of Benefits that describes the benefit plan that includes the Pediatric Dental EHB information.

HOMETOWN HEALTH PROVIDERS INSURANCE COMPANY, INC.

This benefit is serviced by Hometown Health Dental Plan who can be reached at 775-982-3232 for Customer Service and coverage questions.

PART 4 **EXCLUSIONS AND LIMITATIONS**

The following services and benefits are excluded from Medical coverage under this plan. They may be covered under the pharmacy coverage, pediatric dental, or pediatric vision benefits that may be included in this benefit plan. Exclusions for pediatric dental, pediatric vision, and pharmacy benefits are detailed in this document. For a complete listing and narrative of exclusions and limitations, please refer to your EOC.

The following services and benefits are excluded from coverage unless otherwise covered through a separately purchased benefit rider purchased in connection with this Policy or incorporated into the Policy described in this EOC and your Policy-specific summary of benefits.

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

Medical and General Exclusions -

The following services and benefits are excluded from Medical coverage under this plan. They may be covered under the pharmacy coverage, pediatric dental, or pediatric vision benefits that may be included in this benefit plan. Exclusions for pediatric dental, pediatric vision, and pharmacy benefits are detailed in this document. For a complete listing and narrative of exclusions and limitations, please refer to your EOC.

The following services and benefits are excluded from coverage unless otherwise covered through a separately purchased benefit rider purchased in connection with this Policy or incorporated into the Policy described in this EOC and your Policy-specific summary of benefits.

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

1. Services not Medically Necessary or not required in accordance with accepted standards of medical or dental (for the Pediatric Dental Benefit) practice or applicable law are excluded.
2. Treatment for any Injury or Illness that arises out of or in the course of any employment for pay or profit is excluded.
3. Charges for care or services provided before the effective date or after the termination of coverage are excluded.
4. Any loss, expenses, or charges resulting from the Member's participation in a riot or Criminal Act; and losses related to an act of war, insurrection, or terrorism are excluded.
5. Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation, work-hardening programs, and employment training and counseling, are excluded, including services rendered by or billed by a school or member of its staff.
6. 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.
7. 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, care for which there would not normally be a charge are all excluded.
8. Routine examinations primarily for insurance, immigration, travel, licensing, school sports,

adoption purposes, employment, and other third-party physicals are excluded.

9. Expenses for medical or dental reports and or forms and insurance forms including presentation and preparation are excluded.
10. 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.
11. Alternative/Complementary Medicine - For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, 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.

12. Cosmetic surgery or procedures are excluded. Cosmetic surgery generally includes any plastic or reconstructive surgery or medical procedure done primarily to improve the appearance of any portion of the body or restore bodily form without materially correcting a bodily malfunction.

    Cosmetic surgery to treat or prevent mental health or psychological conditions or consequences or socially avoidant behavior is not covered as these do not constitute a bodily malfunction.

    Excluded procedures include:

    a. Cosmetic surgery, including but not limited to surgery for 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 or lifts;
    b. Any off-labeled use of growth hormone;
    c. Cosmetic 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 additionally not covered under this Policy; and
    d. Cosmetics, 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 this EOC and SOB).

Additional cosmetic surgery or medical procedures exclusions include:

e. Complications resulting from excluded cosmetic surgery;
f. Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function;
g. Cosmetic treatment or service related complications, insertion, removal or revision of breast implants (including complications) unless provided post mastectomy;
h. Treatment for the removal, ablation, injection, or destruction of varicose veins;
i. 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;

13. 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) Any procedure or treatment designed to alter physical characteristics of you to those of the opposite sex and any other services, treatments, drugs, or diagnostic procedures or studies related to sex transformations are excluded.
14. All experimental or investigational medical, surgical, or other health care procedures and all transplants are excluded except as otherwise described within this EOC Or SOB. 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 is insufficient to show that the procedure or treatment is:

b. Safe, effective, or superior to existing therapy, or

c. Conclusive in that the evidence demonstrates 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;

d. 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;

e. When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply can not 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;

f. When a nationally recognized medical society states in writing that the procedure or treatment is experimental; or

g. . 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 this EOC for more information.

15. 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 are excluded.
16. Travel expenses, accommodations, travel insurance are not covered. Oxygen provided while traveling on an airline is excluded as are portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements.
17. Any services received outside the United States are excluded unless deemed to be urgent or Emergency care.
18. Except as otherwise provided in this EOC, drug, medicines, procedures, services, and supplies, for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.
19. Termination of pregnancy is excluded, other than medically indicated abortions necessary to save the life of the mother..
20. Services related to job, vocational retraining, or community re-entry are excluded.
21. Sleep therapy (except for central or obstructive apnea when Medically Necessary as prior-authorized by us), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electrosleep therapy, electronarcosis, massage therapy, and gene therapy are excluded.
22. Care or treatment of marital or family problems, occupational, religious, or other social maladjustments, behavior disorders, situational reactions, and hypnotherapy is excluded.
23. 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. 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.
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. Charges related to the acquisition or use of marijuana are excluded, even if used for medicinal purposes.
25. 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.)
26. 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 except as covered and described within this SOB or EOC, 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. Full coverage is provided for Pediatric Vision Essential Health Benefits as provided by the Affordable Care Act.

27. Cryopreservation or storage charges for collection and storage of biologic materials for any purpose are excluded, including with respect to artificial reproduction. Storage costs for umbilical cord blood are also not covered.
28. Stress reduction therapy or cognitive behavior therapy for sleep disorders is excluded.
29. Coverage for human growth hormone or equivalent is excluded unless specifically covered and described within this EOC.
30. Barrier-free and other home modifications are excluded.
31. 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).
32. Religious or spiritual counseling is excluded.

33. 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 has benefits under a Hometown Health 2014 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. This is 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; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval;

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; and

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.

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Pharmacy Benefit Exclusions

The following exclusions are specific to coverage provided traditionally under a pharmacy benefit program. Other exclusions and limitations are listed in the EOC in the "Exclusions and Limitations" section.

1. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by Hometown Health.
2. Any refill in excess of the amount specified by the prescription order. 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.
3. Compounded medications except for compounded medications for palliative care with prior authorization approval.
4. 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.
5. 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. Vitamins except those prescribed prenatal vitamins and vitamins with fluoride that require a prescription and are listed on the Drug Formulary.
6. Drugs dispensed by other than a participating retail pharmacy except as medically necessary for treatment of an emergency or urgent care condition.
7. Drugs listed on the Formulary Exclusions List or those designated as Non-Formulary.
8. Drugs prescribed by a provider not acting within the scope of his or her license.
9. Drugs listed by the FDA as "less than effective" (DESI drugs).
10. Experimental and investigational drugs, including drugs labeled "Caution-limited by Federal Law to Investigation use;" drugs either not approved by the FDA as "safe and effective" as of the date this Prescription Drug Rider was issued or, if so approved, that the FDA has not approved for either inpatient or outpatient use.
11. 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.
12. Growth hormone drugs for persons 18 years or older. Growth hormone therapy for the treatment of documented growth hormone deficiency in children for whom epiphyseal closure has not occurred is covered when services are preauthorized and are supplied by Hometown Health's preferred vendor for the medication.
13. 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.
14. Medical supplies, devices and equipment and nonmedical supplies or substances regardless of their intended use.
15. Medications approved by the FDA for less than six months unless the Hometown Health Pharmacy and Therapeutics Committee, at its sole discretion, decides to waive this exclusion with respect to a particular drug.

