This Schedule of Benefits describes your health insurance Policy provided by Hometown Health Plan, Inc. (Hometown Health), a Health Maintenance Organization (HMO)licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its members.

Network. This Policy is an open access HMO health care plan that provides access to a large network of Providers, with the ability to see in-network Specialty Care Physicians without a referral. There is no coverage for services outside the HMO network unless the services are rendered as part of a covered Emergency room visit, or they have been previously approved by Hometown Health Plan to be paid at the HMO Benefit Level.

Geographic Service Area. This Policy is available only to employees of employers whose primary business location is located in Nevada. Additional eligibility requirements are detailed in the Hometown Health Large Group HMO Evidence of Coverage (EOC).

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

Additional Requirements. This Schedule of Benefits describes what Hometown Health covers and what you pay. 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 comprehensive list of benefits, definitions, requirements, restrictions, exclusions and limitations. In case of conflicts between the EOC and this Schedule of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents. It is important that you review this document and your EOC. Copies of EOCs, Schedules of Benefits, attachments, Preferred Provider lists and other associated documents are available online at www.hometownhealth.com. We will provide you with paper copies of these documents without charge upon your request to our customer services department.

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

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

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

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

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

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

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

The family Deductible is set at two to three times the individual Deductible. Once the family has reached the family Deductible, benefits are payable to all Members of the family regardless of whether the Member has met the individual Deductible. One individual family member cannot contribute more than the individual Deductible amount. This is called an Embedded Deductible.

In-Network – The receipt of covered services from a Participating Provider. *Except as otherwise approved by Hometown Health in advance, all non-Emergency services received from Providers who are not In-Network Providers will not be covered.*

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

Out-of-Network – The receipt of services or benefits from a Non-Preferred Provider resulting in the Member paying for the entire cost of the services. *Except as otherwise approved by Hometown Health in advance, all non-Emergency services received at Providers who are not In-Network Providers will not be covered.*

Out-of-Pocket Maximum– The most a Member will pay during a plan year for covered health benefits. Copayments, Coinsurance and Deductibles paid by Members count towards the Out-of-Pocket Maximum. The

Out-of-Pocket Maximum does not include premiums, cost-sharing for non-covered services and expenses associated with denied claims. When a Member seeks care from an Out-of- Network Provider, the difference between the Provider's bill and the Allowable Amount is the Member's responsibility and does not count towards the Out-of- Pocket Maximum.

Preferred or Participating (In-Network) Provider – A Provider who is directly or indirectly under contract with Hometown Health to provide Covered Services to Members.

Prior Authorization – Approval from Hometown Health that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by Hometown Health. Prior Authorizations protect you from expenses that result from receiving services that are not covered, not medically necessary or are otherwise excluded from coverage under this plan. All benefits listed in this Schedule of Benefits may be subject to Prior Authorization requirements and concurrent review depending upon the circumstances associated with the services. *If a Prior Authorization is required and you do not obtain the required Prior Authorization, the service may not be covered, even if the service is Medically Necessary.* You may find a full list of services that require prior authorization in the EOC or by visiting our website at www.hometownhealth.com.

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

Usual and Customary – The lesser of:

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

b. The amount Hometown Health determines to be the general rate paid to others who render or furnish such treatment, service, or supply to individuals who reside in the same geographic area and whose condition are comparable in nature and severity.

Benefit Summary Table. The following Benefit Summary Table lists the Member's responsibility. This table may not include all eligible benefits. Benefits for services not listed can be found in the EOC.

Benefit Summary Table	
Benefit Category	***Member Responsibility***
Plan Year Deductibles and Out-of-Pocket Maximums	
Individual Medical & Pharmacy Combined Deductible	$0
Family Medical & Pharmacy Combined Deductible	$0
Individual Annual Combined Medical and Pharmacy Out-of-Pocket Maximum	$6,600
Family Annual Combined Medical and Pharmacy Out-of-Pocket Maximum	$13,200
Physician Office Visits	
Primary Care Physician (PCP) Office Visits	$25
Primary care wellness visit *(All necessary wellness visits are covered for children less than two years of age. One wellness visit per Plan Year is covered for members older than two years or as frequently as mandated by the ACA.)*	$0
Obstetrics and gynecology ACA services	$0
Specialist Office Visit including covered maternity care	$45
No referral is required for these visits.	
Preventive Screenings	
Mammography screening	$0
Papanicolaou (Pap) test	$0
Prostate Specific Antigen (PSA) screen	$0
Colorectal screening	$0
Counseling for sexually transmitted infections (STI) HIV counseling and testing	$0
Breastfeeding support, supplies and counseling	$0
Screening for interpersonal and domestic violence	$0
Contraceptives and in office counseling for FDA approved injections, implants, and contraceptive devices not covered under pharmacy benefits	$0
Screening for Gestational Diabetes	$0
High-risk human papillomavirus (HPV) testing	$0
Hospital Facility Services	
Acute care hospital admission	$500
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	$500
Skilled nursing facility *(limited to 100 days per Plan Year)*	$500
Rehabilitation facility *(limited to 60 days per Plan Year)*	$500

