Hometown Health Providers Insurance Company
Summary of Benefits – Silver PPO 7050 S D1000X2 PD LN SG
Benefit Plan: 2014 - **85266NV0020021**

Hometown Health Providers Insurance Company is an insurance company licensed by the State of Nevada to provider 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, Carson, Douglas, Lyons, and Storey Counties. 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 the two Geographic Service Areas.

Additional eligibility requirements are detailed in the Evidence of Coverage for the Small Group Plan offered by Hometown Health Providers Insurance Company.

Hometown Health has partnered with a company to provide specialty network services that includes the Essential Health Benefits mandated by the Affordable Care Act and chosen by the State of Nevada as essential health benefits. 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. A Dental network will be provided by Hometown Health for the pediatric dental essential health benefits as mandated by the ACA. Details of the administration of these benefits are available on www.Hometownhealth.com, and will be fully described in the Evidence of Coverage that governs this Summary of Benefits.

This Summary of Benefits describes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures. Refer to your Evidence of Coverage (EOC) for Policy-specific cost sharing information not described within this Summary of Benefits. In case of conflicts between the EOC and the Summary of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents.

This Summary of Benefits 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 Summary of Benefits and the Evidence of Coverage it supports, the United States Department of Health and Human Services and other regulatory agencies had not issued regulations or guidance with respect to many aspects of these laws. We will provide coverage under this Policy in accordance with these laws and in compliance with applicable regulations and guidance as they are issued. This benefit plan provides Essential Health Benefits as established through the process described by the Affordable Care Act as determined to be minimum coverage for Small Group Plans sold in the State of Nevada and complies with all state mandates described in the Nevada Revised Statutes and Nevada Administrative Code as applicable.

Copies of EOCs, Summaries of Benefits, attachments, riders, 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.

This document contains summary information for your reference. It does not contain all of the Prior Authorization requirements and specific restrictions, exclusions and limitations associated with this benefit plan. Refer to the Hometown Health Providers Insurance Company (Hometown Health) Small Group PPO Evidence of Coverage (EOC) for a more comprehensive list of prior-authorization requirements and specific restrictions, exclusions and limitations.

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

Medical Benefits Definitions

Benefit plan – the specific health insurance policy outlined in this Summary of Benefits

Coinsurance -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.

Copayment – the specific amount payable by the member to a provider of care at the time of service for certain covered services. If the benefit plan has a deductible for a service, the copayment and the deductible both apply to the service. Once the deductible has been satisfied the copayments for a particular service apply until the Out of Pocket maximum for the plan is reached. If there is no deductible for a particular service, and a copayment is listed, the member's cost sharing for that service will be that copayment. Copayments apply to the out of pocket maximums.

Deductible- 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 Hometown Health. There may be separate deductibles for pharmacy and medical benefits according to the benefit plan that is in place, or they may be combined. Services subject to the deductible will be named in the benefit grid.

Deductibles are based on Calendar Year (CYD). A Calendar Year begins January 1st and ends December 31st of the current year.

Health Savings Account (HSA) a bank account owned by an individual used exclusively to pay for current and future medical expenses, HSAs are used in conjunction with qualified health insurance policies as defined by the United States Department of the Treasury. HSA qualified health insurance policies can not cover medical expenses before deductibles or coinsurance except for preventive care services.

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:

a. Provided in accordance with generally accepted standards of medical practice;

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

For purposes of this EOC and SOB, 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.

Non-preferred Providers (out of network)-Healthcare Providers with whom Hometown Health has not contracted to provide discounted covered healthcare services to its members.

Out-of-Pocket Maximum -the maximum payment amount for which the Member or Family is responsible for deductible, copayments, or coinsurance in a Calendar 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 Calendar 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.

Preferred or Participating Provider -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 30 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.

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. Refer to the EOC for more details and information.

Usual and Customary means the lesser of:

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

b. 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

c. What Medicare would pay for such treatment, service, or supply.

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 775-982-3232 or 800-336-0123. Inclusion of a drug in the Drug Formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition. The Drug Formulary is subject to change at the sole discretion of Hometown Health.

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

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.

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

The benefits outlined in the Benefit Summary Table are not a complete listing of the medical, dental, vision, or pharmacy services covered under this benefit plan. Benefits for services not listed can be found in the EOC. Copayments for services not shown in the Benefit Summary Table are determined by the location in which services are provided (such as emergency rooms, urgent care centers or physicians' offices). The copayment or coinsurance amounts listed in the Benefit Summary Table are applicable for covered services received as described in the EOC and the Summary of Benefits. All charges associated with non-covered services or denied claims are the member's responsibility. Charges in excess of the usual and customary amount for services received from non-preferred providers are the member's responsibility.