16. Medications for impotence or erectile dysfunction.
17. Medication consumed or administered at the place where it is dispensed or while a member is in a hospital or similar facility; or take-home prescriptions dispensed from a hospital pharmacy upon discharge unless the pharmacy is a participating retail pharmacy.
18. Over-the-counter drugs, medicines and other substances that do not by federal or state law require a prescription order or for which an over-the-counter product equivalent in strength is available. This applies even if ordered by a physician unless otherwise covered by Hometown Health as part of the requirements of the Affordable Care Act. Drugs consumed in a physician's office except as otherwise provided herein or in the EOC.
19. Performance, athletic performance or lifestyle enhancement drugs and supplies.
20. Prescription drugs purchased from outside of the United States 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.
21. 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.
22. 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.
23. Prophylactic drugs and immunizations for travel.
24. Quantities in excess of a 30-day supply. Prescriptions requiring quantities in excess of the above amount shall be completed on a refill basis except as otherwise provided in the Drug Formulary.
25. Replacement of lost, stolen, spoiled, expired, spilled or otherwise mishandled medication.
26. Prescription orders filled before the effective date or after the termination date of the coverage provided by this rider.
27. Test agents and devices, excluding diabetic test agents.

Prescription benefits are subject to all terms and provisions set forth in this SOB and EOC. In the event that an unintended inconsistency exists between this SOB and the EOC, the EOC will govern the final benefit offered to the member.

Pharmacy Limitations –

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.

1. Nonemergency and non urgent care prescriptions will be covered only when filled at a participating retail pharmacy.
2. 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.
3. Refer to the Certificate for a description of emergency and urgent care coverage. Hometown Health will not reimburse members for out-of-pocket expenses for prescriptions purchased from a participating retail pharmacy or a nonparticipating retail pharmacy in nonemergency, non urgent care situations.
4. 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.

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

Pediatric Vision Plan Exclusions

1. Two pairs of glasses instead of Bifocals
2. Replacements of lenses, frames, or contacts
3. Surgical or Medical Treatment
4. Orthoptics, vision training, supplemental testing

Items not covered under the contact lens coverage

1. Insurance policies or service agreements
2. Artistically painted or non-prescription lenses
3. Additional office visits for contact lens pathology
4. Contact lens modification, polishing or cleaning

Pediatric Dental Benefit Exclusions-

1. Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
2. Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
3. Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
4. Telephone consultations;
5. Any charges for failure to keep a scheduled appointment;
6. Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
7. Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD) unless determined to be medically necessary. Detailed coverage descriptions are available in the EOC under the medical benefit section for services that are available for all members if medical necessity criteria are met.
8. Services or treatment provided as a result of intentionally self-inflicted injury or illness;
9. Office infection control charges;
10. Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
11. State or territorial taxes on dental services performed;
12. Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;

13. Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
14. Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
15. Those which are for specialized procedures and techniques;
16. Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
17. Duplicate, provisional and temporary devices, appliances, and services;
18. Plaque control programs, oral hygiene instruction
19. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
20. Gold foil restorations;
21. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
22. Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
23. Charges by the provider for completing dental forms;
24. Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
25. Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
26. Cone Beam Imaging and Cone Beam MRI procedures;
27. Sealants for teeth other than permanent molars;
28. Precision attachments, personalization, precious metal bases and other specialized techniques;
29. Replacement of dentures that have been lost, stolen or misplaced;
30. Orthodontic care for dependent children age 19 and over;
31. Repair of damaged orthodontic appliances;
32. Replacement of lost or missing appliances;
33. Fabrication of athletic mouth guard;
34. Internal and external bleaching;
35. Nitrous oxide;
36. Oral sedation;
37. Topical medicament center
38. Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
39. When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service).
40. When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by MetLife.
41. All out of network services listed in Section 5 are subject to the usual and customary maximum allowable fee charges.. The member is responsible for all remaining charges that exceed the allowable maximum.

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.

PART 5 **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 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 the summary of benefits and this EOC. These include medical, surgical, diagnostic, therapeutic, and preventive services. To receive benefits at the In-Network level of coverage for services that are not emergency in nature, or for Out-of-Network Services that require an authorization to be paid without a benefit penalty, an authorization must be obtained from Hometown Health Providers. Most services that are eligible for In-Network levels of benefits, generally and customarily are:

- Provided in our Geographic Service Area or in the National Network if purchased as part of the small group plan
- Performed or ordered by a Participating Provider, and
- Prior authorized by us according to our utilization management and quality assurance protocols, if applicable.

B. Scope of the Program

Under the utilization management program, a prior-authorization is required for referrals to Physicians and Providers for certain services to be covered at the In-Network level of coverage. Prior authorization means our determination of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. All benefits listed in this EOC may be subject to prior authorization requirements and concurrent review depending upon the circumstances associated with the services, to receive the benefit coverage at the In-Network level, or for Out-of-Network benefits to be provided without penalty for some services noted in the plan summary of benefits Refer to your plan-specific summary of benefits for services that require prior authorization. You may find a full list of services that require prior authorization for your plan by visiting our website at www.hometownhealth.com.

The following services are subject to a prior authorization for In-Network levels of coverage to be considered

- All inpatient stays and services in any facility type, including Acute and skilled care, mental health care, drug or alcohol detoxification, or rehabilitation (including partial or day hospitalization services stays);
- Inpatient, or same day surgical services;
- Autism services; Mental health and substance abuse services greater than 12 visits per plan year; if covered as part of the benefit plan governed by this EOC
- Home health care;

- Healthcare services and supplies including but not limited to oxygen, oxygen-related equipment and all durable medical equipment with a cost greater than $100;
- Prosthetic and orthopedic devices with a cost greater than $100;
- Transplant services;
- Routine or elective services of all non-Participating Providers, if you are making a request to have those services provided at an In-Network benefit level. In the case of an Emergency or for Urgent Care, payment for services will be provided without a prior authorization in accordance with the terms of your specific Policy;
- Certain medications and complex radiology and cardiac imaging services, a list of which is set forth on our website at www.hometownhealth.com and which you can obtain by calling Customer Services at the number found on the back of your membership card;
- All routine or elective out-of-area services if you are making a request to have those services provided at an In-Network benefit level Anesthesiology and physiatry services including pain management;
- Certain laboratory and diagnostic tests
- Genetic counseling and testing; and
- Second-opinion services.

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, we must approve and/or pre-authorize the service. You are subject to a 50% reduction in benefits if you do not obtain a required prior-authorization for the service even if the service is Medically Necessary. 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.

