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 for PEBP's *Standard* Plan. This Policy is an open access HMO 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 an Emergency room visit, an Urgent Care Center visit received Out-of-Area, or they have been previously approved by Hometown Health to be paid at the HMO Benefit Level.

Geographic Service Area for PEBP's *Standard* Plan. This Policy is available only to PEBP participants who live in the following fourteen northern Nevada counties: Carson City, Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Pershing, Storey, Washoe and White Pine. Additional eligibility requirements are detailed in this EOC and PEBP's Master Plan Document for Enrollment and Eligibility.

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 EOC 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 the 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.

Nondiscrimination. Hometown Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Benefit Plan provides all mental health and substance abuse benefits in accordance with the Mental Health Parity and Addiction Equity Act of 2008.

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 Out-of-Pocket Maximums.

Covered Service – A benefit for services and supplies that we provide or arrange under this Policy and:

- Is Medically Necessary or otherwise specifically listed as a benefit in the Schedule of Benefits or EOC;
- Is rendered by a licensed, certified or registered Provider within the state of the place of service and within the scope of the license of the Provider performing the service;
- For which we provide a Prior Authorization, if Prior Authorization is required; or
- Is not experimental or investigational or otherwise limited or excluded by the EOC.

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

The family Deductible is set at two 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 for Emergency room visits, Urgent Care Center visits received Out-of-Area, or as otherwise approved by Hometown Health in advance, all services received from Providers who are not In-Network Providers will not be covered.*

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, that are:

- 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);

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

A determination that a service is Medically Necessary is not an authorization to receive that service from a Non-Preferred Provider.

Non-Preferred or Non-Participating (Out-of-Network) Provider – A Provider 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, an Urgent Care Center visit received Out-of-Area, 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-Area –Outside of Nevada and outside the area in surrounding states that is within 50 miles of the Nevada border.

Out-of-Network – The receipt of services from a Non-Participating Provider resulting in the Member paying for the entire cost of the services. For Emergency or Out-of-Area Urgent Care Center services received from a Non-Participating Provider, the Member will pay the standard Member cost sharing for that service plus any amount billed by the Non-Participating Provider that is greater than the Allowable Amount.

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.

In no instance will the Member pay more for Covered Services than the Individual In-Network Combined Out-of-Pocket Maximum as provided in the Benefit Summary Table. If coverage is extended to qualified dependents and the family Out-of-Pocket Maximum has been paid, no further payment is required for benefits to be paid on the Member's behalf.

If a member receives a Prior Authorization to receive care from an Out-of-Network Provider, the difference between the Provider's bill and Allowable Amount as determine by Hometown Health, does not count towards

the Out-of-Pocket Maximum. When a Prior Authorization is required but not received, the amount the benefit is reduced is the responsibility of the Member and does not count towards the Out-of-Pocket Maximum.

Preferred or Participating (In-Network) Provider – A Provider who is listed in our current provider directory and 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. We use utilization management and quality assurance protocols to ensure the service being requested is Medically Necessary and covered. 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 and your EOC 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 a state to render home health services, or any other licensed health care institution or health care professional.

Usual and Customary – The lesser of:

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

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

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

Ancillary Charge – An additional cost-sharing charge borne by the Member and calculated as the difference between the contracted reimbursement rate for participating pharmacies for the medication dispensed and the generic-drug product equivalent. Ancillary Charges do not apply toward your Deductible or Out-of-Pocket Maximum. The contracted reimbursement rate for participating pharmacies does not include amounts that Hometown Health may receive under rebate programs offered by pharmaceutical manufacturers.

Brand-Name Prescription Drug or Brand Drug – A prescription drug, including insulin, typically protected under patent by the drug's original manufacturer or developer with a proprietary trademarked name

Diabetic Services – Products for the management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment, supplies and appliances for the treatment of diabetes.

