Hometown Health Providers Insurance Company, Inc.
Summary of Benefits – 85266NV0030042
Benefit Plan: Sierra Nevada 2500 250 – 2015 IF PPO 40-70 D2500 250

Hometown Health

This Summary of Benefits describes your health insurance Policy provided by Hometown Health Providers Insurance Company, Inc. (Hometown Health), an insurance company licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members. This Policy is an open access Preferred Provider Organization (PPO) that provides access to a large network of Preferred Providers who have contracts with Hometown Health. These contracts allow the Member to receive services at the In-Network Benefit level. The Policy also allows Members to seek services from Non-Preferred Providers, generally at a reduced benefit level (higher cost to the Member).

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

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

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

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

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

Benefit Plan – The specific health insurance Policy outlined in this Summary of Benefits.

Calendar Year – The year beginning on January 1 and ending on December 31. All Deductibles and Out-of-Pocket Maximum accumulators are on a Calendar Year basis and reset on January 1 of each year.

Coinsurance – The percentage of covered charges that is due and payable by the Member to a Provider upon receipt of certain covered services. Coinsurance is presented in this Summary of Benefits as the payable by the Member as a percentage of the maximum allowable amount due 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. Coinsurance paid by the Member applies to the Out-of-Pocket Maximums.

Copayment – The specific dollar 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 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 paid by the Member apply to the Out-of-Pocket Maximums.

Deductible – The set amount that must be paid by a Member each Calendar Year before Hometown Health pays for certain covered services, other than preventive care. There may be separate Deductibles for pharmacy, medical or other 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 Summary Table.

A member must satisfy the individual Deductible each Calendar Year for all benefits annotated with an asterisk (*) in the Benefit Summary Table before Copayments and Coinsurance are payable, unless the family has met the family Deductible. A family Deductible is set at twice the individual Deductible. One individual family member cannot contribute more than 50% of the family Deductible amount.

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

a. Provided in accordance with generally accepted standards of medical practice (for purposes of this document, the phrase "generally accepted standards of medical practice" is defined as standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, endorsed through national Physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas with regard to a patient's condition);
b. Clinically appropriate with regard to type, frequency, extent, location, and duration;
c. Not primarily provided for the convenience of the patient, Physician or other Provider of health care;
d. Required to improve a specific health condition of a Member or to preserve his existing state of health;
e. The most clinically appropriate level of health care that may be safely provided to the insured;
f. Effective as proven by scientific evidence, in materially changing health outcomes;
g. Not experimental, investigational, or subject to an exclusion under this Policy;
h. Cost-effective compared to alternative interventions, including no intervention ("cost effective" is not construed to mean lowest cost); and

i. Obtained from a Physician and/or licensed, certified or registered Provider.

Non-Preferred (Out-of-Network) Providers – Health care providers with whom Hometown Health has not contracted to provide discounted covered healthcare services to its members. Generally, Hometown Health pays a lower benefit, or does not pay a benefit at all (see the Benefit Summary Table for details), for services provided by a Non-Preferred Provider, unless the services are rendered as part of an emergency room visit, or they have been previously approved by Hometown Health. *Because Hometown Health is not contracted with Non-Preferred Providers, the Non-Preferred Provider may balance bill you for the amount charged in excess of the Usual and Customary amount paid by Hometown Health. Additionally, Non-Preferred Providers may not follow appropriate Prior Authorization procedures which may result in you receiving services that are not covered, not medically necessary or are otherwise excluded from coverage under this plan.*

Out-of-Pocket Maximum – The maximum amount of Deductible, Copayments, and Coinsurance paid by the Member or Family for covered services in a Calendar Year. Premiums paid by the Member are not included in the Out-of-Pocket Maximum. Some plans have Out-of-Pocket Maximums that accumulate separately for medical, pharmacy and pediatric dental (if offered) benefits. In no instance will the Member pay more for covered services than the Combined Out-of-Pocket Maximum. If coverage is extended to qualified dependents and the family Out-of-Pocket maximum has been paid, no further payment is required for benefits to be paid on the member's behalf.

Different Out-of-Pocket Maximums apply to individuals and families. Different Out-of-Pocket Maximums apply to services received from In-Network Providers and Out-of-Network Providers. Payments made by Members toward Deductibles also count towards the Out-of-Pocket maximum for In-Network benefits. However, Deductibles for Out-of-Network benefits do not apply to Out-of-Pocket Maximum. When a member 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 (In-Network) 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 Hometown Health to provide Covered Services to Members. 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 Hometown Health issues a prior-authorization for an in-network service, Hometown Health will cover services by a non-Participating Provider at the non-preferred benefit level of the Policy, if a non-preferred benefit is available.