Hospital admissions

You are responsible for notifying us of a Hospital stay at least five business days 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 Hospital or related charges for the care that is not Medically Necessary or does not meet our criteria or protocols.

Inpatient and outpatient surgery

You are responsible for making sure we are notified at least five business days 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.

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 if covered under this plan.

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 you specific Policy.

Healthcare services and supplies review

Participating Providers may notify us on your behalf to obtain prior-authorization for the services described in Part A above ("Scope of the Program.").

Non-Participating Providers may not know or attempt to notify us to obtain prior-authorization for services. In such a case, you must confirm that we have pre-authorized a service in order 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. 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. 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, we 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.

E. 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.

F. 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:

- Your Physician has recommended a procedure and you are unsure whether the procedure is necessary or reasonable;
- 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;
- You are unclear about the clinical indications about your condition;
- A diagnosis is in doubt due to conflicting test results;
- Your Physician is unable to diagnose your condition; and
- A treatment plan in progress is not improving your medical condition within a reasonable period of time.

PART 6 **RELATIONSHIP OF PARTIES**

A. Independent Contractors

The relationship of us and our participating 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.

PART 7 **ELIGIBILITY AND ENROLLMENT**

A. To be eligible for membership as a Subscriber under this Evidence of Coverage, the applicant must:

1. Be a United States citizen or national; or

2. Be a lawfully present non-citizen for the entire period for which coverage is sought;

3. Be a legal resident of the United States.

4. Be an employee of an employer whose principal place of business is in the Geographic Service Areas where the Small Group plans are offered.

5. Agree to pay for the cost of Premium that Hometown Health has set

6. Not be incarcerated (except pending disposition of charges).

B. Subscriber

As stated above, the Subscriber is 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 as part of a participating Group Subscription Agreement.

C. Dependent

A subscriber may enroll a dependent if the dependent is listed on the subscriber's online enrollment application and all other required documents are completed and submitted to us.

A subscriber's dependent/s may include the following:

1. The dependent is the subscriber's lawful spouse.

2. The dependent is the subscriber's lawful domestic partner and the following requirements are met:

   a. The Nevada Office of the Secretary of State has issued a Domestic Partnership Certificate where both the subscriber and the subscriber's dependent domestic partner are listed as domestic partners.

   b. The Nevada Domestic Partnership Certificate is current and is submitted to us as evidence of domestic partnership upon request.

   c. The dependent is the 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.

There are special provisions for newborn children and newly adopted children:

d. A newborn natural child will be eligible for coverage effective on the child's date of birth. Coverage for a newborn child will cease after 31 days unless the subscriber enrolls a newborn within 31 days from the child's birth. Premium will be charged following a successful application process by Hometown Health, as of the date of the birth. During the first 31 day-period after birth, coverage for a newborn 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 that are applicable to other sicknesses, diseases and conditions otherwise covered.

e. A newly adopted child will be eligible for coverage effective the date of the child's adoption (or the date of the placement of the child in the employee's home, if earlier), subject to certification of the child's placement by the placement agency. Coverage for a newly adopted child will cease after 31 days unless the subscriber enrolls newly adopted child within 31 days from the effective date of the child's adoption. Premium will be charged following a successful application process by Hometown Health as of the placement date of the child.

"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. A placement terminates when the legal obligation for support terminates.

f. Disabled Child

The child is age 26 or older and all of the following requirements are met:

1. The child is incapable of self-sustaining employment due to a physical handicap or mental retardation;

2. The child is dependent on the employee for support and maintenance; and

3. The dependent child's condition originates before the child reaches the age of 26.

Written proof of such child's incapacity and dependency must be furnished within 31 days after the child reaches age 26 and annually thereafter beginning two years after the child reaches age 26.

g. Legal Ward

1. The child is a legal ward (pursuant to court order) permanently placed in the subscriber's home and meets the other eligibility provisions of this EOC.
2. Foster children, 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.
3. We are directed in accordance with federal law to do so by a Qualified Medical Child Support Order (QMCSO). Generally, a QMCSO is an order or judgment from a court or produced as a result of a state-authorized administrative process directing us to include a child in a Member's coverage.

h. Not be a dependent of a dependent child, other than coverage that is mandated for the first 31 days of life as noted above.

Note: Adding a Dependent

Generally, a dependent may be added at any time subject to the occurrence of a qualifying event like marriage, birth, or adoption. Dependent additions due to birth or adoption are as of the birth or placement date as defined earlier in this document. Dependent additions due to marriage would require that an application be submitted through www.HometownHealth.com that would be subject to underwriting approval. Effective date for those dependent additions would be the day following the date of subscriber acceptance of policy and premium rates and payment of premium.Siblings of the child who has the qualifying event are not eligible for addition to the plan at the time of the qualifying event. The subscriber may-submit an Enrollment/Change Form to add any dependents as members. Additional forms may be required for special dependent status. Subscribers may obtain an Enrollment/Change Form or any additional forms from Hometown Health's Customer Services Department. Contact Hometown Health's Customer Services Department at 775-982-3230.

C. Medicare-Eligible Members

Medicare Eligible individuals maybe covered under this Small Group Plan. . For the purpose of coordination of benefits, Medicare will be the primary payer for members of Small Group Plans who have under 20 subscribers. The Small Group Plan will be primary coverage for groups that hve more than 20 subscribers.

Enrollment

Open enrollment

You may be entitled to apply for coverage during your employer's open enrollment period set forth in the Group Subscription Agreement provided you have satisfied any probationary or waiting period requirements described in your employer's eligibility provisions in the Group Subscription Agreement. To apply for coverage, you must complete an enrollment application and may be required to submit form other necessary documentation as we may determined. Applications may be accepted up to 31 days after the effective date of you eligibility in this Policy.

If you are eligible, you may also apply for coverage for qualified family dependents during an open enrollment period by listing the dependents on your enrollment application. .

Coverage for employees and any dependents meeting the necessary requirements for enrollment will be effective on the Group's initial effective date or on the Group's Policy renewal date.

Newly eligible employees

If you are a new employee, you may be eligible to apply for coverage after you satisfy any probationary or waiting period as defined by your employer's eligibility provisions. To apply for coverage, you must complete an enrollment application. The requirements for coverage and the circumstances under which we may terminate or deny coverage are described above under "Open Enrollment."

Coverage for newly eligible employees and any dependents meeting the necessary

requirements for enrollment will be effective on the employee's initial effective date. If you are a newly eligible employees and do not complete enrollment application and provide any other necessary documentation as we may request within 31 days after the initial effective date of coverage, you and your dependents will not be allowed to enroll until the employer's next open enrollment period unless a qualifying status change event occurs, as described below.

Special enrollment

If you, your spouse, or your dependent is entitled to a special enrollment right as described below you may apply for coverage. You may only add an eligible dependent if you enroll yourself in coverage.

You have a special enrollment right in the following instances:

You initially declined medical and/or dental benefits under this Policy because of other health coverage and you lost eligibility for such coverage due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period.

You acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption. You have 31 calendar days after a birth of a child, marriage, adoption, or placement for adoption to change your election and may do so retroactively to the date of the noted event

Only the dependent who has the qualifying event as noted above is eligible for enrollment. Additional family members or other individuals who do not have current coverage, would not be eligible to enroll at this time, unless they also have a qualifying event.

- You, your spouse, or your dependent:

  Has his or her coverage under a Medicaid plan or a State's children's health insurance program ("CHIP") terminated due to a loss of eligibility or,

  Becomes eligible for premium assistance in connection with coverage under this Policy through Medicaid or CHIP.

  In such instances, you may retroactively add coverage for that person if you request such coverage no later than 60 days after the date of such termination of coverage or eligibility for premium assistance under Medicaid or CHIP.

Notice of ineligibility

It is your responsibility to notify your employer and us of any changes that can or will affect your eligibility or that of your dependents. Failure to notify us of any changes affecting your or your dependents' eligibility may lead to retroactive termination of coverage back to the date for which the event took place that caused your 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.

Provisions for eligibility and ineligibility may also be defined within your employer's eligibility provisions or in a separate benefit plan document or summary plan description.

You are encouraged to ask your employer for a complete description of additional eligibility requirements that your employer may require.

Documentation requirements

The enrollment application must be accurately completed, legible, signed, and delivered to us within the timeframes outlined within this EOC before it will be accepted.

Other forms and or documentation may be requested by us as part of the eligibility verification process. These forms and or documents may include, but are not limited to the following:

A child dependent group health affidavit ,

A notice of credible coverage

A coordination of benefits form,

A birth certificate,

A marriage certificate,

A domestic partnership certificate,

A court order,

Proof of the employee's legal right to work in the U.S., or

A valid Social Security number

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 may result in the termination of coverage for you or your dependents.

PART 8 **POLICY TERMINATION**

Equality

If your employer is a qualifying small employer, your coverage can not be denied or terminated due to your age, health status, economic status, health care needs, or prospective health care costs.

Termination for Cause and Rescission

Your and your dependents' coverage can be terminated or rescinded if there is any evidence of the following actions:

You materially misstate information about yourself on your enrollment application or any other document provided during the coverage application process.

You materially misstate information about your dependents on your enrollment application or any other document provided during the coverage application process.

You knowingly allow someone else to use your identity for the purpose of seeking medical care under this Policy.

You knowingly engage in an activity to defraud us or any organization that we have engaged to provide services under our policies.

Your employer erroneously or purposefully allows you or your dependents to enroll without meeting the eligibility requirements as defined in the Group Subscription Agreement.

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. In some cases your coverage may be rescinded back to your initial enrollment date. If we rescind your coverage, we will provide you and each affected participant with 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 rescission date. A Member has the right to appeal any such 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 and intent of your actions and to apply any and all legal remedies.

Cancellation

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If the Group Subscription Agreement is canceled or terminated, your coverage under this Policy will also be canceled on the effective date of the Group Subscription Agreement's termination.

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 30 days of its due date, your coverage may terminate. We will not be liable for the cost of any health care services that are provided or arranged from the original payment due date.

Subject to the provisions outlined under the individual conversion privilege and transfer section, your coverage will terminate on the last day of the month on which eligibility ceased, for any reason, or on the date of event as determined by the Group Subscription Agreement. This provision also applies to your dependents.

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.

Certificate of Creditable Coverage

When a member's coverage with Hometown Health terminates, Hometown Health will send the subscriber a Certificate of Creditable Coverage, which will identify the length of the member's creditable coverage with Hometown Health. The member may need this letter as proof of prior coverage when the member enrolls with another company.

What Hometown Health Will Pay for After Termination

Except as provided below, Hometown Health will not pay for any services provided after the member's coverage ends even if preauthorization was received. Benefits cease on the date the member's coverage ends as described above. A member may be liable for benefit payments made by Hometown Health on behalf of the member for services provided after the member's coverage has terminated, even if the termination was retroactive.

Hometown Health is only liable for payment of expenses for covered services provided during the effective period of this certificate. Hometown Health is not liable for expenses incurred after coverage under this certificate is terminated or following any amendment(s) made to this certificate in accordance with applicable law that may affect a change in such payment. A member may be liable for benefit payments made on behalf of the member for services provided after the member's coverage has terminated.

Hometown Health does not cover services received after the member's date of the termination even if:

Hometown Health issued a Prior authorization for the services

The services were made necessary by an accident, illness or other event that occurred while the coverage was in effect.

The member was hospitalized at the time of the termination.

PART 9 **CONTINUATION OF COVERAGE**

Federal Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers with 20 or more employees offer continued medical coverage for eligible employees and their dependents whose medical insurance would end due to a qualifying event.

You should call your plan administrator or your employer if you have questions about your right to continue coverage under COBRA.

In order to be eligible for continuation coverage under COBRA, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who was a Member on the day before a qualifying event:

an employee;

an employee's enrolled dependent, including with respect to the employee's children, a child born to or placed for adoption with the employee during a period of continuation coverage under federal law; or

an employee's former spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	**You May Elect COBRA:**		
	For Yourself	**For Your Spouse**	**For Your Child(ren)**
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
Your or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an	N/A	N/A	36 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
eligible family member (e.g., reaches the maximum age limit)			
You become entitled to Medicare	N/A	See table below	See table below
Your employer files for bankruptcy	36 months	36 months	36 months

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For UP To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both your and your employer's costs, plus a 2% administrative fee and other cost as permitted by law. The notice will provide information on where to send your election forms and premium payments.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your coverage under the Policy otherwise would have ended.

While you are covered under the Policy through COBRA, you have the right to change your coverage election under certain circumstances.

Notification Requirements

If your covered dependents lose coverage due to divorce, legal separation, or loss of dependent status, you or your dependents must notify your plan administrator within 60 days of the latest of:

the date of the divorce, legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent;

the date your enrolled dependent would lose coverage under the Policy; or

the date on which you or your enrolled dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your dependents must also notify your plan administrator when a qualifying event occurs that will extend continuation coverage.

If you or your dependents fail to notify your plan administrator of these events within the 60-day period, your plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify your plan administrator within 60 days of the birth or adoption of a child.

Once you have notified your plan administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide your plan administrator with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to your plan administrator. The contents of the notice must be such that your plan administrator is able to determine the covered employee and Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These employees are

entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, you should contact your plan administrator or your employer for additional information. You must contact your plan administrator promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that coverage under the Policy was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage under the Policy will end before the maximum continuation period shown above if:

you or your covered dependent becomes covered under another group medical plan or policy, as long as the other plan doesn't limit your coverage due to a pre-existing condition (as described in Part 7); or if the other plan does exclude coverage due to your pre-existing condition, your COBRA benefits would end when the exclusion period ends;

you or your covered dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;

the first required Premium is not paid within 45 days;

any other monthly Premium is not paid within 30 days of its due date;

your employer ceases to offer coverage under the Policy to its similarly situated employees; or

coverage would otherwise terminate under the Policy as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan or policy which was then replaced by coverage under this Policy, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

USERRA Leaves of Absence

You may be able to continue coverage under this Policy through your employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The continuation coverage is equal to the same coverage as the benefits that are provided to other participants in your employer's health plan. These benefits may be available to you if you are absent from work by reason of service in the United States uniformed service, up to a maximum 24-month period, if you meet the requirements of USERRA. USERRA benefits run concurrently with any continuation coverage that is available through COBRA.