Drug Formulary – A comprehensive list of Brand Drugs and Generic Drugs, approved by the U.S. Food and Drug Administration (FDA), covered under this Benefit Plan. The medications covered under this formulary may be substantially different from other Hometown Health drug formularies

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

Generic Prescription Drug or Generic Drug – A prescription drug, whether identified by its chemical, proprietary or nonproprietary name, that is accepted by the FDA as therapeutically equivalent and

interchangeable with a drug having an identical amount of the same active ingredient(s) in the same proportions, that have the same information printed on the label and that perform in the same manner as the trademarked, brand-name version of the drug.

Injectable Drug – A prescription drug dispensed from a pharmacy (including combination therapy kits) that are injected directly into the body by the Member or the Member's Provider.

Maximum Allowed Amount – The lowest available cost to Hometown Health for a Generic Drug, a prescription drug product or a Brand Drug without a generic drug equivalent available at the time a prescription is filled.

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

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

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

Participating Mail Order Pharmacy – A pharmacy with which Hometown Health has contracted to provide Prescription Drugs, including insulin, to its Members by mail.

Participating Retail Pharmacy – A pharmacy with which Hometown Health has contracted to provide discounted Prescription Drugs to its Members.

Preferred Drug – A Prescription Drug that is usually covered at a lower cost to the Member than a non-Preferred Drug.

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.

Specialty 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.

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 Combined Medical and Pharmacy Out-of-Pocket Maximum	$7,150
Family Combined Medical and Pharmacy Out-of-Pocket Maximum	$14,300
In no case will a member pay more for Covered Services than the Combined Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not include Premiums, cost-sharing for non-covered services, expenses associated with denied claims, Ancillary Charges and amounts that Non-Participating Providers bill and are payable that are greater than the Allowed Amount.	
Physician Office Visits	
Primary Care Physician (PCP) Office Visits	$25
Primary care ACA 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
Prenatal and postnatal office visits	$0
Specialist Office Visit including covered maternity care	$45
No referral is required for these visits. Imaging, surgery and other services provided in an office setting may have a higher copayment or coinsurance.	
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
Inpatient delivery, postpartum care and newborn care services	$500
Outpatient observation *(generally a hospitalization lasting 4 to 48 hours that does not meet inpatient utilization criteria)*	$500

Benefit Summary Table	
Benefit Category	***Member Responsibility***
Skilled nursing facility *(limited to 100 days per Plan Year)*	$500
Rehabilitation facility *(limited to 60 days per Plan Year)*	$500
All Hospital Facility 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	
Virtual Visits for Urgent Care Services *(provided by Renown)*	$0
Urgent Care Services *(includes Out-of-Area Out-of-Network Urgent Care Center Services; Out-of-Network Providers my charge for amounts greater than the Allowed Amount; Out-of-Network Urgent Care is not covered in Nevada)*	$50
Emergency Room Services *(copayment is waived if admitted; Out-of-Network Providers may charge for amounts greater than the Allowed Amount)*	$300
Ambulance (ground)	$150
Ambulance (air and water)	$200
Specialty Imaging and Diagnostic Testing	
Computer Tomography (CT) scan	$250
Positron Emission Tomography (PET) scan	$350
Magnetic Resonance Imaging (MRI/MRA)	$250
Nuclear Medicine	$250
Angiograms and Myelograms	$250
All Other (Non-Specialty) Imaging and Diagnostic Testing (including X-rays and ultrasounds)	
Services provided in a primary care physician office *(except Specialty Imaging and Diagnostic Testing)*	$25
Services provided in a specialty care physician office *(except Specialty Imaging and Diagnostic Testing)*	$45
Services provided in a hospital outpatient setting *(except Specialty Imaging and Diagnostic Testing)*	$75
Diagnostic mammography	$45
Laboratory Services	
General laboratory services *(unless covered under ACA preventive guidelines)*	$0
Outpatient Speech, Occupational and Physical Therapy	
Speech therapy *(See limits below)*	$25
Occupational therapy *(See limits below)*	$25

Benefit Summary Table	
Benefit Category	***Member Responsibility***
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.	
Other Outpatient Therapy and Rehabilitation 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
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 as appropriate.)*	$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 or hospital *(if admitted, see the acute care hospital admission cost sharing)*	$350
Performed in same-day-surgery facility or ambulatory surgery center (ASC)	$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, repair or replacement of a specific item of DME every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria. The purchase or rental of DME, including oxygen and oxygen related equipment, in excess of $100 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. Orthopedic and prosthetic devices in excess of $100 require Prior Authorization)*	$25