Benefits for prescription drugs not listed can be found in the EOC if those medications are covered under the medical benefits. The copayment and coinsurance amounts listed in the Benefit Summary Table are applicable for covered prescription drugs. All charges associated with non-covered prescription drugs or denied claims are the member's responsibility. Charges in excess of the maximum allowed amount for prescription drugs received from a nonparticipating pharmacy are the member's responsibility. Charges in excess of the usual and customary amount do not apply toward the annual Out-of-Pocket coinsurance maximum.

Benefit Summary Table		
Benefit Category	Member Responsibility	
Deductibles –	In-Network	Out-of-Network
Individual Overall Deductible	$1,000	$2,000
Family Overall Deductible	$2,000	$4,000
Individual Medical & Pharmacy Deductible *(if combined)*	N/A	N/A
Family Medical & Pharmacy Deductible *(if combined)*	N/A	N/A
Individual Medical Deductible	$1,000	$2,000
Family Medical Deductible	$2,000	$4,000
Individual Pharmacy Deductible	$0	$0
Family Pharmacy Deductible	$0	$0
Individual Annual Out-of-Pocket Maximum –	$6,000	$12,000
Family Annual Out-of-Pocket Maximum	$12,000	$24,000
Individual Medical, Pharmacy & Pediatric Vision, Pediatric Dental (if included) Out-of-Pocket Maximum	$6,000	$12,000
Family Medical, Pharmacy & Pediatric Vision, Pediatric Dental (if included) Out-of-Pocket Maximum	$12,000	$24,000
Individual Pediatric Dental Deductible *(if included in benefit plan)*	$60	$120
Family Pediatric Dental Deductible *(if included in benefit plan)*	$120	$240
Individual Pediatric Dental Annual Out-of-Pocket Maximum *(if included in benefit plan)*	$1,000	$2,000
Family Pediatric Dental Annual Out-of-Pocket Maximum *(if included in benefit plan)*	$2,000	$4,000
During a Calendar Year, individuals are responsible for paying copayments, coinsurance, and deductibles for certain benefits up to the individual, annual Out-of-Pocket maximum. However if coverage is extended to qualified dependents and the family, annual Out-of-Pocket maximum has been paid, no further payment is required for benefits to be paid on the member's behalf. Out of pocket maximums are different for In-Network and Out-of Network benefit levels. .		
Physician Office Visits – **** - Subject to CYD***	In-Network	Out-of-Network
Primary care (PCP)	30%*	50%*
Primary care - wellness visit PPACA covered	$0	50%*
Obstetrics and gynecology for PPACA services	$0	50%*
Specialist care	30%*	50%*
No referral is required for these visits. All necessary wellness visits are covered for children less than two years of age. One wellness visit per year is covered for members older than two or as frequently as mandated by ACA.		

Preventive Screenings – **** - Subject to CYD***	In-Network	Out-of-Network
Mammography screening	$0	50%*
Papanicolaou (Pap) test	$0	50%*
Prostate Specific Antigen (PSA) screen	$0	50%*
Colorectal screening	$0	50%*
Counseling for sexually transmitted infections (STI) HIV counseling and testing	$0	50%*
Breastfeeding support, supplies and counseling	$0	50%*
Screening for interpersonal and domestic violence	$0	50%*
Contraceptives and Counseling for FDA approved in office including injections, implants, and contraceptive devices not covered under pharmacy benefits	$0	50%*
Screening for Gestational Diabetes	$0	50%*
High-risk human papillomavirus (HPV) testing	$0	50%*
See:http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/guide-clinical-preventive-services.pdf		

Hospital Facility Services – **** - Subject to CYD***	In-Network	Out-of-Network
Acute care hospital admission	30%*	50%*
Outpatient observation	30%*	50%*
Skilled nursing facility (limited to 100 days per Calendar Year)	30%*	50%*
Rehabilitation facility (limited to 60 days per Calendar Year)	30%*	50%*
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services. Inpatient hospital services require Prior Authorization. *In emergencies in which a member is admitted to a hospital for an inpatient stay, in order to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so. You are subject to a 60% reduction in benefits if you do not obtain a required prior-authorization for the service even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network facility admissions as noted above.*		

Urgent Care and Emergency Services – **** - Subject to CYD***	In-Network	Out-of-Network
Urgent Care Center Services	30%*	50%*
Emergency Room Services	30%*	30%*
Ambulance (ground)	30%*	50%*
Ambulance (air and water)	30%*	50%*