You must submit an USERRA election notice to your employer within 60 days after your call to active duty. The Premium for USERRA continuation coverage is 102% of the Premium charged to your employer.

You should contact your employer for information about electing USERRA coverage and how much you must pay for such coverage.

Leaves of Absence

This Policy provides continuing coverage for an employee who is otherwise covered by the Policy while on leave with or without pay as a result of the Family and Medical Leave Act of 1993 (FMLA) or an employer-approved leave of absence. This coverage is the same as that in effect for the Employer Group during the period of disability or leave-of-absence.

The coverage required continues until one of the following occurs:

The date that the employment of the employee is terminated;

The date that the employee obtains another policy of health insurance;

The date that this Policy of group insurance is terminated;

After a total of 12 weeks (consecutive or non-consecutive) during a 12 month period in which benefits would normally be provided to the eligible employee.

PART 10 **SUBROGATION / RIGHT TO REIMBURSEMENT**

We have subrogation and reimbursement rights in certain situations where a third party is responsible for causing your or your dependents' Illness or Injury. This part explains our rights and your responsibilities in these circumstances and outlines how benefits are coordinated, amounts recovered by us are allocated and our rights are applied.

Background

Subrogation and reimbursement are legal terms that apply to certain claims we may have to recover payments made for medical expenses on behalf of a you and/or your dependents where a third party is legally responsible for causing an Injury or Illness to the participant and/or dependent for which medical benefits are paid by us. Subrogation and reimbursement can arise in different situations but a common example is when you or your dependent is injured in an accident caused by a third party's negligence. If we pay medical benefits to such a participant and/or dependent and the participant and/or dependent recovers damages in a lawsuit against the third party who caused the accident, we have a right to be reimbursed for the medical expenses it paid out of your or your dependent's financial recovery from the third party.

Here are some examples of how our subrogation and reimbursement rights might work:

Our rights to subrogation and reimbursement apply regardless of whether a recovery in a lawsuit is designated by the parties as covering damages (such as property damage or pain and suffering) other than medical expenses. An example of how this works is as follows:

Mr. Smith is covered by this Policy. Mr. Smith's car is rear-ended by Mr. Jones and Mr. Smith is injured and receives medical care. We paid medical benefits of $25,000 for Mr. Smith's care. Mr. Smith then sues Mr. Jones and recovers $50,000 in an out-of-court settlement of the lawsuit. In the settlement, the parties describe the settlement amount as covering only Mr. Smith's pain and suffering. Despite the parties' description of the payment in the settlement agreement, Mr. Smith is required to repay us the $25,000 it paid in medical expenses from the $50,000 Mr. Smith recovered through the settlement.

In asserting subrogation and reimbursement rights, we seek to conserve its resources for the benefit of all Members and their dependents, impose the expense for Injuries or Illness on those responsible for causing them, and avoid unjust enrichment.

By accepting benefits under this Policy to pay for treatments, devices, or other products or services related to such Illness or Injury, you agree that we have rights of recovery, reimbursement and subrogation to the extent of any benefits paid for an Illness or Injury that is caused or compensated by a third party.

Subrogation Rights

Our subrogation rights come into play when we pay benefits on your behalf or on behalf of your dependent for an Illness or Injury for which you receive, or have a right to receive, compensation of any kind (whether by a court judgment, settlement, or otherwise). In these situations, we will

be subrogated to your (or your dependent's) recovery, or right to recovery, of compensation for your damages from any person, insurance company, other benefits plan or any other organization. This means that we "stand in your shoes"—we assume your right to receive the compensation from the other person, their insurance company, their benefits plan, or any other organization to the full extent of the medical benefits paid.

Damages will include, but will not be limited to, compensation received and/or claimed for personal injury and/or property loss and/or medical expenses. Our subrogation rights will not be decreased, restricted, or eliminated in any way if you or your dependent recover or have the right to recover no-fault insurance benefits.

Reimbursement Rights

If you or your dependent obtain any recovery—regardless of how it's designated or structured—from or on behalf of any insurance company or any third party responsible for the condition giving rise to the medical expense, you or your dependent must fully and completely reimburse us for all payments made by us to or on behalf of you and/or your dependents for such a medical expense. We have the right to a full and complete reimbursement from you or your dependents of all payments made by us, from any recovery you or your dependent obtains from any insurance company or any responsible third party even if you or your dependents have not or will not be fully compensated or made whole for the Injuries caused by the responsible third party.

Equitable Lien

By accepting benefits under this Policy, you and your dependents agree to an equitable lien by agreement against any recovery you may receive in an action against a third party who caused an Injury or Illness which resulted in us paying medical expenses for you or your dependents. As a result, you and your dependents must repay to us the benefits paid on your behalf out of the amounts recovered from the other person or their insurance company, benefits plan, or any other organization. Our right of reimbursement applies even if your and your dependents' claims are settled without an admission of fault and even if you or your eligible dependent recover or have the right to recover no-fault insurance benefits. **We have a lien on any amount recovered by you or your eligible dependents, regardless of whether the amount is designated as payment for medical expenses. Our lien arises through operation of the Policy. No additional reimbursement agreement is necessary. This lien will remain in effect until we are reimbursed in full.**

Constructive Trust

If you (or your attorney or other representative) receive any payment through a judgment, settlement or otherwise—for an Illness or Injury that is caused by a third party for which we have paid medical expenses, you agree to maintain the funds in a separate, identifiable account and that we have an equitable lien on the funds. In addition you agree to serve as a constructive trustee over funds to the extent that we have paid expenses related to that Illness or Injury. This means that you will be deemed to be in control of the funds.

HOMETOWN HEALTH PROVIDERS INSURANCE COMPANY, INC.

Our Obligation to Pay Benefits

We will pay covered expenses incurred by you or your dependent as a result of an Illness or Injury for which you receive, or may have a right to receive, compensation of any kind from another person (or entity), an insurance company, or any other organization, only on the condition that you or your eligible dependents, or another duly authorized person on your behalf, agree to do and will do the following:

Reimburse us to the extent of covered expenses paid by us (any amounts credited to Deductibles will be removed), immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) for damages that include, but are not limited to, personal injury, property loss or medical expenses. Your or your eligible dependent's heirs, beneficiaries, and personal representatives will also be bound by this obligation.

Serve as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent we paid benefits for such sickness or Injury.