Benefit Summary Table	
Benefit Category	***Member Responsibility***
Ostomy supplies *(Limited to 30 days of therapeutic supplies per month. Prior Authorization required.)*	$25
Special Food Products *(Limited to a maximum benefit of four (4) sets of thirty (30) days of therapeutic supplies per Plan Year. Prior Authorization required.)*	$25
Alcohol and Substance-Abuse Treatment	
Inpatient treatment	$500
Outpatient treatment – specialist	$25
Withdrawal treatment – inpatient	$500
Withdrawal treatment – outpatient	$25
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.	
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 600 hours (approximately 130 visits) of therapy for habilitation and 600 hours (approximately 130 visits) of therapy for rehabilitation 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.	
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; Prior Authorization required.)*	$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

Benefit Summary Table	
Benefit Category	***Member Responsibility***
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 (excluding surgical services)	$45
All other services (including surgical services)	$350
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 or respite 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. Inpatient hospice care providing nursing care for a maximum of 8 inpatient days per Plan Year. Inpatient respite care will be authorized only when we determine that home respite care is not appropriate or practical.	
Office based services	$45
All other services	$0
Medical Pharmacy and Immunizations *(Received in a Physician's Office or Facility)*	
Special pharmaceuticals	40%
Covered immunizations	$0
All other medical pharmacy	$40
Some medications, injection and infusion drugs require Prior Authorization.	
Formulary Drugs *(Received from a Pharmacy)*	
Tier 1 (T1) – Generic Drugs	$7 copay / 30 day supply
Tier 2 (T2) – Preferred Brand Drugs	$40 copay / 30 day supply
Tier 2 (T2) – Preferred Brand Oncological Drugs *(Preferred Brand Oncological Drugs require Prior Authorization and must be purchased at a designated Pharmacy)*	$40 copay / 30 day supply
Tier 2 (T2) – Preferred Brand Drugs with a Formulary Generic Drug alternative	$40 copay / 30 day supply plus the Ancillary Charge
Tier 3 (T3) – Non-Preferred Brand or Generic Drugs	$75 copay / 30 day supply

Benefit Summary Table	
Benefit Category	***Member Responsibility***
Tier 4 (T4) – Specialty Pharmaceutical Drugs *(Specialty Pharmaceuticals require Prior Authorization. Most Specialty Pharmaceuticals must be obtained through a specialty Pharmacy designated by Hometown Health and are limited to a 30-day supply per fill.)*	40%
Tier 5 (T5) – Preventive Drugs *(prescribed in accordance with the U.S. Preventive Task Force Recommendations A & B; excludes select Brand Drug formulations with an available Generic Drug alternative)*	$0
Non-Formulary Drugs	
Generic and Brand Drugs that are considered medically necessary.	$75 copay / 30 day supply plus the Ancillary Charge
Excluded Generic and Brand Drugs	Not Covered
Additional Details	
Diabetic Supplies – Cost sharing for diabetic supplies is based on the tier (Generic, Brand, etc.). Includes insulin, insulin syringes with needles, glucose blood-testing strips, lancets and lancet devices. Orally Administered Chemotherapy – Cost sharing for orally administered chemotherapy will not exceed $100 per 30 day supply except for Members on a High Deductible Health Plan and for Members who select a Non-Formulary drug with a Formulary alternative. Mail Order – A Copayment for a 90 day supply of a Prescription Drug filled through a Participating Mail Order Pharmacy is two times the Copayment of a 30-day supply. See your EOC for additional details.	

Exclusions

The remainder of this Schedule of Benefits lists the general medical and pharmacy benefit exclusions of this Policy. Benefits listed as excluded will not be covered by Hometown Health unless they are explicitly listed as covered elsewhere in the EOC or are otherwise explicitly covered through a separately purchased benefit rider. Any amount you pay toward services that are not covered or otherwise excluded will not count toward your Deductible and Out-of-Pocket Maximum. Additional exclusions that apply to only a particular service or benefit are listed in the description of that service or benefit in this Schedule of Benefits and the EOC. For a complete listing and narrative of exclusions and limitations, please refer to the EOC.