Imaging and Diagnostic Testing – **** - Subject to CYD***	In-Network	Out-of-Network
Computer Tomography (CT) scan	30%*	50%*
Positron Emission Tomography (PET) scan	30%*	50%*
Magnetic Resonance Imaging (MRI)	30%*	50%*
All other imaging services	30%*	50%*
High-Technology imaging services require Prior Authorization, CT, CTA, MRI, MRA, PET for consideration to be paid at the in-network benefit level		
Laboratory Services – **** - Subject to CYD***	In-Network	Out-of-Network
General laboratory services unless covered under ACA preventive guidelines	30%*	50%*
Outpatient Therapy and Rehabilitation Services – **** - Subject to CYD***	In-Network	Out-of-Network
Speech therapy (Limited to 60 visits per Calendar Year all modalities combined.)	30%*	50%*
Occupational therapy (Limited to 60 visits per Calendar Year all modalities combined.)	30%*	50%*
Physical therapy (Limited to 60 visits per Calendar Year all modalities combined.)	30%*	50%*
Coverage for these therapies is provided with these limits for both habilitative and rehabilitative services as a limit of 60 visits per Calendar Year for each habilitative and rehabilitative services as per the medical necessity of these services.		
Wound therapy	30%*	50%*
Cardiac and pulmonary rehabilitation *(Limited to medically necessary services; 60 visits per Calendar Year all modalities combined.)*	30%*	50%*
Chemotherapy	30%*	50%*
Infusion therapy (including home infusion therapy)	30%*	50%*
Port Wine Stain Removal	30%*	50%*
Radiation therapy	30%*	50%*
Rehabilitation services require Prior Authorization.		
Surgical Services – **** -Subject to CYD***	In-Network	Out-of-Network
Performed in primary care physician's office	30%*	50%*
Performed in specialty care physician's office	30%*	50%*
Performed in outpatient facility	30%*	50%*
Performed in same-day-surgery facility	30%*	50%*

Bariatric Surgery Limited to one Medically necessary gastric restrictive surgery per lifetime	30%*	50%*
Surgical services require Prior Authorization for both in-network and out-of network services. You are subject to a 60% reduction in benefits if you do not obtain a required prior-authorization for the service even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network facility surgical services as noted above.		
Medical Supplies, equipment and prosthetics **** - Subject to CYD***	In-Network	Out-of-Network
Durable medical equipment. One purchase of specific item of DME, including repair and replacement every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria	30%*	50%*
Hearing Aids One hearing aid per ear per year; Single purchase; repair and replacement, every 3 years	30%*	50%*
Orthopedic and prosthetic devices Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years	30%*	50%*
Ostomy supplies (Limited to 30 days worth of therapeutic supplies per month)	30%*	50%*
Special Food Products limited to a maximum benefit of four (4) thirty (30) days of therapeutic supplies per Member per Calendar Year.	30%*	50%*
All medical supplies, including oxygen and oxygen-related equipment, require Prior Authorization. Certain supply orders are limited to a 30-day supply.		
Alcohol and Substance-Abuse Treatment – **** - Subject to CYD***	In-Network	Out-of-Network
Inpatient treatment	30%*	50%*
Outpatient treatment – specialist	30%*	50%*
Withdrawal treatment – inpatient	30%*	50%*
Withdrawal treatment – outpatient	30%*	50%*
Inpatient alcohol and substance- abuse treatment require Prior Authorization. Benefits for inpatient and outpatient withdrawal treatment are combined when determining the annual benefit limit.		
Medical Pharmacy and Immunizations– **** - Subject to CYD***	In-Network	Out-of-Network
Special pharmaceuticals	30%*	50%*
Covered immunizations	$0	50%*
All other medical pharmacy	30%*	50%*
Some medications, injection and infusion drugs require Prior Authorization.		
Mental Health – **** - Subject to CYD***	In-Network	Out-of-Network

Inpatient medically necessary services for mental health disorders	30%*	50%*
Outpatient and office visits – Mental health *(authorization is required for more than 12 visits per Calendar Year)*	30%*	50%*
Applied Behavioral Therapy for the treatment of Autism *Therapy visits limited to five hundred fifteen (515) total hours of therapy per member per Calendar Year.*	30%*	50%*
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. You will be subject to a 60% reduction in benefits if you do not obtain a required prior-authorization for the services even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network facility mental health services as noted above.		
Other Medical Services – **** - Subject to CYD***	In-Network	Out-of-Network
Spinal manipulation and Chiropractic services *Limited to 20 visits per Calendar Year and 100 visits per lifetime*	30%*	50%*
Home health care *Home health care requires Prior Authorization for in-network benefits to be considered*. (30 visits per year). *These 30 visits per year may provide for private duty nursing in the home.*	30%*	30%*
Infertility Services Medically Necessary services to diagnose problems of infertility for a covered individual. *One diagnostic evaluation for infertility every year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the Evidence of Coverage (EOC)*	30%*	50%*
Temporomandibular Joint Services (TMJ) Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. *Limited to annual maximum of one surgery and a lifetime maximum of two surgeries. Full scope of TMJ benefit coverage is detailed in the EOC.*	30%*	50%*
Hospice 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.	30%*	50%*