Sign and deliver requested documents to us. If you or your eligible dependents fail or refuse to sign whatever form or document is requested by us or our representative within 30 days of the request, we will no longer have any obligation to pay any covered expense incurred by you or your eligible dependents.

Do whatever else is needed to enforce our subrogation and reimbursement rights including:

Immediately notifying us in writing whenever you or your eligible dependent believe or first learn that any person, insurance company or benefits plan, or any other organization, is or may be responsible, or has agreed or may agree to pay, either totally or in part, for any damages you or your eligible dependent has suffered or may suffer as a result of any Illness or Injury. Damages include, but are not limited to, any personal injury and/or property damage and/or medical expenses.

Immediately notifying us in writing, whenever a representative of any other person (or entity), insurance company or benefits plan, or any other organization, contacts you or your eligible dependent or your representative, or is contacted by you or your eligible dependent or by your representative, in order to settle, adjust or in any way resolve your or your eligible dependent's or estate's claim for damages. A claim will include any cause of action filed in any court and/or any verbal or written demand made by you or your eligible dependent or on your behalf, for compensation for damages you or your eligible dependent have suffered or may suffer as a result of any Illness or Injury.

Refusing any settlement, adjustment or resolution of your or your eligible dependent's or estate's claim for damages until you or your eligible dependent or your representative have received our written authorization allowing you or

your representative to accept a settlement, adjustment or resolution offered by any person, insurance company or benefits plan, or any other organization.

Not taking any action that would prejudice or harm our subrogation and reimbursement rights.

Cooperating fully with us in asserting its reimbursement and subrogation rights, supplying us with any and all information, and executing any and all forms we may need for this purpose.

By accepting benefit under this Policy, you have agreed to these conditions.

NOTE: We may obtain reimbursement or satisfy its subrogation rights by reducing the covered expenses paid by us to you or your eligible dependent for covered expenses already incurred but not yet paid, and for covered expenses incurred in the future.

An example of this is as follows:

Mr. Smith is covered by this Policy. Mr. Smith's car is rear-ended by Mr. Jones and Mr. Smith is Injured and receives medical care. We paid medical benefits of $25,000 for Mr. Smith's care. Mr. Smith then sues Mr. Jones and recovers $50,000 through an out-of-court settlement of the lawsuit. Mr. Smith, however, was not "made whole" by the settlement because his damages (including medical expenses, pain and suffering, and property damage) exceeded the $50,000 he received in the settlement. Although Mr. Smith was not "made whole" by the settlement, he may be asked to repay us the $25,000 it paid in medical expenses from the $50,000 he recovered in the lawsuit.

Attorney's Fees

We will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with pursuing a claim unless we agrees to do so in writing.

An example of this is as follows:

Mr. Smith is covered by this Policy. Mr. Smith's car is rear-ended by Mr. Jones and Mr. Smith is Injured and receives medical care. We paid medical benefits of $100,000 for Mr. Smith's care. Mr. Smith then sues Mr. Jones and recovers $150,000. Although Mr. Smith was awarded $150,000, he incurred legal fees of $50,000 leaving him with a net recovery of $100,000. Although Mr. Smith incurred legal fees of $50,000, he is not allowed to reduce his repayment obligation to us due to his having incurred legal fees and, therefore, must repay us the full $100,000 we paid in medical expenses.

Coordination of Benefits

Notwithstanding any coordination of benefits rules provided in this EOC, benefits under this Policy will be secondary to any no-fault auto insurance.

Allocation of Amounts Recovered by Us

Our lien includes attorney's fees and the costs of collection. If our lien is satisfied by direct recovery, the remainder, if any, will be paid to you or your eligible dependent or to your representative or estate.

No Benefits Where Compensation Has Already Been Received

We will not pay out benefits to you to the extent you or your eligible dependent have already received compensation for your Injury.

Cap on Expenses Paid

We agree to pay for Hospital and medical expenses up to a maximum of $20,000 per incident.

Scope of Rights

These subrogation and reimbursement provisions may be interpreted by us, in our sole discretion, to permit us to obtain full satisfaction of any lien or right to reimbursement from you or your eligible dependent or any other person who received payment on your behalf (including, but not limited to, a parent, spouse, guardian, or estate). We may, in our sole discretion, allocate the responsibility for reimbursement or satisfaction of a lien among you, your eligible dependents, and any other person, such as your or your eligible dependents' legal counsel.

Right to Receive and Release Information

Subject to the our obligation under Health Insurance Portability and Accountability Act of 1996, or any other applicable law, for the purpose of implementing these subrogation and reimbursement provisions, we may, without the consent of or notice to any person, release to or obtain from any insurance company, other organization or person any information that we regard as necessary, with respect to you or your eligible dependent claiming benefits under this Policy. When you are claiming benefits under this Policy, you and your eligible dependents, must furnish us with the information needed to enforce the subrogation and reimbursement provisions.

IMPORTANT: Our Right to Terminate Your Coverage and/or Offset Future Benefits

We may terminate your coverage and/or offset your future benefits for the value of benefits advanced in the event that that we do not recover, if you do not provide the information, authorizations, or otherwise cooperate in a manner that we considers necessary to exercise its rights or privileges under this Policy.

Effect of Our Interpretation

We will have the exclusive discretionary power to construe provisions of this Policy.

Heirs and Estate of Any Covered Person

Our rights under this section remain enforceable against the heirs and estate of any covered person.

HOMETOWN HEALTH PROVIDERS INSURANCE COMPANY, INC.

PART 11 **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 is a process by which another group health plan or Medicare (if you are enrolled in both this Policy and another group plan or Medicare) may be responsible for claims payment either as the primary or secondary carrier.

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 allowable cost of the Covered Services. This coordination of benefits provision helps to contain the cost of health care coverage.

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 group health insurance plan that covers you. All provisions of this EOC, including but not limited to the use of Participating Providers and prior authorization requirements apply whether this Policy is primary or secondary.

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:

Plan - an entity providing group health care benefits or services by any of the following methods:

Group insurance or any other arrangement for coverage for individuals whether on an insured or uninsured basis; or

Group service plan contracts, group practice, individual practice and other prepayment coverage; or

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; or

Any coverage under labor management trustee plans, union welfare plans, employer organization plans, employee benefits plans, or employee benefit organization plans; or

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; or

Coverage under a governmental program, including Medicare and Worker's Compensation plans.

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.

Allowable Expense - the eligible medical expense for Medically Necessary Covered Services.

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.

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 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

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.

Determination Rules

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

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.

Non-dependent/Dependent—The benefits of the plan that covers a person as an employee are primary to those of the plan that covers the person as a dependent;

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":

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

If both parents have the same birthday, the benefits of the policy that covers a parent longer, is the primary policy.

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:

First, the plan of the parent with custody of the child;

Then, the plan of the spouse of the parent with custody of the child; and

Finally, the plan of the parent not having custody of the child;

With respect to 1, 2, and 3 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.

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;

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.)

