

Hometown Health Plan, Inc.

State of Nevada  
HMO

*Hometown  
Health* 



[www.hometownhealth.com](http://www.hometownhealth.com)



HOMETOWN HEALTH PLAN  
HEALTH MAINTENANCE ORGANIZATION (HMO)

AMENDMENT TO THE EVIDENCE OF COVERAGE  
(EOC) for  
STATE OF NEVADA

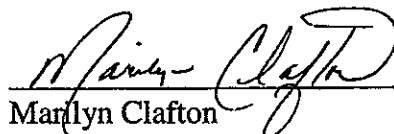
Effective July 1, 2008, the Evidence of Coverage (EOC) for Hometown Health's HMO is hereby amended in the following manner:

- I. Page 34, Part 7A, Section 2 c – Eligible Family Dependents is changed to read:

Grandchildren can be eligible for coverage ONLY when under documented legal guardianship.

- II. Page 34, Part 7A, Section 2 d – Eligible Family Dependents is changed to read:

Any unmarried child as defined in subsection (b), above, who is **between 19 and twenty – four (24)** years of age provided the child is able to provide documentation acceptable to Hometown Health Plan that he or she is a full-time student in an accredited educational institution, i.e., a preparatory school or an educational institution which is eligible for payment of benefits under the Veterans Administration program, but excluding church-related preparatory programs.

  
Marilyn Clifton  
Underwriter

## **Hometown Health Plan Amendment to the 2005 HMO Evidence of Coverage**

Below, "Part 4, Utilization Management Program, A. Scope of the Program" page 30, of the 2005 Evidence of Coverage (EOC) has been amended to reflect the following changes:

An "Open Access" HMO allows a plan member to self-refer to select specialists contracted with Hometown Health Plan without first obtaining a referral from a primary care provider. The "Open Access" HMO gives you the ability to see select contracted specialists when you like without seeing your Primary Care Physician (PCP) first. A specialist is a doctor whose practice is limited to a specific branch of medicine, such as a Cardiologist. When you need to see a select specialist, all you need to do is call the specialist directly to make an appointment.

.....

### **PART 4                      UTILIZATION MANAGEMENT PROGRAM**

The Managed Care/Utilization Management program evaluates and determines the appropriateness of medical care resources utilized by our members. The focus of the program is based on providing our members with access to quality care and monitoring the appropriate utilization of services at the most cost-effective level.

<b>A. SCOPE OF THE PROGRAM</b>
--------------------------------

The Utilization Management program applies to healthcare services utilized by eligible members. Covered services are subject to this Utilization Management program including, the following which require prior authorization:

- All inpatient services in any facility type, including acute and skilled care, mental health care, drug or alcohol detoxification, or rehabilitation.
- Surgical services performed while an inpatient, same day surgery or outpatient office
- Home health care
- Durable Medical Equipment (DME), prosthetic and orthopedic devices over \$100
- Transplant services, including the evaluation process
- Medications specified by Hometown Health Plan as Special Pharmaceuticals
- Botox injections

Please note:

- Upon confirmation of pregnancy, Hometown Health Plan must be notified.
- Non-covered services remain non-covered even if the service is given in the provider's office.
- Services that still require PCP referral and Hometown Health authorization include:
  - All out-of-area services
  - Any non-contracted provider or service
  - Plastic surgery services
  - Gastric bypass or lap banding services
  - Anesthesiology and Physiatry services including pain management
  - Genetic counseling and testing
  - Second-opinion services

It is the obligation of the member to comply and cooperate with the Managed Care/Utilization Management program. Prior authorization by Hometown Health Plan does not guarantee that all charges are covered under the policy. Charges submitted for payment are subject to all of the terms of the policy.

## **HOMETOWN HEALTH PLAN, INC. EVIDENCE OF COVERAGE – HMO**

Hometown Health Plan, Inc. (Hometown Health) is 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.

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

Copies of EOC's, Summary of Benefits, Attachments, Riders and other associated documents are available online at [www.hometownhealth.com](http://www.hometownhealth.com) in the Member's section under "View My Benefits." Paper copies of these documents can be provided to the subscriber upon request by contacting:

Hometown Health  
Attn: Customer Service  
830 Harvard Way  
Reno, Nevada 89502

Email: [Customer\\_Service@hometownhealth.com](mailto:Customer_Service@hometownhealth.com)

Phone Numbers:

- Main: 775-982-3232
- Toll Free: 800-336-0123
- Fax: 775-982-3741 (direct to the attention of Customer Services Department)
- TTY/TDD: 775-982-3240 (impaired hearing)
- Español: 775-982-3242

**HOMETOWN HEALTH PLAN, INC.**

**TABLE OF CONTENTS**

- PART 1 DEFINITIONS.....1
- PART 2 NOTICE OF PRIVACY PRACTICES.....13
  - A. Hometown Health’s Pledge to Protect Medical Information.....13
  - B. Information About Our Members .....13
  - C. How We Protect Your Medical Information .....13
  - D. How We May Use and Disclose Medical Information About You .....14
  - E. Special Situations.....15
  - F. Medical Information of Former Members of Hometown Health .....16
  - G. Your Rights Regarding Medical Information About You .....17
  - H. Changes to This Notice.....19
  - I. Complaints .....19
  - J. Other Uses of Medical Information .....19
- PART 3 SCHEDULE OF BENEFITS .....20
  - A. Professional Services .....20
  - B. Hospital, Skilled Nursing and Services in an Outpatient Surgical Center.....31
  - C. Emergency Services.....32
  - D. Urgent Care Services .....33
- PART 4 EXCLUSIONS AND LIMITATIONS .....34
  - A. Exclusions .....34
  - B. Limitations .....41
- PART 5 UTILIZATION MANAGEMENT PROGRAM.....42
  - A. Scope of the Program.....42
  - B. Authorization and Prior-Authorization Process.....43
  - C. Concurrent Review and Case Management.....43
  - D. Retrospective Review .....44
  - E. Expedited Appeal Process.....44
- PART 6 DELIVERY OF AND RESTRICTIONS TO SERVICES AND BENEFITS.....45
- PART 7 RELATIONSHIP OF PARTIES.....46
  - A. Independent Contractors .....46
  - B. Provider Relationship with Patient .....46