Benefit Summary Table	
Benefit Category	***Member Responsibility***
All inpatient hospital and facility admission services require Prior Authorization. In Emergencies in which a Member is admitted to a hospital for an inpatient stay, to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so. *Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services. Maternity care is covered except as noted in the Infertility section of covered services in the Evidence of Coverage.*	
Urgent Care and Emergency Services	
Urgent Care Services	$50
Emergency Room Services	$300
Ambulance (ground)	$150
Ambulance (air and water)	$200
Imaging and Diagnostic Testing	
Computer Tomography (CT) scan *(requires Prior Authorization)*	$250
Positron Emission Tomography (PET) scan *(requires Prior Authorization)*	$350
Magnetic Resonance Imaging (MRI/MRA) *(requires Prior Authorization)*	$250
Nuclear Medicine *(requires Prior Authorization)*	$250
Diagnostic mammography	$45
All other imaging and diagnostic services	Depends upon site of service
Services provided in a primary care physician office	$25
Services provided in a specialty care physician office	$45
Services provided in a hospital outpatient setting	$75
Laboratory Services	
General laboratory services *(unless covered under ACA preventive guidelines)*	$0
Outpatient Therapy and Rehabilitation Services	
Speech therapy *(See limits below)*	$25
Occupational therapy *(See limits below)*	$25
Physical therapy *(See limits below)*	$25
Coverage for Medically Necessary speech therapy, occupational therapy and physical therapy is limited to 90 visits per Plan Year for all three therapy types combined as per the medical necessity of these services.	
Cardiac and pulmonary rehabilitation *(Limited to Medically Necessary services; 60 visits per Plan Year all modalities combined.)*	$75
Wound therapy in an outpatient hospital or outpatient facility setting *(For wound therapy in an office based setting, see the Physician Office Visit section of this Benefit Summary Table.)*	$75
Chemotherapy in an outpatient hospital, outpatient facility or physician's office	$75

Benefit Summary Table	
Benefit Category	***Member Responsibility***
Radiation therapy in an outpatient hospital, outpatient facility or physician's office	$75
Infusion therapy *(Includes home infusion therapy. Does not include the cost of special pharmaceuticals used in infusion therapy. For cost of the special pharmaceuticals, used in infusion therapy, see the special pharmaceuticals benefits in the Medical Pharmacy and Immunizations section or your Pharmacy Benefits.)*	$50
Port Wine Stain Removal	$50
Rehabilitation services require Prior Authorization.	
Surgical Services	
Performed in primary care physician's office	$25
Performed in specialty care physician's office	$45
Performed in outpatient facility	$350
Performed in same-day-surgery facility	$350
Bariatric Surgery *(Limited to one Medically Necessary gastric restrictive surgery per lifetime)*	$350
Diagnostic and/or therapeutic endoscopy	$150
All surgical services require Prior Authorization.	
Medical Supplies, Equipment and Prosthetics	
Durable Medical Equipment (DME) *(Limited to one purchase of specific item of DME, including repair and replacement every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME, orthopedic, or prosthetic devices in excess of $150 require Prior Authorization.)*	$0
Orthopedic and prosthetic devices *(Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years)*	$25
Ostomy supplies *(Limited to 30 days of therapeutic supplies per month)*	$25
Special Food Products *(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Plan Year.)*	$25
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	
Inpatient treatment	$500
Outpatient treatment – specialist	$25
Withdrawal treatment – inpatient	$500
Withdrawal treatment – outpatient	$25

Benefit Summary Table	
Benefit Category	***Member Responsibility***
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	
Special pharmaceuticals	30%
Covered immunizations	$0
All other medical pharmacy	$30
Some medications, injection and infusion drugs require Prior Authorization.	
Mental Health	
Inpatient Medically Necessary services for mental health disorders	$500
Mental health outpatient and office visits	$25
Applied Behavioral Therapy for the treatment of Autism *(Limited to 120 visits not to exceed 515 total hours of therapy per Plan Year.)*	$25
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization. Mental health office visits that are not part of a mental health treatment program do not require Prior Authorization. This Benefit Plan provides all mental health and substance abuse benefits in accordance with the Mental Health Parity and Addiction Equity Act of 2008.	
Other Medical Services	
Chiropractic and spinal manipulation services *(Limited to 20 office visits per Plan Year and 100 office visits per lifetime)*	$45
Alternative Care including acupuncture services *Limited to 20 visits per Plan Year and 100 visits per lifetime*	$45
Home health care *(Limited to 30 visits per Plan Year; May provide for private duty nursing in the home; Requires Prior Authorization for in-network benefits to be considered.)*	$25
Office Based Infertility Services- Medically Necessary services to diagnose problems of infertility for a covered individual. *(Limited to one diagnostic evaluation for infertility every Plan Year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the EOC. These limits and exclusions apply to both office based and non-office based infertility services. For cost sharing for infertility services that are not performed in the office, see the applicable section in this Benefit Summary Table)*	$45
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 one (1) surgery per Plan Year and two (2) surgeries in a lifetime.)* *Office based services* *All other services*	 $45 $350