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 charge for the Covered Service, then the secondary plan will apply its allowable expense to the unpaid balance. You must first file a claim with the primary plan to receive any benefits from the secondary plan.

Right to Receive and Release Information

In order 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:

Release to any person, insurance company, or organization, the necessary claim information;

Receive from any person, insurance company, or organization, the necessary claim information; and

Require any person claiming benefits under this Policy to give us any information needed by us to coordinate those benefits.

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:

Any persons to or for whom such payments were made,

Any group insurance companies or service plans, and

Any other organizations

PART 12 **MEDICARE COORDINATION OF BENEFITS**

If you are age 65 or older, entitled to benefits under Medicare, and work for an employer that did not employ 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, then Medicare is the primary payer for you and your spouse. The benefits of this Policy will then be the secondary form of coverage.

If you or your spouse is age 65 or older, entitled to benefits under Medicare, and work for an employer that employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, the following rules apply:

This Policy is primary payer for any person age 65 or older who is an active employee or the spouse of an active employee of any age.

You may decline coverage under the Group contract and elect Medicare as the primary form of coverage. If you elect Medicare as the primary form of coverage, the Policy, by law, cannot pay benefits secondary to Medicare for Medicare-covered Members. However, your will continue to be covered by the Policy as primary unless:

We are notified in writing, that you do not want benefits under the Policy; or

You otherwise cease to be eligible for coverage under the Policy.

Disability

If you are under age 65, have current employment status with an employer with fewer than 100 employees, and become disabled and entitled to benefits under Medicare due to such disability, then Medicare will be primary for you and this Policy will be the secondary form of coverage.

If you are under age 65, have current employment status with an employer with at least 100 employees, and you become disabled and entitled to benefits under Medicare due to such disability (other than ESRD, as discussed below) this Policy will be primary for you and Medicare will be the secondary form of coverage.

End Stage Renal Disease (ESRD)

This Policy will remain primary for the first 30 months of your eligibility or entitlement to Medicare due to end stage renal disease. However, if this Policy is currently paying benefits as secondary to Medicare for you, this Policy will remain secondary upon your entitlement to Medicare due to ESRD.

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PART 13 **DOUBLE COVERAGE**

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.

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 to Medicare, including Medicare Parts B and D, except Medicare Copayments/Coinsurance and Deductibles.

PART 14 **MEMBER CLAIMS AND APPEAL PROCEDURES**

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 following procedures will be followed if a medical service site matter cannot be resolved at the site or if the concern involves a claim for benefits.

Definitions

Adverse benefit determination means 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 managed care/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.

A **claim for benefits** means 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.

Appeal means the formal process you can use to request review of an adverse benefit determination.

An **informal appeal** is 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.

Expedited appeal means the process that you can use to request a review of an adverse benefit determination of an Urgent Care claim.

A **final internal adverse benefit determination** is an adverse benefit determination that we have upheld at the completion of our internal review process.

An **Urgent Care claim** means 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.

A **1st level formal appeal** is an appeal filed in writing that our customer services department investigates.

If a 1st level formal appeal is not resolved to your satisfaction, you may then file a **2nd level formal appeal**. A 2nd Level formal appeal is submitted in writing on a request for formal hearing form and reviewed by the Grievance Committee. The 2nd level formal appeal is voluntary for Urgent Care claim appeals.

The **Grievance Committee** is a committee of three or more persons, the majority of which must be Members insured by us. The Grievance Committee is chaired by one of our executives or board members, or his or her designee, and is comprised of such other persons as the chairperson deems appropriate.

Your **authorized representative** is a person that you designate to act on his or her behalf in pursuing a claim for benefits or an appeal of an adverse benefit determination.

For the purpose of submitting a request for an external review for a final adverse determination, an authorized representative means a person who has obtained the consent of an insured to represent him in an external review of a final adverse determination conducted under applicable law.

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.

Internal Claims and Appeals Procedures

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.

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 and appeals procedure. 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.

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:

Our receipt of the specified information, or

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 an 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.

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 you appeal waived. The informal appeal is a voluntary level of appeal and you may immediately make a 1st level 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

Name of person filing the appeal

Our customer services department representative will inform you of the resolution or proposed resolution of the appeal within 20 working days, unless more time is required for fact-finding.

1st Level 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 1st level formal appeal. You must submit the 1st level 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 1st level 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 1st level 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 Group name; 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.

You can ask for an expedited appeal of an Urgent Care claim. Expedited appeals are not available for appeals regarding post-service claims.

If your Physician requests an expedited appeal, or supports your request for an expedited appeal, and indicates that waiting for 15 days could seriously harm your health or subject you to unmanageable severe pain, we will automatically grant an expedited appeal.

If you submit a request for an expedited appeal without the support of your Physician, we will decide whether your health requires an expedited appeal. If we do not grant an expedited appeal, we will provide a decision within 15 days, subject to the above.

We will review your appeal. The review 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;

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

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

Limited extensions may be required if additional information is required.

If the proposed resolution to the 1st level formal appeal is not acceptable to you, you are entitled to file a 2nd level formal appeal. We will inform you of this right at the time we inform you of the resolution of your 1st level 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.

2nd Level Formal Appeal

When a 1st level formal appeal is not resolved in a manner to your satisfaction, you may initiate a 2nd level formal appeal to the Grievance Committee. You or you authorized representative must submit this appeal in writing on a request for formal hearing form, which will be attached to 1st level formal appeal decision letter, within 60 days after the you have been informed of the resolution of the 1st level formal appeal.

Exhaustion of the 1st level formal appeal procedure is a precondition to filing a 2nd level formal appeal. If you do not file your 2nd level formal appeal in a timely manner, we

will deem it waived with respect to the adverse benefit determination to which it relates. The 2nd level formal appeal is voluntary for Urgent Care claim appeals.

You are entitled to receive the same reasonable access to, and copies of documents, referenced above under the 1st level formal appeal.

The Grievance Committee will determine if a formal presentation is appropriate and, if so, will make every reasonable effort to schedule one at a time mutually convenient to the parties. Repeated refusal on your part to cooperate in the scheduling of the formal presentation shall relieve the Grievance Committee of the responsibility of hearing a formal presentation, but not of reviewing the 2nd level formal appeal. If the Grievance Committee determines that a formal presentation is appropriate, we will permit you to have assistance in presenting the matter to the Committee, including representation by counsel. However, you must notify us at least one week before the date of the scheduled formal presentation of your intent to be represented by counsel or to have others present during the formal presentation.

Upon receipt of the request for formal hearing form, the request will be forwarded to the Grievance Committee along with all available documentation relating to your appeal.

The Grievance Committee will consider the 2nd level of appeal, schedule a formal presentation if applicable, obtain additional information from you or others, as it deems appropriate. The Grievance Committee will not include any individuals who made the initial adverse benefit determination or decided the 1st level formal appeal nor will it include the subordinate of such individuals. The Grievance Committee will not afford deference to the initial adverse benefit determination or 1st level formal appeal decision.