**HOMETOWN HEALTH PLAN, INC.**

PART 8 BLANK.....47

PART 9 ELIGIBILITY AND ENROLLMENT .....48

    A. Eligibility .....48

    B. Enrollment.....50

PART 10 TERMINATION OF COVERAGE.....53

    A. Equality .....53

    B. Termination for Cause .....53

    C. Cancellation .....53

    D. Refunds .....54

PART 11 INDIVIDUAL CONVERSION PRIVILEGE AND TRANSFER .....55

    A. Who May Obtain Conversion Coverage.....55

    B. Who May Not Obtain Conversion Coverage.....55

    C. Overinsurance .....55

PART 12 CONTINUATION OF COVERAGE .....57

    A. Federal Continuation of Coverage.....57

    B. Nevada Continuation of Coverage.....61

    C. Employer Approved Leave of Absence.....63

    D. Total Disability Under Nevada State Law .....64

PART 13 DOUBLE COVERAGE.....65

    A. Workers' Compensation.....65

    B. Medicare .....65

PART 14 SUBROGATION / RIGHT TO REIMBURSEMENT .....66

PART 15 COORDINATION OF BENEFITS .....68

    A. The Purpose of COB .....68

    B. Benefits Subject to COB.....68

    C. Definitions.....68

    D. When COB Applies .....69

    E. Determination Rules .....69

    F. How COB Works.....70

    G. Right to Receive and Release Information .....70

    H. Right to Recover Payment .....70

PART 16 MEDICARE COORDINATION OF BENEFITS .....71

    A. Definitions.....71

# HOMETOWN HEALTH PLAN, INC.

	B. Effect on Benefits .....	71
	C. Rules for Determining Order of Benefits.....	71
	D. Beginning of Coordination Periods .....	72
	E. End of Coordination Periods.....	72
PART 17	MEMBER APPEAL PROCEDURE .....	74
	A. Definitions.....	74
	B. Procedures.....	74
PART 18	GENERAL PROVISIONS .....	78
	A. Assignment .....	78
	B. Authorization to Examine Medical Records.....	78
	C. Balance Billing.....	78
	D. Cancellation .....	78
	E. Charge for Service or Purchase.....	78
	F. Clerical Error .....	78
	G. Entire EOC.....	78
	H. Form or Content of EOC.....	79
	I. Gender.....	79
	J. Membership Card.....	79
	K. Interpretation of EOC .....	79
	L. Modifications .....	79
	M. Notice.....	79
	N. Notice of Claim.....	79
	O. Policies and Procedures .....	80
	P. Return of Overpayment.....	80
	Q. Claims Procedures .....	80

# HOMETOWN HEALTH PLAN, INC.

## PART 1 DEFINITIONS

---

**Acupuncture** – piercing of peripheral nerves with needles to relieve the discomfort of painful disorders or for therapy

**Acute** – a short illness or injury, generally of a sudden onset and/or infrequent occurrence, in which illness or injury is not always present

Acute conditions may become chronic.

**Adverse Benefit Determination** (a.k.a. adverse determination) – a determination of a managed care organization to deny all or part of a service or procedure that is proposed or being provided to an insured on the basis that it is not medically necessary or appropriate or is experimental or investigational

The term does not include a determination of a managed care organization that such an allocation is not a covered benefit. Receipt of an adverse benefit determination entitles the member or the member's Authorized Representative to appeal the determination (see member appeal procedures).

**Alcoholism/Substance Treatment Center** – the detoxification or rehabilitation facility licensed by the state to treat alcoholism/substance abuse

**Alternative Medicine** – therapeutic procedures and approaches to medical diagnosis and therapy that are currently not considered parts of conventional medical practice

These generally include, but are not limited to: acupressure, acupuncture, aromatherapy, herbal medicine, vitamin or supplement therapies, homeopathic medicine, holistic medicine, and other non-traditional therapies or managements for illnesses, diseases, or conditions.

**Appeal** – the formal process a member can use to request review of a plan decision that typically involve benefits or service issues

**Authorization** – the approval of services or medications through the use of the Utilization Management and Quality Assurance protocols

Authorization does not guarantee payment. Payment is dependent upon eligibility at the time covered services are received.

**Authorized Representative** – a person designated by the member to act on his or her behalf in pursuing a claim for benefits or an appeal of an adverse benefit determination

The designation must be in writing unless the claim or appeal involves an urgent care claim and a health care professional with knowledge of the member's medical condition is seeking to act on the member's behalf as his or her authorized representative.

For the purpose of submitting a request for an external review for a final adverse determination, an Authorized Representative means a person who has obtained the consent of an insured to represent him in an external review of a final adverse determination conducted pursuant to NRS 695G.241 to 695G.310, inclusive.

## **HOMETOWN HEALTH PLAN, INC.**

**Benefit Period** – the period (the group’s effective date through December 31 of that year) during which covered services are incurred for which benefits may be paid

A benefit period for a member ends on the earliest of:

- a. The last day of the calendar year in which it was established
- b. The day that coverage under this policy ends
- c. The day that the maximum benefits are paid

**Blood Services for Surgery** – blood and supplies provided during a surgical procedure that requires blood replacement

**Calendar Month** – any one of the twelve months of the calendar

**Calendar Year** – a period of time beginning January 1 and concluding December 31 of the same year

**Centers for Medicare & Medicaid Services (CMS)** – the federal agency that administers Medicare

**Chelation Therapy** – the treatment and removal of lead poisoning or other heavy metal poisoning from the body

**Chemotherapy** – drug therapy to treat cancers and other diseases and conditions

**Chronic** – an illness, condition, or injury that continues or is expected to continue for at least six months that can recur frequently or is always present

Chronic conditions may have acute episodes.

**Chronic Pain** – ongoing pain that lasts more than six months that is due to non-life threatening causes may continue for the remainder of the member’s life and that has not responded to currently available treatment methods

**Claim for Benefits** – a request for a plan benefit or benefits made by a member or on behalf of a member, including any preservice claims (requests for prior authorization or pre-determination) and any post-service claims

**Clinical Trials** – the process for testing of new types of medical care that are in the final stages of research to find better ways to prevent, diagnose or treat diseases

**Cognitive Therapy** – treatment to improve a member’s thinking processes and intellectual capabilities

**Coinsurance** – the percentage of covered charges that is due and payable by the member to a provider upon receipt of certain covered services

Coinsurance applies after all deductibles have been paid, unless otherwise stated within the Summary of Benefits or EOC.

**Coordination of Benefits (COB)** – a process by which another group health plan or Medicare (if the member is enrolled on both Hometown Health and another group plan or Medicare) may be responsible for claims payment either as the primary or secondary carrier

## **HOMETOWN HEALTH PLAN, INC.**

**Copayment** – the specific amount payable by the member to a provider of care at the time of service for certain covered services

**Cosmetic or Reconstructive Surgery** – any plastic or reconstructive surgery, or medical procedures 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.

**Covered Services** – benefits for services and supplies that Hometown Health must provide or arrange for a member that are:

- a. Medically necessary or otherwise specifically listed as a benefit in the Summary of Benefits or EOC
- b. Rendered by a licensed provider within the state of the place of service and within the scope of the license of the provider performing the service
- c. Prior authorized by Hometown Health if preauthorization is required per this document
- d. Not experimental or investigational or otherwise limited or excluded by this EOC, or by amendment or rider to this EOC

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

**Custodial Care** – health services or other related services (such as assistance in activities of daily living) that either:

- a. Do not seek a cure
- b. Are provided during periods when acute care is not required or when the medical condition of a member is not improving
- c. Do not require continued administration by licensed medical personnel, or
- d. Assist in the activities of daily living

**Deductibles** – the set amount that must be paid by a member before Hometown Health pays for covered services, before benefits are payable by the plan where the benefit plan includes a deductible

**Denied Preauthorization** – a preauthorization request that was submitted to Hometown Health and has not been approved

## **HOMETOWN HEALTH PLAN, INC.**

### **Developmental Care** – services or supplies which:

- a. Are provided to a member who has not previously reached the level of intellectual, speech, motor or physical development normally expected for the member’s age, and such conditions were not a result of an injury or illness
- b. Are primarily provided to assist in the development of those skills referred to in item “a” above, and
- c. Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness)

### **Domiciliary Care** – services or supplies which:

- a. Primarily provide a protective environment and assistance with basic personal needs for the member
- b. Are primarily provided because the member's own home arrangements are not appropriate, and
- c. Are not part of an active treatment plan intended to or reasonably expected to improve the member’s condition of functional ability

### **Durable Medical Equipment (DME)** – medical equipment which:

- a. Can withstand repeated use
- b. Is not disposable
- c. Is prescribed by a Primary Care Physician or Specialist
- d. Is appropriate for use in the home, and
- e. Is not useful in the absence of an illness or injury

**Elect Facilities** – healthcare facilities within the Hometown Health network that provide services on favorable financial terms to Hometown Health for its members

**Elect Providers** – providers within the Hometown Health network who provide services on favorable financial terms to Hometown Health for our members

**Eligible Employee** – a permanent employee who has a regular work week of 30 or more hours

The term includes a sole proprietor or a partner of a partnership if the sole proprietor or partner is included as an eligible employee under a health benefit plan of a small employer, unless otherwise specified in the group application.