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. c. Respite care providing nursing care for a maximum of 8 inpatient respite care days per Calendar Year and 37 hours per Calendar Year for outpatient respite care services. Inpatient respite care will be provided only when we determine that home respite care is not appropriate or practical. Medically necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits describe above.		
Pharmacy Benefits **** - Subject to CYD***	In-Network	Out-of-Network
Generic Drugs (subject to Deductible if noted)	$20	50%*
Preferred Brand Drugs (subject to Deductible if noted)	$40	50%*
Non-Preferred Brand Drugs (subject to Deductible if noted)	$80	50%*
Preventive Medication	$0	50%*
Special Pharmaceuticals *Special pharmaceuticals require Prior Authorization.* *Most special pharmaceuticals must be obtained through a specialty pharmacy designated by Hometown Health and are limited to a 30-day supply per fill*	30%*	50%*
Diabetic Supplies *The copayments or coinsurance for items used in connection with diabetic services are based on the classification of the items. Diabetic supplies are classified consistently with prescription drugs as being: formulary generic, formulary brand-name, formulary brand-name (with a formulary generic alternative), or non-formulary generic or brand-name.*	30%*	50%*

Includes insulin, insulin syringes with needles, glucose blood-testing strips, glucose urine-testing strips, ketone testing strips, lancets and lancet devices		
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

- 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 Diptheria, Pertussis, Varicella, Zoster. These may be administered or dispensed at the pharmacy, but are part of the preventive services covered in the benefits outlined under the Evidence of Coverage.
- Contraceptive products – Prescription contraceptive products for women are covered prescription drug products upon the participating physician's order only at a participating retail pharmacy:
    1. Oral contraceptives
    2. Diaphragms: One per 365 consecutive day period
    3. Injectable contraceptives: The prescription provider's copayment applies for each vial.
    4. Contraceptive patches
    5. Contraceptive ring
    6. Norplant and IUDs are covered when obtained from a participating physician.

  The participating physician will provide insertion and removal of the device. An office visit copayment or coinsurance may apply if services during that visit are for more than the contraceptive visit. There will be no

copayment or coinsurance for the contraceptive devices as noted above if dispensed or inserted by a participating physician.

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

Pediatric Vision	In-Network	Out-of-Network
Well Vision Exam: Complete eye exam covered in full*; once per calendar year*	$0	30%
Lenses *Once per calendar year* Single vision Lined bifocal Lined trifocal *Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full Polycarbonate, plastic, or glass covered in full. Scratch and UV resistant covered in full.*	$0	30% 30% 30%
Frame *From Pediatric Exchange Collection covered in full.*	$0	30%
Elective Contact Lenses In lieu of eyeglasses, elective contact lens services and materials are covered in full, with the following service limitations: Standard (one pair annually) = 1 lens/eye (2 lenses) Monthly (6 month supply) = 6 lenses/eye (12 lenses) Bi-weekly (3 months supply) =6 lenses/eye (12 lenses) Dailies (1 month supply) = 30 lenses/eye (60 lenses) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide	$0	30%

better visual correction.		
Pediatric Dental	In-Network	Out-Of-Network
Individual Pediatric Deductible *(applied to all services)*	$60	$120
Family Pediatric Deductible *(applied to all services)*	$120	$240
Individual Pediatric Maximum Out-of-Pocket *(applied to all services)*	$1,000	$2,000
Family Pediatric Maximum Out-of-Pocket *(applied to all services)*	$2,000	$4,000
	Covered	Frequency
Preventive Services Cleanings Fluoride Treatments (including fluoride varnishes) Sealants Space maintainers	 100% 100% 100% 100%	 2 x year 2 x year 1 x lifetime 2 units per 12 months, 4 units per lifetime
Diagnostic Services Dental examinations X-rays Bitewing Full Mouth Panoramic	 100% 100% 100% 100%	 2 x year 2 x year 1 x every 3 years
Fillings Silver amalgam Tooth colored composite	 50% 50%	 1 unit per 36 months per tooth for both
Crowns/Tooth caps Stainless steel crowns Metal (only) crowns Metal/porcelain crowns Porcelain (only) crowns	 50% 50% 50% 50%	 Once per lifetime per tooth for all covered crown types
Root Canals (endodontics) Root canals on baby teeth (pulpotomies) Root canals on permanent teeth	 50% 50%	 Once per 36 months
Gum (periodontal) therapy	50%	Four units per 60 months
Dentures Partial Dentures Complete Dentures Bridges	 50% 50% 50%	 Once per five years
Orthodontics Retainers(orthodontic) Braces	 50% With Prior Authorization	 2 per lifetime Must be medically necessary
Oral Surgery Simple extractions Surgical extractions	 50% 50%	