Medical and General Exclusions

The following services and benefits are excluded from medical coverage under this Benefit Plan. They may be covered under the pharmacy benefits that may be included in this Benefit Plan if explicitly indicated that the benefit is covered.

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. Complications resulting from procedures, services, medical treatments or medications that are not covered by this Benefit Plan are excluded.
3. Treatment for any Injury or Illness related to employment is excluded.
4. Charges for care or services provided before the effective date or after the termination of coverage are excluded.
5. Charges for copies, presentation and preparation of your records, charts or x-rays, completion of insurance forms, creation of medical or dental reports and costs to forward or mail such copies, forms, reports, records, charts or x-rays are excluded.
6. Any loss, expenses, or charges resulting from the Member's participation in a riot or Criminal Act are excluded.
7. Any loss related to an act of war, insurrection, or terrorism are excluded.
8. Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation, work-hardening programs, job related training requirements and employment training and counseling, including services rendered by or billed by a school or member of its staff are excluded.
9. Services related to job, vocational retraining, or community re-entry are excluded.
10. Care for military service-connected disabilities and conditions for which you are legally eligible to receive from governmental agencies and for which facilities are reasonably accessible to you are excluded.
11. Care for conditions that federal, state, or local law requires be treated in a public facility, care provided under federally or state funded health care programs (except the Medicaid program), care required by a public entity and care for which there would not normally be a charge are excluded.
12. Routine examinations, care or treatment primarily for insurance, immigration, travel, licensing, school sports, adoption and employment purposes and other third-party physicals are excluded.

13. Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, 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.
14. Termination of pregnancy is excluded, other than medically indicated abortions necessary to save the life of the mother.
15. Any services received outside the United States are excluded unless deemed to be urgent or Emergency care.
16. Any Urgent Care services that are received Out-of-Network are excluded unless the Urgent Care service is received Out-of-Area.
17. Travel expenses, accommodations and travel insurance are not covered. Oxygen provided while traveling on an airline and portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements are excluded.
18. Costs related to room and board for family members are excluded.
19. Costs related to room and board for the member are excluded except if the cost is charged by the hospital as part of a medically necessary inpatient hospital admission and the expenses are incurred between the time of admission and the time of discharge.
20. 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.
21. Cosmetic surgery or procedures are excluded. Cosmetic surgery generally includes any plastic or reconstructive surgery or procedure done to improve the appearance of any portion of the body or restore bodily form without materially correcting a bodily malfunction.

    Excluded cosmetic surgery or procedures include:

    a. Surgery or treatment to remove sagging or extra skin; any augmentation or reduction procedures; electrolysis; liposuction; liposculpting; body contouring or recontouring to remove excess skin on any part of the body including but not limited to: tummy tucks, belt lipectomies, breast reductions, enhancements or lifts are excluded;

    b. Laser treatments, rhinoplasty and associated surgery, epikeratophakia surgery, kerato-refractive eye surgery including but not limited to implants for correction of presbyopia, correction of facial or breast asymmetry (except that breast asymmetry will be provided pursuant to coverage as provided in the EOC for mastectomy benefits), treatment of male-pattern baldness, electrolysis, waxing or other methods of hair removal, or hair treatment, keloid scar therapy, any procedures utilizing an implant that cannot be expected to substantially alter physiologic functions are excluded ;

    c. Treatment or service related complications, insertion, removal or revision of breast implants unless provided post mastectomy are excluded;

    d. Implants that do not improve physical function are excluded;

e. Cosmetic surgery to treat or prevent mental health or psychological conditions or consequences or socially avoidant behavior are excluded;

f. 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 are excluded.

g. Complications resulting from excluded cosmetic surgery are excluded; and

h. Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function are excluded.