## **HOMETOWN HEALTH PLAN, INC.**

**Emergency** – healthcare services that are provided to an insured by a recognized provider of health care after the sudden onset of a medical condition with symptoms of such severity that a prudent person would believe that the absence of immediate medical attention could result in:

- a. Serious jeopardy to the health of the insured member
- b. Serious jeopardy to the health of an unborn child
- c. Serious impairment of a bodily function, or
- d. Serious dysfunction of any bodily organ or part

**Emergent Hospital Admission** – an admission for hospital confinement that results from a sudden and unexpected onset of a condition that requires medical or surgical care

In the absence of such care, the member could reasonably be expected to suffer serious bodily injury or death. Examples include but are not limited to heart attacks, severe chest pain, burns, loss of consciousness, serious breathing difficulties, spinal injuries and other acute conditions as Hometown Health shall determine as emergencies.

**Employer** – the company or organization that actively employs workers

The employer group is shown on the face page of the Group Subscription Agreement.

**Exclusion** – an item or service that is not a covered benefit as described within this EOC

Refer to the Exclusions and Limitations section.

**Expedited Appeal** – the process a member or the member’s authorized representative can use to request a review of a plan decision, faster than a formal appeal, that typically involve benefits or service issues

If a member appeals a decision regarding a denied authorization (before service) and the member or his or her doctor believes that the health of the member could be seriously harmed by waiting too long for a decision, the member or member's authorized representative can request an expedited appeal. Decisions regarding expedited appeals generally are made within 72 hours. This could be referred to as an “urgent care claim.”

**Expense** – the cost incurred for a covered service or supply

Expense is considered incurred on the date that the service or supply is received.

Expense does not include any charge:

- a. For a service that is not medically necessary.
- b. That is more than the maximum allowed amount for a service or supply.
- c. That is not covered under this EOC.

## **HOMETOWN HEALTH PLAN, INC.**

**Experimental or Investigational Procedures and Items** – experimental medical, surgical or other procedures or treatments, including prescription medications

A procedure or treatment will be considered experimental or investigational at the discretion of Hometown Health:

- 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, 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 the Medicare program
- c. When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply can not be legally marketed in the United States without the final approval of the FDA 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
- e. When the written protocols used by a facility performing the procedure or treatment state that it is experimental

Coverage for clinical trials may still be covered. Refer to the Clinical Trials section of this EOC.

**Family Dependents** – members of the subscriber's family who meet the eligibility requirements of this EOC and who have been enrolled by the subscriber

Refer to the Eligibility and Enrollment portion of this EOC.

**Food and Drug Administration (FDA) Approval** – the FDA acceptance of the specific treatment for a specific condition

**Gastric Restrictive Services** – surgical interventions to accomplish weight loss in individuals who are obese or morbidly obese

**Genetic Counseling** – the process of explaining medical and scientific information about an inherited condition, birth defect or other genome related effects to an individual or family

Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk and review testing options, where available.

## **HOMETOWN HEALTH PLAN, INC.**

**Grace Period** – the time from the first day that a member’s premium becomes due and ends when 30 days have passed

The plan coverage remains in force during the grace period.

**Grievance Committee** – a committee of three or more persons, the majority of which must be members of Hometown Health, chaired by the Chief Executive Officer for Hometown Health (or equivalent position) or his or her designee, and comprised of such other persons as the chairperson deems appropriate

**Group** – an employer or other party that has entered into a Group Subscription Agreement with Hometown Health under which Hometown Health will arrange and administer health services for eligible members of the group who enroll

**Group Open Enrollment Period** – the periods established by the group and Hometown Health pursuant to the Group Subscription Agreement during which eligible persons may submit an application for enrollment with Hometown Health

**Group Subscription Agreement (GSA)** – the agreement between Hometown Health and the Group under which Hometown Health provides health benefit coverage for subscribers and their eligible family dependents

The GSA includes provisions outlining the group’s eligibility provisions where the group has the ability to determine certain eligibility provisions not contradictory to eligibility provisions described within the group’s policy.

**Home Health Agency** – an organization licensed by the state to render home health services

**Home Health Care** – skilled nursing, therapies, and other health related services provided in the home environment for other than convenience for patient or patient’s family, personal assistance or maintenance of activities of daily living or housekeeping

**Hospital** – a legally operated facility defined as an acute care or tertiary hospital that is licensed by the state and may be approved by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission or JCAHO), the American Osteopathic Association (AOA) or by the Medicare program

**Hospital Services** – acute care and tertiary services furnished and billed by a hospital

**Illness or Injury** – a disorder or disease of the body or mind or an accidental bodily wound

All illnesses due to the same cause or to a related cause are considered one illness.

**Inherited Metabolic Disease** – a disease caused by an inherited abnormality of a person’s body chemistry

**Infertility Services** – medical services to diagnose the condition of a person who is unable to conceive or produce conception

**Late Enrollee** – an eligible subscriber or dependent who does not enroll within the open enrollment period of the group or who waives coverage at time of eligibility

**Lipomas** – localized collections of fatty tissue that are benign

## **HOMETOWN HEALTH PLAN, INC.**

**Medical Assessment Form (MAF)** – a questionnaire used by Hometown Health to better understand the medical conditions related to a group’s employees and dependents seeking coverage under a Hometown Health policy

If a MAF is required to be completed as part of the enrollment process, all questions asked within the MAF must be answered and all medical conditions related to the questions asked within the MAF must be fully described using the employee’s or dependent’s best abilities.

**Medical Director** – a physician licensed by the State of Nevada and designated by Hometown Health to monitor and review the utilization and quality of health services provided to members

**Medical Group** – any organization or association of physicians that has contracted with Hometown Health to provide or arrange for services to members

Hometown Health does not guarantee the continued availability of any particular provider or provider group.

**Medical Pharmacy** – drugs, pharmaceuticals, immunizations, or biologics whose distribution, administration or supply of pharmaceuticals is generally in a healthcare facility, physician’s office, and not in a retail pharmacy setting

**Medically Necessary or Medical Necessity** – 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 necessary and:

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

**Medicare** – Title XVIII of the Social Security Act of 1935, as amended

**Member** – a subscriber and eligible dependents covered under a group policy

**Ostomy Care Services** – care and supplies provided to the member after colon, ileum or bladder surgery to carry on normal activities with minimal inconvenience

**Out-of-Area Services** – services provided outside the Hometown Health’s service area

## **HOMETOWN HEALTH PLAN, INC.**

**Out-of-Pocket Maximum** – the maximum payment amount for which the member or family is responsible for copayments or coinsurance in a plan year for certain covered services

Deductibles, unless otherwise stated, do not typically count towards the out-of-pocket maximum. Refer to the Summary of Benefits and other provisions within this EOC for additional information.