When the Grievance Committee's review is complete, we will inform you in writing of the resolution no later than:

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

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

Independent Medical Evaluation

In the event we require you to undergo an independent evaluation for any final determination of medical or chiropractic benefits or care, we will choose a participating Physician or chiropractor who is certified to practice in the same field of practice as your primary treating Physician or chiropractor or who is formally educated in that field to conduct the evaluation. The independent evaluation will include a physical examination of you (unless deceased), and a personal review of all X-rays and reports prepared by the primary treating Physician or chiropractor. A certified copy of all reports of findings will be sent to you within five working days by certified United States mail.

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.

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 29 C.F.R. 2560.503-1 and 29 C.F.R. 2590.715-27179 and will update such process in accordance with any applicable standards established by the Secretary of the U.S. Department of Labor.

External Review

Submitting Claims for External Review

If, upon our final review, we deny your claim for benefits and you disagree with our decision, you or your authorized representative may submit your claim to the external review process described below. This step is not mandatory. The external review process is only available for an adverse benefit determination in which we determine that an admission, availability of care, continued stay, or other health care service that is covered under this Policy has been reviewed and, based on the information provided, does not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced or terminated.

In most circumstances, before you may submit your claim to the external review process, you must exhaust our internal claims procedure. In certain circumstances, however, you may receive an expedited external review (as described below). Also, if we do not provide you with a written decision on your claim (except in the case of a retrospective review determination) within 30 days from the date your claim for benefits was filed, you may not have to exhaust the internal claims process before filing a request for external review.

Within four months of the date you receive an adverse benefit determination or final adverse benefit determination, you or your authorized representative may file a request for external review by contacting the Nevada Office for Consumer Health Assistance (OCHA) at 775-687-3370 or toll free at 888-333-1597.

Expedited External Review

You or your authorized representative may make a written or oral request for an expedited external review if you have received an adverse benefit determination of an Urgent Care claim and:

- You have a medical condition where the time for completing the internal review process would seriously jeopardize your life, health, or ability to regain maximum function; and
- You have filed a request for an expedited internal appeal.

You or your authorized representative may also make a written or oral request for an expedited external review if you have received a final adverse benefit determination and:

- You have a medical condition where the time for completing the internal review process would seriously jeopardize your life, health, or ability to regain maximum function; or

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.

In addition, you or your authorized representative may submit your claim to the external review process if you receive an adverse benefit determination or final adverse benefit determination that involves a denial of coverage based on a determination that a recommended or requested health care service or treatment is experimental or investigational. In such a case, you or your authorized representative may make an oral request for an expedited external review if your treating physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

You can initiate an expedited external review by calling the Office of Consumer Health Assistance at 775-687-3370 or toll free 888-333-1597. If you are not entitled to an expedited internal review, you will be notified as expeditiously as possible.

Standard and Expedited External Review Timeframes

Should you or your authorized representative file a request for a standard or expedited external review by the OCHA, you can anticipate the timeframe for review to be as follows:

OCHA will notify us of your request within one (1) business day after receipt of your request for external review.

We will make a preliminary determination of eligibility within five (5) business days of receipt of the request from OCHA.

Within one (1) business day after completion, we will notify you and the OCHA in writing whether the request is complete and eligible for review.

We will notify you and the OCHA once it determines that a request is eligible for external review.

Within 1 business day after receiving notice from us, OCHA will assign the Independent Review Organization (IRO) and notify us of the name of the IRO. OCHA will also notify you in writing that the request is eligible and provide the name of the IRO.

You may, within five (5) business days after receiving the IRO notice, submit in writing to the IRO any additional information.

Any information submitted to the IRO by you after five (5) business days has passed, MAY be considered as well.

The IRO must select one or more clinical reviewers within one (1) business day after receipt of assignment. We have five (5) business days to submit documentation used in the adverse determination assigned to the IRO.

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.

The IRO has one (1) business day after receipt of any information received from you to submit it to us.

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.

Each clinical reviewer shall provide a written opinion to the IRO within twenty (20) days. If it is an expedited review, it may be provided orally or in writing to the IRO, but in no event in more than five (5) calendar days. If the opinion is provided orally, then the written opinion is required within forty eight (48) hours following the date the opinion is provided to the IRO.

If it is not an expedited review, the IRO has twenty (20) days to review the opinion of each of the clinical reviewers.

If it is an expedited review, the IRO has forty eight (48) hours to review the opinion of the clinical reviewers.

If the opinions are equally split, the IRO shall seek another opinion to break the tie.

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

Authorization for Release of Medical Records

When filing a request for external review, you or your authorized representative 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.

Independent Review Organizations

An independent third party with clinical and legal expertise and with no financial or personal conflicts with us will conduct all external reviews. 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.

The independent review organization will provide written notice of the final external review decision within 45 days after it receives the request for external review. If the independent review organization reverses our denial of your claim, the decision will be final and we must immediately provide coverage or payment.

Notice of Appeal Rights

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.

You may request additional explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact us when you:

Do not understand the reason for the denial;

Do not understand why the health care service or treatment was not fully covered;

Do not understand why a request for coverage of a health care service or treatment was denied;

Cannot find the applicable provision in your Evidence of Coverage or Certificate of Coverage;

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.

If your claim was denied due to missing or incomplete information, you or your Provider

may resubmit the claim to us with the necessary information to complete the claim.[1]

Appeals

All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to 830 Harvard Way, Reno, NV 89502 within **180** days of the date you receive our denial.[2] We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within 30 days of receiving your appeal. If you do not receive our decision within 30 days of receiving your appeal, you are entitled to file a request for external review.

External Review

If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision reviewed by independent 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 by submitting a request for external review within **4 months** after receipt of this notice to the Office for Consumer Health Assistance, 555 East Washington #4800, Las Vegas NV 89101, Phone: (702) 486 3587, (888) 333 1597, or Fax (702) 486 3586, Web: www.govcha.nv.gov. For standard external review, a decision will be made **within 45** days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. For details, please review your Evidence of Coverage or Certificate of Coverage, contact us, the Office for Consumer Health Assistance or contact the Nevada Division of Insurance.

[1] See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

[2] Unless your Policy or applicable state law allows you additional time.

PART 15 **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 a Participating Provider for Covered Services that you receive, such Provider is prohibited from billing you for the difference. Because this Provider is a Participating 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 Group Subscription Agreement, Summary of Benefits, riders, , questionnaires, and applicable attachments if any, 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 or dependent 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. 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.

K. Notice

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

Hometown Health
Attention: Customer Services Department
830 Harvard Way
Reno, Nevada 89502.

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.

L. 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.

M. Policies and Procedures

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

N. 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.

O. Return of Overpayment

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

Hometown Health Providers Insurance Company, Inc. is licensed by:

State of Nevada
Department of Business and Industry
Division of Insurance
1818 East College Parkway
Carson City, Nevada 89706
Toll Free No. 1-888-872-3234
Hours Monday through Friday 8 a.m. to 5 p.m.
Pacific Time (PT)