22. Cosmetics are excluded.
23. Treatment for the removal, ablation, injection, or destruction of varicose veins is excluded.
24. Charges that result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by us and present significant symptomatic medical problems) or any treatment of obesity, unless otherwise provided in the EOC are excluded.
25. 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) are excluded.
26. 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 EOC or the applicable Schedule of Benefits.
27. Aroma therapy, massage therapy, reiki therapy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), colonic irrigation, magnetic innervation therapy and electromagnetic therapy are excluded.
28. Charges related to the acquisition or use of marijuana are excluded, even if used for medicinal purposes.
29. Except as otherwise provided in the EOC, drugs, medicines, procedures, services, and supplies to correct or enhance erectile function, enhance sensitivity or for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment are excluded.
30. Any off-labeled use of growth hormone is excluded.
31. Coverage for human growth hormone or equivalent is excluded unless specifically covered and described within the EOC.
32. Cryopreservation or storage charges for collection and storage of biologic materials, including umbilical cord blood, for artificial reproduction or any other purpose are excluded.
33. Platelet rich plasma and stem cell related musculoskeletal injections are excluded.

34. 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:
        i. Is insufficient to show that the procedure or treatment is safe, effective, or superior to existing therapy; or
        ii. Does not conclusively demonstrate that the service or therapy improves the net health outcomes for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even in the event that the service, drug, biological, or treatment may be recognized as a treatment or service for another condition, screening, or Illness;
    b. If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institutes of Health, the Food and Drug Administration, or Medicare;
    c. When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration or any other state or federal regulatory agency, and such final approval has not been granted for that particular indication, condition, or disease;
    d. When a nationally recognized medical society states in writing that the procedure or treatment is experimental; or
    e. When the written protocols used by a facility performing the procedure or treatment state that it is experimental.

    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.
35. 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.
36. 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.
37. Charges for the fitting and cost of visual aids, vision therapy, eye therapy, orthoptics with eye exercise therapies, refractive errors including but not limited to eye exams and surgery done in treating myopia (except for corneal graft); ophthalmological services provided in connection with the testing of visual acuity for the fitting for eyeglasses or contact lenses, eyeglasses or contact lenses (except coverage for the first pair of eyeglasses or contact lenses following cataract surgery); and surgical correction of near or far vision inefficiencies such as laser and radial keratotomy are excluded, except as otherwise specified in the EOC and your Schedule of Benefits.

38. Orthotic braces that straighten or change the shape of a body part are excluded.
39. Cranial helmets are excluded except for cranial helmets used to facilitate a successful post-surgical outcome.
40. Orthopedic shoes, foot orthotics or other supportive devices of the feet are excluded, except when such devices are:
    a. An integral part of a covered leg brace and its expense is included as part of the cost of the brace:
    b. For diabetes mellitus and for foot deformity, history of pre-ulcerative calluses, history of previous ulceration, peripheral neuropathy with evidence of callus formation, poor circulation or previous amputation of the foot or part of the foot:
    c. For rehabilitation prescribed as part of post-surgical or post-traumatic casting care; or
    d. Prosthetic shoes for members with a partial foot.
41. 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.
42. 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.
43. Barrier-free and other home modifications are excluded.
44. 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.
45. Care or treatment of marital or family problems, occupational, religious, or other social maladjustments, behavior disorders, situational reactions, and hypnotherapy is excluded.
46. Religious or spiritual counseling is excluded.
47. Stress reduction therapy or cognitive behavior therapy for sleep disorders is excluded.
48. 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.
49. 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.
50. Therapies, psychological services, counseling, or tutoring services for developmental delay or learning disability are excluded.
51. 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.
52. Services designed to treat infertility conditions:

    Medically Necessary services to diagnose problems of infertility are covered for one workup per year up to three (3) evaluations per lifetime. Up to six (6) cycles of artificial insemination are covered per

lifetime for covered members. For the covered female, services include the preparation of the sperm and the insemination, provided that the sperm has not been purchased or the donor compensated for his biological material or services, and that the donor is covered under a Hometown Health individual or small group plan. Costs related to the actual insemination of a non-covered person, are not covered under the terms of this benefit plan. The following services are not covered:

a. All other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in- vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit are excluded. This exclusion 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 are excluded;

c. Any services related to a Member serving in the capacity of a surrogate mother, including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the Member's ability to become pregnant or to carry a pregnancy to term, or maternity services are excluded; 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 is excluded.