**Outpatient Observation** – the continuous evaluation and monitoring of a medical condition in a facility, generally limited to a maximum of 48 hours

**Partial Hospitalization** – the continuous treatment for at least four hours but not more than 12 hours in any period of 24 consecutive hours

Partial hospitalization services can be performed in a hospital or treatment center.

**Participating Provider** – a physician, medical group, hospital, skilled nursing facility, home health agency or any other licensed institution or health professional who is listed in the current Hometown Health Directory and who is under contract with Hometown Health to provide covered services to members

A current Hometown Health Directory can be found on the Hometown Health Web site at [www.hometownhealth.com](http://www.hometownhealth.com) under the Provider Directory link or can be requested by contacting Hometown Health's Customer Service department.

A participating provider's agreement with Hometown Health or the association of a particular health care professional with a participating provider may terminate, and a member will be required to use another participating provider. Not all physicians, medical groups, hospitals, skilled nursing facilities, home health agencies, or other licensed institutions or health professionals who have contracts with Hometown Health are participating providers. Hometown Health does not guarantee the continued availability of any particular participating provider. Participating providers cannot determine whether a service is a covered benefit under this policy or on behalf of Hometown Health.

Participating providers are also referred to as preferred providers, while non-participating providers are referred to as non-preferred providers.

**Physical Therapy** – the treatment to improve the physical capabilities of a member in an attempt to restore the member's previous level of good health or the level of health before an acute incident that required the therapy

**Physician** – a licensed doctor of medicine, osteopathy, dentistry or podiatry

**Plan Year** – a period of time beginning on the first effective date of the plan and ending 12 months later. Plan years that begin on July 1 end on June 30 of the following calendar year.

**Policy** – the Group Subscription Agreement (GSA), this Evidence of Coverage (EOC), the plan specific Summary of Benefits, Riders or Amendments

**Preexisting Condition** – a medical condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of the new coverage, excluding genetic information without a related diagnosis

## **HOMETOWN HEALTH PLAN, INC.**

**Preferred Provider** – a participating provider

**Preferred Provider Organization (PPO)** is a managed care organization which contracts with specific providers to deliver healthcare services at negotiated rates.

**Premium** – a periodic payment, typically monthly, paid to Hometown Health for this insurance policy

Refer to the premium payment requirements outlined within the group's policy.

**Prescription Drug** – a drug, medicine, or supply that bears the legend in its packaging:

"CAUTION - FEDERAL (U.S.A.) LAW PROHIBITS DISPENSING WITHOUT A PRESCRIPTION."

**Primary Care Physician (PCP)** – a physician charged with arranging and coordinating all aspects of a member's health care

Some plans may require that the member select a PCP to manage his or her healthcare needs. PCPs are family practitioners, general practitioners, internists and pediatricians.

**Prior Authorization** – a determination of medical necessity and benefit coverage using Utilization Management and Quality Assurance protocols prior to the services being rendered

All benefits listed in this EOC may be subject to prior authorization requirements depending upon the circumstances associated with the services.

**Protected Health Information (PHI)** – any personal health information that someone could identify as belonging to a specific person

This information could appear on applications, forms or surveys. PHI may include specific information such the member's name, address, date of birth, Social Security number, gender, marital status and information on your dependents. PHI includes the member's medical information as reflected in records of medical history, past medical claims and payments, and information from consumer or medical reporting agencies and medical providers or third parties.

Hometown Health is required by law to protect this information for all of our members. The law prevents Hometown Health from communicating this information to any family member, including spouses, without the member's consent.

**Provider** – a professional who delivers health care services or an institution that supervises the rendering of such care

**Qualified Enrollee** – an eligible subscriber or dependent who enrolls under this group policy within 31 days of first becoming eligible

## **HOMETOWN HEALTH PLAN, INC.**

**Qualified Late Enrollee** – an eligible subscriber or dependent who becomes eligible and enrolls under this group policy within 31 days of becoming eligible due to:

- a. A qualifying life event
- b. Open enrollment, but only if he or she were covered on another group health plan offered by this employer; without a lapse in coverage
- c. A court order for coverage for the spouse and/or a dependent minor of an eligible subscriber under this group policy, or
- d. A change of status from not being an eligible employee to being an eligible employee, subject to any waiting period

**Qualifying Life Event** – an event in a subscriber’s or a dependent’s life that would allow the subscriber or the dependent to enroll in this group’s medical policy outside of the open enrollment period

In all cases of qualifying life events, the subscriber or dependent must enroll within 31 days of the date of the qualifying life event, and the dependent may enroll only if the subscriber enrolls or is already enrolled in this group’s medical policy. Only the following will be considered a qualifying life event:

- a. The subscriber or eligible dependent was covered under any provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) relating to the continuation of coverage and such continuation of coverage was exhausted
- b. The subscriber or eligible dependent was not covered under COBRA but was covered under a different health benefit plan and this coverage was lost as a result of cessation of contributions by his or her employer, termination of employment and eligibility, reduction in the number of hours of employment, death, divorce or legal separation from a covered spouse, or
- c. The eligible dependent became a dependent through marriage, birth, adoption, or placement for adoption under the provision of the Health Insurance Portability and Accountability Act of 1996

**Referral** – Hometown Health’s approval to see a certain specialist or to receive certain covered services

**Rehabilitative Therapy** – physical, speech, occupational, cardiac and pulmonary therapy rehabilitation services that must be performed by a physician or by a therapy provider licensed in accordance with state regulations for that therapy discipline

**Service Area** – the area within which Hometown Health has received regulatory approval to operate

**Short Term Therapy** – therapy that is limited to treatment for conditions that are subject to significant clinical improvement within 90 days of the start of therapy

**Skilled Nursing Care** – services that are considered by Medicare to be eligible for Medicare coverage as meeting a skilled need and that can only be performed by, or under the supervision of, a licensed or registered nurse

## **HOMETOWN HEALTH PLAN, INC.**

**Skilled Nursing Facility** – a facility that is duly licensed by the state and/or federal government and that provides inpatient skilled nursing care, rehabilitation services or other related health services that are not custodial or convenience in nature

**Special Food Products** – food products that are specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease

The term does not include a food that is naturally low in protein.

**Specialty Care Physician** – a physician, other than those designated as PCP's by Hometown Health, who provides medical care in a specific branch of medicine generally referable to a particular bodily system or area

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

**Subscriber** – a person (typically an employee of the group) who meets all applicable eligibility requirements of this EOC and whose enrollment form has been accepted by Hometown Health

**Tertiary Care** – the highest or most complex level of care for the treatment of a particular medical condition and not generally available in a community hospital

**Urgent Care Claim** – a request for coverage that is treated expeditiously because the member could be seriously harmed by waiting too long for a decision

If the request for coverage was prospectively denied and the member appeals the decision to deny the authorization, the member can request an expedited appeal.

**Urgent Care Services or Urgently Needed Services** – covered services provided for an unforeseen illness or injury when a member is temporarily out of the service area or when the member's PCP is unavailable, typically because the sudden illness or injury occurs outside of normal office hours

Routine or follow-up care is not a covered urgent care service.