Benefit Summary Table	
Benefit Category	***Member Responsibility***
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 Plan Year and 37 hours per Plan Year for outpatient respite care services. Inpatient respite care will be provided only when we determine that home respite care is not appropriate or practical. *Office based services* *All other services*	 $45 $0

Exclusions

This plan does not cover certain services. The following are examples of services and benefits which are excluded from coverage. Please refer to the EOC for additional limitations and exclusions associated with this plan.

1. Services which are not Medically Necessary or are not required in accordance with accepted standards of medical practice or applicable law are excluded.
2. Treatment for any Injury or Illness related to employment 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 reports, including presentation and preparation are excluded.
10. Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, laboratory and other diagnostic testing and other services including hospitalizations or Partial Hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless we determine that such services are independently Medically Necessary are excluded.
11. 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 the EOC for mastectomy benefits), treatment of male-pattern baldness, electrolysis, waxing or other methods of hair removal, or hair treatment, keloid scar therapy, any procedures utilizing an implant that cannot be expected to substantially alter physiologic functions are additionally not covered under this Policy; 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 the EOC).

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; and

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.

12. All experimental or investigational medical, surgical, or other health care procedures and all transplants are excluded except as otherwise described within the EOC. We will consider a procedure or treatment as experimental or investigational as follows:

    a. If outcome data from randomized controlled clinical trials, recommendations from consensus panels, national medical associations, or other technology evaluation bodies and from authoritative, peer-reviewed US medical or scientific literature 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.

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

13. 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.

14. Travel expenses, accommodations and travel insurance are not covered. Oxygen provided while traveling on an airline and are portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.

15. Any services received outside the United States are excluded unless deemed to be urgent or Emergency care.

16. The fitting and cost of hearing aids including both surgical implanted bone conduction hearing aids and externally worn hearing aids are excluded regardless of the etiology of the deafness.

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

18. Termination of pregnancy is excluded, other than medically indicated abortions necessary to save the life of the mother.

19. Charges for cognitive therapy are excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.

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 and when a Prior Authorization has been received from Hometown Health), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electro-sleep therapy, electro-narcosis, massage therapy, and gene therapy are excluded.

22. Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability are excluded.

23. Treatment of mental retardation, Down syndrome, or autism (unless covered and described within the EOC) that a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency is excluded.

24. Care or treatment of marital or family problems, occupational, religious, or other social maladjustments, behavior disorders, situational reactions, and hypnotherapy is excluded.

25. Prescription Drugs:
    Medically Necessary prescription drugs are only covered as set forth in the EOC or a separately purchased Pharmacy rider.
    Exclusions for prescription drugs under the EOC include, but are not limited to:
    a. Over-the-counter drugs, whether or not prescribed by a Physician; these are limited to those preventive medications per ACA that are available if a Pharmacy Rider is purchased
    b. Medicines and other substances not requiring a prescription even if ordered by a Physician;
    c. Drugs consumed in a Physician's office other than immunizations, allergy serum, and chemotherapy drugs;
    d. Self-injectable drugs are not covered except as otherwise covered and described within the EOC; and
    e. Prescription drugs purchased from outside of the United States except Canadian pharmacies licensed by the Nevada State Board of Pharmacy. (Licensed Canadian pharmacies are listed on the Nevada State Board of Pharmacy Web site at www.bop.nv.gov.)

26. 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 or covered in a separately purchased Pharmacy rider.

27. 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.

28. Natural and herbal remedies that may be purchased without a prescription (over the counter), through a web site, at a Physician or chiropractor's office, or at a retail location are excluded, unless otherwise specified in the description of Alternative Medicine benefits.

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

30. 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.)

31. 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 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.

32. Cryopreservation or storage charges for collection and storage of biologic materials for any purpose are excluded, including with respect to artificial reproduction.

33. Stress reduction therapy or cognitive behavior therapy for sleep disorders is excluded.

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

35. Barrier-free and other home modifications are excluded.

36. Services provided by personal trainers or gym or health club memberships, exercise programs, or exercise physiologists are excluded (even if recommended by a Professional or physician to treat a medical condition).
37. Religious or spiritual counseling is excluded.
38. 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.

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.