Prior Authorization – A determination made by Hometown Health of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. 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. You may find a full list of services that require Prior Authorization by visiting our website at www.hometownhealth.com. There may be Prior Authorization or pre-treatment requirements for pharmacy, dental, and vision benefits that are provided in this Benefit Plan. Refer to the EOC for more details. Prior Authorizations protect you from expenses that result from receiving

services that are not covered, not medically necessary or are otherwise excluded from coverage under this plan. *If a Prior Authorization is required and you do not obtain the required Prior Authorization, you will be subject to a 50% reduction in benefits, or the service may not be covered, even if the service is Medically Necessary.*

Usual and Customary – The lesser of:

a. A Provider's usual charge for furnishing a treatment, service, or supply;
b. The charge Hometown Health determines 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. Specific terms related to pharmacy benefits that may be used throughout this Summary of Benefits are defined as follows. For additional definitions and information, see the EOC that governs this Summary of Benefits and the Drug Formulary.

Ancillary Charge – An additional cost-sharing charge borne by the member and calculated as the difference between the contracted reimbursement rate for participating pharmacies for the medication dispensed and the generic-drug product equivalent

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.

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 Benefit 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.

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

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

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

For certain outpatient prescription drugs, a prescribing physician must contact Hometown Health or the PBM to request and obtain coverage for such drugs. Hometown Health or the PBM will respond to the physician by telephone or other telecommunication device once 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.

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

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

Benefit Summary Table

This Benefit Summary Table lists the Member's responsibility. This table may not include all charges. Items marked with an asterisk (*) are subject to the Calendar Year Deductible (CYD).

Benefit Category	In-Network	Out-of-Network
Calendar Year Deductibles and Out-of-Pocket Maximums		
Individual Overall Deductible	$2,750	$5,500
Family Overall Deductible	$5,500	$11,000
Individual Medical & Pharmacy Deductible *(if combined)*	N/A	N/A
Family Medical & Pharmacy Deductible *(if combined)*	N/A	N/A
Individual Medical Deductible	$2,500	$5,000
Family Medical Deductible	$5,000	$10,000
Individual Pharmacy Deductible	$250	$500
Family Pharmacy Deductible	$500	$1,000
Individual Combined Out-of-Pocket Maximum	$5,000	$10,000
Family Combined Out-of-Pocket Maximum	$10,000	$20,000
Out-of-Pocket Maximums are applied differently for In-Network and Out-of-Network benefit levels if an Out-of-Network option is offered in this Benefit Plan. For Deductibles and Out-of-Pocket Maximums for pediatric dental benefits (if offered), see the Pediatric Dental Benefit Summary Table.		
Physician Office Visits (* - subject to CYD)		
Primary care (PCP) *(No charge for the first 2 in-network PCP visits each Calendar Year)*	$40	50%*

Benefit Category	In-Network	Out-of-Network
Primary care - wellness visit ACA covered	$0	50%*
Obstetrics and gynecology for ACA services	$0	50%*
Specialist care	$60	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 Calendar Year is covered for members older than two or as frequently as mandated by ACA. PCP and specialist visits include telemedicine only available through select providers.		
Preventive Screenings (* - subject to CYD)		
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%*
Hospital Facility Services (* - subject to CYD)		
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. Maternity care is covered except as noted in the Infertility section of covered services in the Evidence of Coverage. *All inpatient hospital and facility admission services require Prior Authorization. If you do not obtain the required prior-authorization for the service, you will be subject to a 50% reduction in benefits, or the service may not be covered, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network inpatient hospital and facility admissions. In emergencies in which a member is admitted to a hospital for an inpatient stay, to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so.*		
Urgent Care and Emergency Services (* - subject to CYD)		
Urgent Care Center Services	30%*	50%*
Emergency Room Services *(if the benefit is a Copayment, it is waived if the member is admitted to the hospital)*	$500	$500
Ambulance (ground)	30%*	50%*