**Urgent Hospital Admission** – an admission for a medical condition resulting from injury or serious illness that is less severe than an emergency admission but requires care within a short time, including complications of pregnancy

**Utilization Management (UM) and Quality Assurance (QA) Protocols** – procedures adopted by Hometown Health to ensure that the services provided to members are medically necessary and that the most cost-effective preventive, acute and tertiary care are provided to members consistent with the provision of quality care

**Waiting Period** – the length of time that an eligible employee must work continuously for the employer before he or she is eligible for insurance as described within the GSA

# HOMETOWN HEALTH PLAN, INC.

## **PART 2 NOTICE OF PRIVACY PRACTICES**

---

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

### **A. Hometown Health's Pledge to Protect Medical Information**

We understand that medical information about you and your health is personal. We are committed to protecting your medical information, including nonpublic, personal financial information relating to your healthcare. We create a record of your benefits, eligibility status and claims history. We need this record to provide you with quality healthcare benefits and to comply with certain legal requirements. Hospitals, physicians and other healthcare providers who provide healthcare services to Hometown Health members may have different policies or notices regarding their uses and disclosures of your medical information.

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

1. Make sure that medical information that identifies you is kept private
2. Give you this notice of our legal duties and privacy practices with respect to medical information about you
3. Follow the terms of the current privacy notice

### **B. Information About Our Members**

While providing healthcare benefits, we may receive the following information about you:

1. Information provided by you on applications, forms, surveys and our web site, such as your name, address, date of birth, social security number, gender, marital status and dependents
2. Information provided by your employer, benefits plan sponsor or association about any group product you may have
3. Information about your transactions and experiences with our health plan and our affiliates, such as services purchased, account balances, payment history, claims history, policy coverage and premiums
4. Information from consumer or medical reporting agencies, medical providers or third parties, such as medical information and demographic information

### **C. How We Protect Your Medical Information**

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

## **HOMETOWN HEALTH PLAN, INC.**

safeguard medical information against inappropriate access, use and disclosure, consistent with applicable law.

### **D. How We May Use and Disclose Medical Information About You**

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

1. For payment - we may use and disclose your medical information in order to pay for your medical benefits under our health plan. These activities may include making benefit determinations and paying claims.
2. For healthcare operations - we may use and disclose medical information about you for health plan operations. These uses and disclosures are necessary to run the health plan and make sure that all of our members receive quality benefits and customer service. For example, we might use your medical information for:
  - a. Newsletters that offer members information on healthcare issues such as asthma, diabetes, and breast cancer
  - b. Administration of Hometown Health contracts, which, where applicable, may involve claims management; utilization review and management; data and information systems management; medical necessity review; coordination of care, benefits and services; response to member inquiries or requests for services; conduct grievances, appeals and external review programs; benefits and program analysis and reporting; risk management; detection and investigation of fraud and other unlawful conduct; auditing; underwriting and ratemaking; and other activities described below.
  - c. Operation of disease and case management programs in plans that offer these programs, through which we or our contractors perform risk and health assessments; identify and contact members who may benefit from participation in disease or case management programs; and send relevant information to those members who enroll in the programs and their providers.
  - d. Quality assessment and improvement activities, such as peer review and credentialing of participating providers; program development; and accreditation by independent organizations, where applicable.
  - e. If we are providing health benefits to you as a beneficiary of an employer-sponsored group health plan, we may disclose your Protected Health Information to the sponsor of the plan, subject to certain limitations.
  - f. Transitioning of policies or contracts from and to other health plans.
  - g. We may disclose your medical information to another entity that has a relationship with you and is subject to the federal privacy laws, for their healthcare operations relating to quality assessment and improvement activities, reviewing the competence

## **HOMETOWN HEALTH PLAN, INC.**

- and qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.
3. To your family and friends - we may disclose your medical information to a family member, friend or other person to the extent necessary to help with your healthcare or payment for your healthcare. Before we disclose your medical information to a person involved in your healthcare or payment for your healthcare, we will provide you with an opportunity to object to such uses and disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.
  4. As required by law - we will disclose medical information about you when required to do so by federal, state or local law. We must also share your medical information with authorities that monitor our compliance with privacy laws.
  5. To avert a serious threat to health or safety - we may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

### **E. Special Situations**

#### 1. Military and veterans

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

#### 2. Public health risks

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

- a. to prevent or control disease, injury or disability
- b. to report births and deaths
- c. to report the abuse or neglect of children, elders and dependent adults
- d. to report reactions to medications or problems with products
- e. to notify people of recalls of products they may be using
- f. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- g. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect or domestic violence

We will make this disclosure only if you agree or when required or authorized by law.

#### 3. Health oversight activities

We may disclose medical information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights laws.

## HOMETOWN HEALTH PLAN, INC.

### 4. Lawsuits and disputes

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

### 5. Law enforcement

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

- a. in response to a court order, subpoena, warrant, summons or similar process
- b. to identify or locate a suspect, fugitive, material witness or missing person
- c. about the victim of a crime if, under certain, limited circumstances, we are unable to obtain the person's agreement
- d. about a death that we believe may be the result of criminal conduct
- e. in emergencies, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

### 6. Disaster relief

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

### 7. National security and intelligence activities

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

### 8. Protective services for the president and others –

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

### 9. Inmates –

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

- a. for the institution to provide you with healthcare,
- b. to protect your health and safety or the health and safety of others, or
- c. for the safety and security of the correctional institution.

## **F. Medical Information of Former Members of Hometown Health**

Hometown Health does not destroy the medical information of individuals who terminate their coverage with us. The information is necessary and is used for many purposes described above, even after an individual leaves a plan, and in many cases is subject to legal retention

## HOMETOWN HEALTH PLAN, INC.

requirements. The practices and procedures that protect that information against inappropriate use or disclosure, however, apply regardless of the status of any individual member.

### **G. Your Rights Regarding Medical Information About You**

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

#### 1. Right to inspect and copy

- a. You have the right to inspect and copy medical information that may be used to make decisions about your healthcare benefits. Usually this includes benefits, eligibility and claims records, but may not include some mental health information.
- b. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 89502. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- c. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by Hometown Health will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

#### 2. Right to amend

If you think that medical information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Hometown Health.

You must make your request for an amendment in writing and submit it to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 89502. Your request must include a reason that supports your request. We may deny your request for an amendment if the information:

- a. was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- b. is not part of the medical information kept by or for Hometown Health
- c. is not part of the information that you are permitted to inspect and copy
- d. is accurate and complete

#### 3. Right to an accounting of disclosures

You have the right to request an “accounting of disclosures.” This is a list of our disclosures of medical information about you other than:

## HOMETOWN HEALTH PLAN, INC.

- a. for our own uses for treatment, payment and healthcare operations, as those functions are described above,
- b. to you based on your authorization, and
- c. for certain government functions.

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

#### 4. Right to request restrictions

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

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

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

- a. The information that you want to limit
- b. Whether you want to limit our use, disclosure or both
- c. To whom you want the limits to apply (for example, disclosures to your spouse).

#### 5. Right to request confidential communications

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

You must make your request for confidential communications in writing to Hometown Health Customer Services, 830 Harvard Way, Reno, NV 89502. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

#### 6. Right to a paper copy of this notice

You may ask us to give you a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our Web site, [www.hometownhealth.com](http://www.hometownhealth.com).