Care of abscesses Cleft palate treatment Cancer treatment Treatment of fractures Biopsies	50% 50% 50% 50% 50%	 Ltd to Medical necessity Covered under Phys svc Ltd to medical necessity Once per lifetime Ltd to medical necessity
Treatment of jaw joint problems (TMJ)	50%	Service May be provided by a medical doctor or a dentist. Limited to medical necessity.
Emergency room services provided by a dentist	50%	Emergency care involved those services necessary to control bleeding, relieve significant pain, and/or eliminate acute infection, and those procedures required to prevent pulpal death and or the imminent loss of teeth.
Inpatient Hospital Services	With Prior Authorization	Prior Authorization required, unless it is a medical emergency.
Anesthesia General anesthesia Intravenous conscious sedation Non-intravenous conscious sedation Analgesia (nitrous oxide)	50%	

Other Benefit Information –

Certain services require the member to receive authorization from Hometown Health prior to receiving the service. If Prior Authorization for these services is not received, the scheduled benefits for these services will be reduced by 50 percent. Refer to the Utilization Management Program, Certification and Prior Authorization sections, in the EOC for a more comprehensive list of services requiring Prior Authorization.

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

1. emergency services (as defined in the EOC):

- without requiring a Prior Authorization, even if the emergency services are provided out-of-network, without regard to whether the provider furnishing the emergency services is a participating provider;
- if the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from preferred providers;
- if the emergency services are provided out-of-network, by complying with the cost sharing requirements promulgated pursuant to the Affordable Care Act; and

- without regard to any other term or condition of the coverage, other than the exclusion of or coordination of benefits, an affiliation or waiting period permitted under applicable federal law, or applicable cost sharing; and

2. Preventive services described in the Public Health Service Act, Section 2713(a) (as amended by the Protection and Affordable Care Act) without any cost sharing requirements.

Coinsurance payments for services requiring Prior Authorization for which the member did not receive Prior Authorization will not be applied toward meeting the associated Out-of-Pocket coinsurance maximums. Only coinsurance payments for covered services apply toward the Out-of-Pocket coinsurance maximum.

Member payments for charges related to services provided by non-preferred providers above the usual and customary amount do not apply toward the annual Out-of-Pocket coinsurance maximum.

After the member has paid the annual Out-of-Pocket coinsurance maximum and any applicable deductibles, Hometown Health will pay 100 percent of the charges for covered services up to the usual and customary amount.

Only amounts paid for covered services by members apply toward meeting the deducible. Member payments applied toward meeting a deductible limit are not included in the calculation of the annual Out-of-Pocket coinsurance maximum. Neither deductibles nor copayments accrue toward the coinsurance Out-of-Pocket maximum.

Members may elect to seek services from non-preferred healthcare providers provided the member pays the additional deductible and coinsurance amounts and any additional charges over a usual and customary charge for the service provided. Members also may be required to obtain Prior Authorization before seeking services from non-preferred providers.

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:

a. Complications resulting from excluded cosmetic surgery;

b. Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function;

c. Cosmetic treatment or service related complications, insertion, removal or revision of breast implants (including complications) unless provided post mastectomy;

d. Treatment for the removal, ablation, injection, or destruction of varicose veins;

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

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

13. 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:

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

        ii. 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;

b. If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institutes of Health, the Food and Drug Administration, or Medicare;

c. When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration or any other state or federal regulatory agency, and such final approval has not been granted for that particular indication, condition, or disease;

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

e. When the written protocols used by a facility performing the procedure or treatment state that it is experimental.

Coverage for clinical trials may still be covered even if the procedure or treatment is otherwise experimental or investigational. Refer to the Clinical Trials section of 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 provided that pregnancy is a covered benefit under the benefit plan.
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 is 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.

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 aides 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 Hometown Health.
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.