Benefit Category	In-Network	Out-of-Network
Ambulance (air and water)	30%*	50%*
Imaging and Diagnostic Testing (* - subject to CYD)		
Computer Tomography (CT) scan	$500	50%*
Positron Emission Tomography (PET) scan	$500	50%*
Magnetic Resonance Imaging (MRI/MRA)	$500	50%*
Nuclear Medicine	$500	50%*
Plain X-ray	30%*	50%*
Diagnostic mammography	30%*	50%*
All other imaging services	30%*	50%*
Services provided in a primary care physician office *(except CT, CTA, PET, MRI, MRA and Nuclear Medicine)*	$40	50%*
Services provided in a specialty care physician office *(except CT, CTA, PET, MRI, MRA and Nuclear Medicine)*	$60	50%*
High-Technology imaging services, including CT, CTA, MRI, MRA, PET and Nuclear Medicine require Prior Authorization for consideration to be paid at the in-network benefit level.		
Laboratory Services (* - subject to CYD)		
General laboratory services *(unless covered under ACA preventive guidelines)*	30%*	50%*
Outpatient Therapy and Rehabilitation Services (* - subject to CYD)		
Speech therapy *(See limits below)*	$40	50%*
Occupational therapy *(See limits below)*	$40	50%*
Physical therapy *(See limits below)*	$40	50%*
Coverage for Medically Necessary speech therapy, occupational therapy and physical therapy are limited to 60 visits for all three therapy types combined, separately for both habilitative and rehabilitative services, per Calendar Year. Visit maximums are for both In-Network and Out-of-Network visits combined, and for outpatient facility/provider visits combined.		
Wound therapy in an outpatient hospital setting	30%*	50%*
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 60 visits per Calendar Year all modalities combined.)*	30%*	50%*
Chemotherapy in an outpatient hospital setting	30%*	50%*
Infusion therapy (including home infusion therapy)	30%*	50%*
Port Wine Stain Removal	30%*	50%*
Radiation therapy outpatient hospital or in a physician's office	30%*	50%*
Rehabilitation services require Prior Authorization.		
Surgical Services (* - subject to CYD)		
Performed in primary care physician's office	30%*	50%*
Performed in specialty care physician's office	30%*	50%*

Benefit Category	In-Network	Out-of-Network
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%*
Diagnostic and/or therapeutic endoscopy	30%*	50%*
All surgical services require Prior Authorization. If you do not obtain the required prior-authorization for the service, you will be subject to a 50% reduction in benefits, or the service may not be covered, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network facility surgical services.		
Medical Supplies, Equipment and Prosthetics (* - subject to CYD)		
Durable Medical Equipment (DME) *(Limited to one purchase of specific item of DME, including repair and replacement every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of Durable Medical Equipment, orthopedic, or prosthetic devices in excess of $150 require prior authorization.)*	30%*	50%*
Hearing Aids *(Limited to one hearing aid per ear every 3 years; 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 sets of (30) days of therapeutic supplies 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)		
Inpatient treatment	30%*	50%*
Outpatient treatment – specialist	$40	50%*
Withdrawal treatment – inpatient	30%*	50%*
Withdrawal treatment – outpatient	$40	50%*
Inpatient and outpatient programs for alcohol and substance abuse treatment require Prior Authorization. Alcohol and substance abuse office visits that are not part of an alcohol or substance abuse program do not require Prior Authorization. This Benefit Plan provides all mental health and substance abuse benefits in accordance with the Mental Health Parity and Addiction Equity Act of 2008.		
Medical Pharmacy and Immunizations (* - subject to CYD)		
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)		

Benefit Category	In-Network	Out-of-Network
Inpatient Medically Necessary services for mental health disorders	30%*	50%*
Outpatient and office visits	$40	50%*
Applied Behavioral Therapy for the treatment of Autism *(Limited to 150 visits not to exceed 515 total hours of therapy per Calendar Year)*	$40	50%*
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. If you do not obtain the required prior-authorization for the service, you will be subject to a 50% reduction in benefits, or the service may not be covered, even if the service is Medically Necessary. This requirement applies to both in-network and out-of-network facility mental health services. Mental health office visits that are not part of a mental health treatment program do not require Prior Authorization. This Benefit Plan provides all mental health and substance abuse benefits in accordance with the Mental Health Parity and Addiction Equity Act of 2008.		
Other Medical Services (* - subject to CYD)		
Chiropractic and spinal manipulation services *(Limited to 20 office visits per Calendar Year and 100 office visits per lifetime)*	30%*	50%*
Alternative/Complementary Medicine - Services or supplies related to alternative or complementary medicine including, acupuncture, Holistic Medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and bio and neuro feedback *(Limited to $1,000 maximum benefit per Calendar Year)*	30%*	50%*
Home health care *(Limited to 30 visits per Calendar Year; May provide for private duty nursing in the home; Requires Prior Authorization for in-network benefits to be considered.)*	Specialist visit $60 copay per visit for office based services. 30% coinsurance subject to CYD depending on site of service.	50%*
Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. *(Limited to one diagnostic evaluation for infertility every Calendar Year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the Evidence of Coverage (EOC)*	Specialist visit $60 copay per visit for office based services. 30% coinsurance subject to CYD depending on site of service.	50%*