## **HOMETOWN HEALTH PLAN, INC.**

To obtain a paper copy of this notice, please contact Customer Services at 775-982-3232.

### **H. Changes to This Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Hometown Health Web site, at hometownhealth.com. The notice will contain on the first page, in the top right-hand corner, the effective date. Each time that you enroll in a Hometown Health benefit plan, we will offer you a copy of the current notice in effect. We also may publish the current notice in our newsletter at least annually.

### **I. Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with Hometown Health or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Hometown Health, contact Hometown Health Customer Services at 775-982-3232. We will provide you with the address to file a complaint with the U.S. Department of Health and Human Services upon request. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

### **J. Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you by signing an authorization, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

# HOMETOWN HEALTH PLAN, INC.

## PART 3 SCHEDULE OF BENEFITS

---

If a member incurs expenses for covered services, Hometown Health will pay that expense after the applicable copayment(s) or coinsurance is satisfied. The specific copayment and coinsurance amounts are shown in your plan specific Summary of Benefits. Hometown Health will pay up to the maximum benefit specified for covered services.

The following is a description of covered services. All covered services must be medically necessary and ordered by a member's PCP. Prior-authorization is required for many services. Limitations may apply. The Schedule of Benefits should be read in conjunction with the Limitations and Exclusions and your plan specific Summary of Benefits. Your plan specific Summary of Benefits lists specific cost sharing information not listed within this EOC.

### A. Professional Services

1. Alcohol and substance abuse services (inpatient and outpatient)

#### **Large groups, as defined in the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act)**

Covered benefits for large groups for inpatient and outpatient alcohol and substance abuse services will be provided under the same provisions as medical and surgical benefits, with no additional financial or treatment limitations.

#### **Small groups (generally groups with 2 to 50 eligible employees) and groups subject to the Special Rule for Collective Bargaining Agreements, as described in the Act**

Covered benefits for small groups and for groups subject to the Special Rule for Collective Bargaining Agreements (where the implementation date for the Act is not yet effective) for general mental health (including services related to the treatment of Attention Deficit Disorder) and severe mental illness will be provided in accordance with under the following provisions:

- a. Covered services are limited to diagnosis, medical treatment, and medical aspects of rehabilitation. Non-medical ancillary services such as Narcotics Anonymous or Alcoholics Anonymous will not be covered. Covered services include:
  - i. Treatment for withdrawal from the physiological effects of Alcohol or Substance Abuse (limited to \$1,500 per calendar year)
  - ii. Inpatient treatment (limited to \$9,000 per calendar year), and
  - iii. Outpatient counseling, including group and family counseling (limited to \$2,500 per calendar year)
- b. Benefits for covered services will be paid in the same manner as benefits for those services for any other illness covered by this EOC provided that the member is entitled to these benefits and treatment is received in:
  - i. A facility for the treatment of abuse of alcohol or drugs which is certified by the Health Division of the Department of Human Resources
  - ii. A hospital or other medical facility or facility which is licensed by the Health Division of the Department of Human Resources, accredited by the Joint

## HOMETOWN HEALTH PLAN, INC.

Commission on Accreditation of Healthcare Organizations and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities

2. Alternative medicine (see homeopathic and acupuncture care)
3. Ambulance services
  - a. Provided in an emergency
  - b. Provided in non-emergency setting when ordered by member's PCP and prior-authorized by Hometown Health
4. Blood services for surgery
5. Chemotherapy
6. Clinical trials

The routine medical treatment costs, including all items and services that are otherwise generally available to Hometown Health members, received as part of a clinical trial or study is covered if:

- a. The medical treatment is provided in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome.
- b. The clinical trial or study is approved by:
  - i. An agency of the National Institutes of Health
  - ii. A cooperative group, a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health
  - iii. The Food and Drug Administration (FDA) as an application for a new investigational drug
  - iv. The United States Department of Veterans Affairs
  - v. The United States Department of Defense
  - vi. The medical treatment is provided by a provider of health care and the facility and personnel have the experience and training to provide the treatment in a capable manner
  - vii. There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study
  - viii. There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment
  - ix. The clinical trial or study is conducted in Nevada, and
  - x. The member has signed, before his/her participation in the clinical trial or study, a statement of consent indicating that he/she has been informed of, without limitation:

## HOMETOWN HEALTH PLAN, INC.

- The procedure to be undertaken;
  - Alternative methods of treatment; and
  - The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.
- c. Medical treatment is limited to:
- i. Coverage for any drug or device that is approved for sale by the Food and Drug Administration (FDA) without regard to whether the approved drug or device has been approved for use in the medical treatment of the member
  - ii. The cost of any reasonable necessary health care services that are required as a result of the medical treatment provided in the clinical trial or study or as a result of any complication arising out of the medical treatment provided in the clinical trial or study, to the extent that such health care services would otherwise be covered under Hometown Health
  - iii. The initial consultation to determine whether the member is eligible to participate in the clinical trial or study
  - iv. Health care services required for the clinically appropriate monitoring of the member during the clinical trial or study
7. Colorectal screening
8. Diabetic services for type 1, 2 and gestational diabetes
- a. Management and treatment of diabetes including infusion pumps and related supplies, medication, equipment, supplies and appliances for the treatment of diabetes
  - b. Self-management of diabetes, including:
    - i. Training and education provided after a member is initially diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes
    - ii. Training and education which is necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition which requires modification of his/her program of self-management of diabetes, and
    - iii. Training and education which is necessary because of the development of new techniques and treatment for diabetes
9. Durable medical equipment (DME)
- a. The purchase, rental, repair or maintenance of DME for other than kidney dialysis
  - b. DME includes, but not limited to:
    - i. Oxygen equipment (all oxygen and oxygen related equipment, except for oxygen while traveling on an airline)
    - ii. Wheelchairs
    - iii. Hospital beds

## HOMETOWN HEALTH PLAN, INC.

- iv. Glucose monitors
- v. Warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea (limited to 90 days)

Hometown Health's coverage will be based on an amount equal to the generally accepted cost of DME that provides the necessary level of care at the lowest cost. In determining Hometown Health's liability, Hometown Health will be guided by nationally established standards of the rental or purchase of such equipment.

### 10. Family planning

Services for vasectomies and tubal ligations

### 11. Food products

Special food products for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originated from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat (limited to \$2,500 per calendar year)

### 12. Gastric restrictive services

Covered services include prior-authorized medically necessary gastric restrictive services for obesity or morbid obesity with associated illnesses, including but not limited to:

- Cardiac disease (e.g., CHF)
- Sleep Apnea
- Diabetes
- Hypertension
- Disorders of the pituitary gland and its hypothalamic control
- Disorders of the adrenal glands
- Cushing's syndrome

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

#### **Gastric (Bypass) Restrictive (aka: Roux-En-Y) Procedures**

Initial Surgery and follow-up care (no complications)

- \$20,000 Lifetime Maximum for the facility charges
- No Maximum for physician services

Treatment due to complications

- \$150,000 for the physician and facility services only – combined. There is no coverage for any other services.

#### **Lap Band Procedures**

Initial Surgery and follow-up care (no complications)

- \$20,000 Lifetime Maximum for the facility charges

## HOMETOWN HEALTH PLAN, INC.

- No Maximum for physician services

Treatment due to complications

\$50,000 for the physician and facility services only – combined. There is no coverage for any other services such as home health, TPN (feeding services etc...)