53. Medically Necessary prescription drugs are only covered as set forth in the EOC. The following prescription drugs are excluded from the medical benefit under the EOC, but may be included under the prescription drug benefit if explicitly indicated that the prescription drug is covered:

a. Birth control drugs, devices, and implants that are not approved by the Food and Drug Administration are excluded;

b. Over-the-counter drugs, whether or not prescribed by a Physician are excluded; these are limited to those preventive medications that are available if a Pharmacy Rider is purchased;

c. Medicines and other substances not requiring a prescription even if ordered by a Physician are excluded;

d. Drugs consumed in a Physician's office other than immunizations, allergy serum, and chemotherapy drugs are excluded;

e. Self-injectable drugs are not covered except as otherwise covered and described within the EOC; and

f. Prescription drugs purchased from outside of the United States except Canadian pharmacies licensed by the Nevada State Board of Pharmacy are excluded. (Licensed Canadian pharmacies are listed on the Nevada State Board of Pharmacy Web site at www.bop.nv.gov.)

Pharmacy Benefit Exclusions

The following services and benefits are excluded from pharmacy coverage under this Benefit Plan. These services may be covered under the medical or other benefits included in this Benefit Plan if explicitly indicated that the benefit is covered.

1. Drugs not Medically Necessary or not required in accordance with accepted standards of medical practice or applicable law are excluded.
2. Drugs to treat complications resulting from procedures, services, medical treatments or medications that are not covered by this Benefit Plan are excluded.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by Hometown Health are excluded.
4. Any refill in excess of the amount specified by the prescription order is excluded. Before recognizing charges, Hometown Health may require a new prescription or evidence as to need if a prescription or refill appears excessive under accepted medical practice standards.
5. Compounded medications except for compounded medications for palliative care with Prior Authorization are excluded.
6. Cosmetics or any drugs used for cosmetic purposes or to promote hair growth even for documented medical conditions, including but not limited to health and beauty aids are excluded.
7. Dietary or nutritional products or appetite suppressants or other weight-loss medications (such as appetite suppressants, including the treatment of obesity) whether prescription or over-the-counter are excluded.
8. Vitamins are excluded except those prescribed prenatal vitamins and vitamins with fluoride that require a prescription and are listed on the Drug Formulary.
9. Drugs dispensed by other than a Participating Retail Pharmacy are excluded except as Medically Necessary for treatment of an Emergency or Urgent Care condition.
10. Drugs listed on the Formulary Exclusions List, designated as Non-Formulary, or not included on the Formulary are excluded.
11. Drugs prescribed by a provider not acting within the scope of his or her license are excluded.
12. Drugs listed by the FDA as "less than effective" (DESI drugs) are excluded.
13. Experimental and investigational drugs, including drugs labeled "Caution-limited by Federal Law to Investigation use" are excluded.
14. Drugs either not approved by the FDA as "safe and effective" as of the date this Benefit Plan was issued or, if so approved, that the FDA has not approved for either inpatient or outpatient use are excluded.
15. Drugs prescribed for a use, condition or diagnosis that was not included in the FDA's approval of the drug (off label prescribed drugs) are excluded.