Benefit Category	In-Network	Out-of-Network
Temporomandibular Joint (TMJ) Disorder Services *(TMJ disorder and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. Limited to 1 surgery per Calendar Year and 2 surgeries in a lifetime. Full scope of TMJ benefit coverage is detailed in the EOC.)*	Specialist visit $60 copay per visit for office based services. 30% coinsurance subject to CYD depending on site of service.	50%*
Hospice Services are covered for Members with a life expectancy of 6 months or 185 days or less as certified by his or her Provider *(Limited to a lifetime benefit maximum of 185 days)*: a. Part-time intermittent home health care services totaling fewer than 8 hours per day and 35 or fewer hours per week. b. Outpatient counseling of the Member and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific Policy). Counseling must be provided by a psychiatrist, psychologist, or social worker. Members who are eligible for mental health benefits under their specific Policy should refer to the applicable description of such benefits to determine coverage. Medically Necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits describe above. 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.	Specialist visit $60 copay per visit for office based services. 30% coinsurance subject to CYD depending on site of service.	50%*
Pharmacy Benefits (* - subject to CYD)		
Generic Drugs	$20	N/A
Preferred Brand Drugs	$50*	N/A
Non-Preferred Brand Drugs *(Must be pay the designated Copayment and Coinsurance, not to exceed the drug cost)*	$50 and 50%	N/A
Preventive Medication *(See Other Pharmacy Benefits below)*	$0	N/A
Special Pharmaceuticals *(Special pharmaceuticals require Prior Authorization. Most special pharmaceuticals must be obtained through a specialty pharmacy designated by Hometown Health and are limited to a 30-day supply per fill)*	30%*	N/A
Diabetic Supplies - Preferred Brand *(See Other Pharmacy Benefits below)*	$50*	N/A
Diabetic Supplies - Non-Preferred Brand *(See Other Pharmacy Benefits below)*	$50 and 50%	N/A
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.		

Benefit Category	In-Network	Out-of-Network

1. Aspirin to prevent cardiovascular diseases (CVD): 45 years and older; quantity limit 1/day; generic only; OTC (requires a prescription).
2. Sodium fluoride products (not in combination): 5 years old and younger, whose primary water source is deficient in fluoride; tablet 0.5mg, chewable tablet 0.25mg-05mg, solution
3. Folic Acid for all women planning or capable of pregnancy: Age limit 55 years old or younger; (not in combination); 0.4mg and 0.8mg; quantity limit 1/day; OTC (requires a prescription)
4. Iron Supplements for asymptomatic children aged 6 to 12 months who are increased risk for iron deficiency anemia: Age limit 0-1 year; prescription or OTC (requires a prescription); iron suspension, ferrous sulfate elixir, syrup and solution
5. Tobacco Cessation – The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products: Limit of 2 cycles (12 weeks per cycle) per Calendar Year; OTC generics only; generic Zyban only; Rx or OTC (requires a prescription); Nicotrol Inhaler and Nasal Spray; Nicotine polacrilex gum or lozenge; Nicotine TD patch 24hr kits; Bupropion HCl SR tabs; Varenicline (Chantix) tablets
6. Immunizations: Vaccines: The following vaccines are covered if provided by a Certified Immunizing pharmacist: Influenza, Hepatitis A & B; Human Papillomavirus inactivated; Poliovirus; Rubella; Meningococcal, Pneumococcal; Rotavirus; Tetanus Diptheria, Pertussis, Varicella, Zoster. These may be administered or dispensed at the pharmacy, but are part of the preventive services covered in the benefits outlined under the Evidence of Coverage.

- Contraceptive products – Prescription contraceptive products for women are covered prescription drug products upon the participating physician's order only at a participating retail pharmacy:
  1. Oral contraceptives
  2. Diaphragms: One per 365 consecutive day period
  3. Injectable contraceptives: The prescription provider's Copayment applies for each vial.
  4. Contraceptive patches
  5. Contraceptive ring
  6. Norplant and IUDs are covered when obtained from a participating physician.