### 13. Genetic counseling/testing

- a. Genetic Testing may only be done after consultation with an appropriately certified Genetic Counselor or as approved by Hometown Health medical director.

Limited to a lifetime benefit maximum of \$2,500

- b. Genetic counseling will be covered in connection with pregnancy management in the following circumstances:
  - i. Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality
  - ii. Parents of a child with mental retardation, autism, Down syndrome, trisomy conditions, or fragile X syndrome
  - iii. Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein (AFP) test, test for sickle cell anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects
  - iv. Parents affected with an autosomal dominant disorder, contemplating pregnancy
  - v. Mother is a known or presumed carrier of an X-linked recessive disorder

### 14. Home health care

- a. House Calls - provided by a member's PCP as the nature of the illness dictates
- b. Home Care - provided by a home health agency.

Such care will not be available if it is substantially or primarily for a member's convenience. Home care will be provided in the home only on a part-time and temporary basis (limited to a plan year benefit maximum of \$5,000). Certified Nurse's Aides and Home Health Aides are not covered.

- c. Home health care does not include over-the-counter medical equipment, over-the-counter supplies, or any prescription drugs. These benefits are only available to the extent that they are covered elsewhere in this EOC or Pharmacy Rider.

### 15. Hospice services

Hospice care services for members with a life expectancy of six (6) months or 185 days or less as certified by his or her PCP. (limited to a lifetime benefit maximum of 185 days).

## **HOMETOWN HEALTH PLAN, INC.**

- a. Intermittent home health care
- b. Outpatient counseling of the member and his or her immediate family, (limited to \$500 for all family members combined). Counseling must be provided by:
  - A licensed psychiatrist;
  - A licensed psychologist; or
  - A licensed social worker.
- c. Respite care provides nursing care for a maximum of three, 48-hour periods in the hospice benefit period. Inpatient respite care will be provided only when Hometown Health determines that home respite care is not appropriate or practical.

### **16. Homeopathic and acupuncture care**

Office visits for homeopathic and acupuncture services, (limited to \$1,000 per plan year).

### **17. Infertility services**

Medical services to diagnose problems of infertility (limited to \$2,500 per lifetime).

- a. Diagnostic services are limited to:
  - General history and physical examination (progesterone level, VDRL, CBC, urinalysis, SMAC-12, T3, T4, TSH and T6)
  - Pap smear
  - HSG
  - Sims-Huhner
  - Three separate semen analyses
  - Semen culture
  - FSH and LH
- b. All other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, artificial insemination and/or embryo transplants) including services, tests, supplies, devices, or drugs intended to produce a pregnancy are not covered services.

### **18. Kidney dialysis services**

Kidney dialysis services and related therapeutic services and supplies, (e.g., epogen) to the extent these are not covered by the Medicare program (limited to \$60,000 in any 12 consecutive months).

### **19. Lab and diagnostic services**

X-ray and laboratory procedures, services and materials, including:

- Diagnostic X-rays (Radiological/Cardiology related/Neurological)
- Mammograms
- Fluoroscopy

## HOMETOWN HEALTH PLAN, INC.

- Electrocardiograms
- Laboratory tests

### 20. Mastectomy reconstructive surgery

Breast reconstructive surgery and the internal or external prosthetic devices for members who received mastectomy surgery as a covered benefit while a member of this group medical plan. External prosthesis are limited to the billed charges or the allowed charges set by the Centers for Medicare and Medicaid Services (CMS), whichever is less.

- a. If reconstructive surgery is begun within 3 years after the mastectomy, coverage will be extended to the member or former member for all eligible charges for such reconstructive surgery as would have been provided at the time of the mastectomy. If a covered mastectomy is performed while a member of Hometown Health and the mastectomy is paid for by Hometown Health, subject to all the terms and conditions of this EOC, Hometown Health will also provide coverage for: (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical structure; and (c) prostheses; and (d) physical complications for all stages of mastectomy, including lymphedemas.
- b. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal the amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all the terms, conditions and exclusions contained in the policy at the time of reconstructive surgery. No benefits will be paid for reconstructive surgery or any complications resulting from reconstructive surgery more than 3 years after the mastectomy if the patient is no longer a member of this plan.

### 21. Maternity care and care of newborns

Hospital and medical services for pregnant members, including prenatal and postpartum care, related delivery room and ancillary services and newborn care; Newborn care includes care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of newborn to and from the nearest facility staffed and equipped to treat the newborn's condition.

Maternity and newborn care will include up to forty-eight (48) hours of inpatient care for a mother and her newborn child following a vaginal delivery and up to ninety-six (96) hours of inpatient care for a mother and her newborn child following a Caesarian delivery. The time periods will commence at the time of the delivery. Any decision to shorten the length of inpatient stay to less than those time periods will be made by the attending physician after conferring with the mother.

### 22. Medical care and preventive services

Medical care and services, including:

- Office visits and consultations
- Hospital and Skilled Nursing Facility services

## HOMETOWN HEALTH PLAN, INC.

- Periodic physical examinations and routine immunizations in accordance with Hometown Health's Medical Practice Guidelines
- Routine gynecologic examination (1 per plan year), including annual cytologic screening test (Pap smear) for women; pelvic examination; urinalysis and breast examination
- Screening mammograms including an initial baseline mammogram for female members 35 - 39 and annually for women 40 years of age or older
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies
- Allergy testing and serum
- Influenza, Pneumovax, Haemophilus influenza B, Hepatitis A, Hepatitis B, Hepatitis C, Rubella and Tetanus immunizations.
- Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.

Medical pharmacy and Immunization – immunizations, biologics, injectables, or other special pharmaceuticals and a contraceptive diaphragm (one device per a 12 month period, unless otherwise prescribed by a participating physician)

Special pharmaceuticals – the distribution, administration, and/or supply of pharmaceuticals, frequently in conjunction with other services

Special pharmaceuticals (which may include injectables or medications given by other routes of administration) may be delivered in any setting and are typically greater than \$200 per dosage unit or per prescription. A list of special drugs classified as special pharmaceuticals is maintained and updated on an ongoing basis by Hometown Health. Special pharmaceuticals have a separate out-of-pocket maximum. Copayment(s) for special pharmaceuticals do not apply toward out-of-pocket maximum.

### 23. Mental health services

#### **Large groups, as defined in the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act)**

Covered benefits for large groups for general mental health (including services related to the treatment of Attention Deficit Disorder (ADD & ADHD)) and severe mental illness will be provided under the same provisions as medical and surgical benefits, with no additional financial or treatment limitations.

#### **Small groups (generally groups with 2 to 50 eligible employees) and groups subject to the Special Rule for Collective Bargaining Agreements, both described in the Act**

Covered benefits for small groups and for groups subject to the Special Rule for Collective Bargaining Agreements (where the implementation date for the Act is not yet effective) for general mental health (including services related to the treatment of ADD & ADHD) and severe mental illness will be provided in accordance with under the following provisions:

## HOMETOWN HEALTH PLAN, INC.

### a. General Mental Health

General mental health includes: outpatient evaluation, crisis intervention and short-term psychotherapy that leads to significant clinical improvement and achieve treatment goals. Outpatient general mental health services are limited to 10 visits of 50-minute duration. The outpatient general mental health visit limitation applies to private visits, group visits or any combination thereof.