16. Fertility drugs, drugs for gene therapy, nicotine patches and gum, oxygen, laxatives unless otherwise provided herein or pursuant to the EOC and nutritional additives or any prescription medication or formulation with nutritional or vitamin additives are excluded
17. Growth hormone drugs for persons 18 years or older are excluded. Growth hormone therapy for the treatment of documented growth hormone deficiency in children for whom epiphyseal closure has not occurred is covered when a Prior Authorization is received and are supplied by Hometown Health's preferred vendor for the medication.
18. Immunization or immunological agents, including but not limited to biological sera, blood, blood plasma or other blood products administered on an outpatient basis, antihemophilic factors, including tissue plasminogen activator (TPA), allergy sera and testing materials, unless otherwise provided herein or pursuant to the EOC are excluded.
19. Medical supplies, devices and equipment and nonmedical supplies or substances are excluded regardless of their intended use.
20. Medications approved by the FDA for less than six months are excluded unless the Hometown Health Pharmacy and Therapeutics Committee, at its sole discretion, decides to waive this exclusion with respect to a particular drug.
21. Medications for impotence or erectile dysfunction are excluded.
22. Medication consumed or administered at the place where it is dispensed or while a member is in a hospital or similar facility are excluded. Take-home prescriptions dispensed from a hospital pharmacy upon discharge are excluded unless the pharmacy is a Participating Retail Pharmacy.
23. Over-the-counter drugs, medicines and other substances for which a prescription order is not required regardless of whether the drug was prescribed by a physician, or for which an over-the-counter product equivalent in strength is available are excluded, unless the drug is required to be covered by law.
24. Drugs consumed in a physician's office are excluded except as otherwise provided herein or in the EOC.
25. Performance, athletic performance or lifestyle enhancement drugs and supplies are excluded.
26. Prescription drugs purchased from outside of the United States are excluded except from Canadian pharmacies licensed by the Nevada State Board of Pharmacy. A list of licensed Canadian pharmacies can be found on the Nevada State Board of Pharmacy website: www.bop.nv.gov.
27. Prescription medications that are available without charge under local, state or federal programs, including worker's compensation or occupational disease laws, or medication for which a charge is not made are excluded.
28. Prescription refills dispensed more than one year from the date the latest prescription order was written or as otherwise permitted by applicable law of the jurisdiction in which the drug was dispensed are excluded.
29. Prophylactic drugs and immunizations for travel are excluded.
30. Quantities in excess of a 30-day supply received at retail pharmacies or a 90-day supply received at mail order facilities are excluded. Prescriptions requiring quantities in excess of the above amount, including early refills of ophthalmic products due to inadvertent wastage, shall be completed on a refill basis with

a valid prescription and authorization, except as otherwise provided in the Drug Formulary or through the mail order or online prescription drug program.

31. Replacement of lost, stolen, spoiled, expired, spilled or otherwise mishandled medication is excluded.
32. Prescription orders filled before the effective date or after the termination date of the coverage provided by this Benefit Plan are excluded.
33. Test agents and devices, excluding diabetic test agents are excluded.

Additional Pharmacy Limitations –

1. A Participating Retail Pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.
2. Non-Emergency and non- Urgent Care prescriptions will be covered only when filled at a Participating Retail Pharmacy.
3. Members are required to present their ID cards at the time the prescription is filled. A member who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from Hometown Health, and the member will be responsible for the entire cost of the prescription.
4. If a Member does not use this Policy (does not use their insurance card) to purchase a prescription drug and then requests reimbursement for the purchase of the prescription drug in a non-Emergency, non-Urgent Care situation, Hometown Health will only reimburse the Member the amount that Hometown Health would have paid if the prescription drug were purchased using the Policy. Because Hometown Health has access to contract discounts, the amount that Hometown Health pays could be considerably less than the amount the Member can get without using this Policy, resulting in a much higher cost to the Member compared to if the Member used this Policy to purchase the drug.
5. Hometown Health retains the right to review all requests for reimbursement and, at its sole discretion make reimbursement determinations subject to the grievance procedure section of the certificate.
6. Hometown Health is not responsible for the cost of any prescription drug for which the actual charge to the member is less than the required Copayment or payment that applies to the prescription drug Deductible amount or for any drug for which no charge is made to the recipient.
7. The contracted reimbursement rate for participating pharmacies does not include amounts that Hometown Health may receive under a rebate programs offered at the sole discretion of individual pharmaceutical manufacturers.

Limitations

If the provision of Covered Services provided under this Policy is delayed or rendered impractical due to circumstances not within our control, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Provider's personnel, or similar causes, we will make a good faith effort to arrange for an alternative method of providing coverage. In such event, we and our Providers will render the Covered Services provided under this Policy insofar as practical and according to their best judgment; but we and our Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

For more information go to

www.HometownHealth.com