  The participating physician will provide insertion and removal of the device. An office visit Copayment or Coinsurance may apply if services during that visit are for more than the contraceptive visit. There will be no Copayment or Coinsurance for the contraceptive devices as noted above if dispensed or inserted by a participating physician.
- The dispensing of each type will require a separate prescription. Oral-contraceptive prescription quantities are limited to one 21-day cycle supply or one 28-day cycle supply per month. Formulary generic drugs and brand drugs that do not have a generic equivalent (single source brand) will have no Copayment for the member. Brand drugs that have a generic equivalent (multi-source brand) under a generic benefit will require the member to pay the difference between the brand drug and the generic, as is the case with other multi-source brands. Non-formulary drug co-pays will be applied to Non-Formulary contraceptive drugs.
- Diabetic supplies – Diabetic Supplies include insulin, insulin syringes with needles, glucose blood-testing strips,

Benefit Category	In-Network	Out-of-Network
glucose urine-testing strips, ketone testing strips, lancets and lancet devices. Diabetic supplies are covered if Medically Necessary upon prescription or upon physician's order only at a participating retail. The member must pay applicable Copayments or Coinsurance. Original and refill prescriptions are limited to a 90-day supply at a participating retail pharmacy unless otherwise limited by Hometown Health or the drug manufacturer. A 30-day filled prescription is required prior to a 90-day filled prescription. • Hormone replacement therapy – Hormone replacement therapy (HRT) prescription drugs are covered if approved by the FDA or required by state or federal law and lawfully prescribed or ordered by a physician when Medically Necessary. Certain HRT prescription drugs require prior authorization. • Orally Administered Chemotherapy – Orally Administered Chemotherapy will be paid at the Preferred Brand Drug rate. The cost to the Member for Orally Administered Chemotherapy will not to exceed $100 per prescription, except for HDHP/HSA eligible plans.		
Pediatric Vision		
Well Vision Exam *(Complete eye exam covered in full once per Calendar Year. One low vision exam is covered every 5 years)*	$0	50%*
Lenses *(Limited to once per Calendar Year. Single vision, lined bifocal, lined trifocal or lenticular lenses covered in full. Polycarbonate, plastic, or glass covered in full. Scratch and UV resistant covered in full.)*	$0	50%*
Frame *(From Pediatric Exchange Collection covered in full.)*	$0	50%*
Elective Contact Lenses and materials are covered in full, in lieu of eyeglasses, with the following service limitations: • Standard (one pair per Calendar Year) = 1 lens/eye (2 lenses) • Monthly (6 month supply) = 6 lenses/eye (12 lenses) • Bi-weekly (3 months supply) =6 lenses/eye (12 lenses) • Dailies (1 month supply) = 30 lenses/eye (60 lenses) Necessary contact lenses are covered in full for members who have specific conditions for which contact lenses provide better visual correction.	$0	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, or the service may not be covered. 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 ACA) without any cost sharing requirements.
3. Genetic disease testing services under the conditions provided in the EOC and as required pursuant to state and federal law.

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

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

Members may elect to seek services from non-preferred healthcare providers provided the member pays the additional Out-of-Network Deductible and Coinsurance amounts and any additional charges over 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.

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

- Costs for services in excess of the usual and customary amount for services received from Non-Preferred Provider;
- Services for which the member did not receive Prior Authorization when Prior Authorization is required;
- Costs for prescription drugs in excess of the usual and customary amount;
- Non-covered services;
- Non-covered prescription drugs;
- Denied claims; and
- Prescription drugs received from a nonparticipating pharmacy.

Medical and General Exclusions

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

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 practice or applicable law are excluded.
2. Complications resulting from procedures, services, medical treatments or medications that are not covered by this Benefit Plan.
3. Treatment for any Injury or Illness that arises out of or in the course of any employment for pay or profit is excluded.
4. Charges for care or services provided before the effective date or after the termination date of coverage are excluded.
5. 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.
6. 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.
7. 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.
8. 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.
9. Routine examinations primarily for insurance, immigration, travel, licensing, school sports, adoption purposes, employment, and other third-party physicals are excluded.
10. Expenses for medical or dental reports and or forms and insurance forms including presentation and preparation are excluded.
11. 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.
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 and 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, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery), and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as covered and described within this Summary of Benefits or EOC.
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 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.

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

The following services and benefits are excluded from pediatric vision coverage under this Benefit Plan.

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
5. Contact lens insurance policies or service agreements
6. Artistically painted or non-prescription lenses
7. Additional office visits for contact lens pathology
8. Contact lens modification, polishing or cleaning

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.