ADD & ADHD treatment for members under 18 years old is limited to one evaluation and management visit per lifetime and three medication management visits per calendar year.

### b. Severe Mental Illnesses

Treatment of the following conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder and obsessive-compulsive disorder (excluding medication management) are subject to the following limitations:

- i. Outpatient severe mental illness services – limited to 40 visits per calendar year
- ii. Inpatient severe mental illness services – limited to 40 days of hospitalization per calendar year (two visits for partial hospitalization may be substituted for each day of inpatient hospitalization)

## 24. Oral surgery, dental services, and temporomandibular joint disorder (TMJ)

Oral surgery procedures will be provided (inpatient or outpatient) related to the following:

- a. Accidental injury to the jaw bones or surrounding tissues when the injury occurs and the repair takes place while a member of the plan

Services must commence within 90 days after the accidental injury (services that commence after 90 days are not covered).

- b. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth
- c. Non-dental surgical procedures and hospitalization required for newly born and children placed for adoption or newly adopted to treat congenital defects, such as cleft lip and cleft palate
- d. Medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including treatment of fractures
- e. TMJ services are covered only when the required services are not recognized dental procedures.

Benefits are subject to 50% coinsurance for all TMJ related services. Lifetime benefit maximum is \$2,500.

## HOMETOWN HEALTH PLAN, INC.

- f. Dental general anesthesia for a dependent child when services are rendered in a hospital or outpatient surgical facility, when enrolled dependent child is being referred because, in the opinion of the dentist, the child:
  - i. Is under 18 and has a physical, mental or medically compromising condition
  - ii. Is under 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy, or
  - iii. Is under age 5
- g. Prior-authorization is required for dental general anesthesia in a hospital or outpatient surgical facility. Dental anesthesiology services are covered only for procedures performed by a qualified specialist in pediatric dentistry, a dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

### 25. Orthopedic devices and prosthetic devices

- a. Orthopedic devices are limited to braces for problems requiring complete immobilization or for support, or if the braces are custom fitted or have rigid bar or flat steel supports and stays, splints, devices for congenital disorders, post and pre-operative devices.
- b. Prosthetic devices, approved by Centers for Medicare & Medicaid, required to substitute for missing or non-functioning body parts or organs are limited to:
  - i. Devices provided in connection to an illness or injury, which occurred subsequent to a member's effective date of coverage under this EOC
  - ii. Adjustment of initial prosthetic device  

Repair and replacement of prosthetic devices are not covered except in limited situations involving mastectomy reconstructive surgery
  - iii. The first pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery

### 26. Ostomy care supplies

Care and supplies provided to the member after colon, ileum and/or bladder surgery to carry on normal activities with a minimum of inconvenience.

### 27. Outpatient observation (in facility)

Services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital. If the hospital intends to keep a patient in observation status for more than 24-48 hours, observation status will become an inpatient admission for administration of benefits.

## **HOMETOWN HEALTH PLAN, INC.**

### 28. Podiatry services

Podiatry services for the treatment of acute conditions of the foot such as infections, inflammation, or injury and other foot care, which is disease related

### 29. Radiation therapy

### 30. Second opinions

Second Opinions are covered when prior-authorized by Hometown Health.

### 31. Short-term rehabilitative therapy

- a. Outpatient short-term speech, physical, and occupational rehabilitative therapy for acute conditions which are subject to significant clinical improvement over a three-month (90 day) period from the date outpatient therapy commences (limited to 20 visits each for speech, physical, and occupational therapy per plan year)
- b. Outpatient services for cardiac rehabilitation and pulmonary rehabilitation (limited to 40 visits/sessions per plan year for each type of therapy)
- c. Inpatient short term rehabilitative services are limited to treatment of conditions which are subject to significant clinical improvement over a continuous 30 day period from the date inpatient therapy commences in a distinct rehabilitation unit of a hospital, skilled nursing facility or other facility approved by Hometown Health. (limited to 30 days per plan year)

### 32. Skin lesions

Removal of suspicious lesions for pathological analysis

### 33. Spinal treatment (non surgical)

Spinal manipulations and adjustments (limited to \$1,000 per plan year)

### 34. Transplant services

Organ transplants when the member is the organ recipient: cornea, artery or vein, kidney, joint, heart valve, implantable prosthetic lenses (in connection with cataracts), prosthetic bypass or replacement vessels, bone marrow, heart, lungs

Combined expenses incurred for any and all body organ transplant services, including, but not limited to, follow-up care, immunosuppressive medications and donor expenses are limited to a lifetime maximum of \$400,000.

## **HOMETOWN HEALTH PLAN, INC.**

- a. Related services limited to: tests necessary to identify an organ donor, the reasonable expense of acquiring the donor organ, transportation of the donor organ (but not the donor), and life support where such support is for the sole purpose of removing the donor organ, follow-up care and immunosuppressive medications.
- b. Immunosuppressive medications are covered after an organ transplant operation (limited to a three (3) year maximum benefit).

### **B. Hospital, Skilled Nursing and Services in an Outpatient Surgical Center**

1. Inpatient hospital services include, but are not limited to:
  - a. Semi-private room and board (private room when medically necessary)
  - b. General nursing care facilities, services, and supplies on an inpatient basis, including: meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care or cardiac care units and related services, X-ray services, laboratory and other diagnostic tests, non-experimental and non-investigational prescription drugs, biologicals, anesthesia and oxygen services, blood and blood plasma and its administration, special duty nursing when medically necessary, radiation therapy, inhalation therapy, and chemotherapy (including chemotherapy drugs)
  - c. Inpatient care short-term rehabilitative services are limited to treatment of conditions which are subject to significant clinical improvement over a continuous 30 day period from the date inpatient therapy commences in a distinct rehabilitation unit of a hospital, skilled nursing facility or other facility approved by Hometown Health. (Inpatient short-term rehabilitative services are limited to 30 days per plan year).
  - d. Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthesiologist together with preoperative and postoperative care
  - e. Inpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program.

#### **Large groups, as defined in the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act)**

Covered benefits for large groups for inpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program will be provided under the same provisions as medical and surgical benefits, with no additional financial or treatment limitations.

#### **Small groups (generally groups with 2 to 50 eligible employees) and groups subject to the Special Rule for Collective Bargaining Agreements, as described in the Act**

Covered benefits for small groups and for groups subject to the Special Rule for Collective Bargaining Agreements (where the implementation date for the Act is not yet effective) for inpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program are limited to \$9,000 per calendar year.

## HOMETOWN HEALTH PLAN, INC.

### f. Inpatient severe mental health services

#### **Large groups, as defined in the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act)**

Covered benefits for large groups for severe mental illness will be provided under the same provisions as medical and surgical benefits, with no additional financial or treatment limitations.

#### **Small groups (generally groups with 2 to 50 eligible employees) and groups subject to the Special Rule for Collective Bargaining Agreements, both described in the Act**

Covered benefits for small groups and for groups subject to the Special Rule for Collective Bargaining Agreements (where the implementation date for the Act is not yet effective) for severe mental illness will be limited to 40 days of hospitalization per calendar year (two visits of partial hospitalization may be substituted for each one day of hospitalization).

2. Outpatient hospital or outpatient surgical center services
3. Hospital services such as radiation therapy, chemotherapy (including chemotherapy drugs) and outpatient surgery
4. Skilled nursing facility services (limited to 30 days per plan year) for non-custodial care

Prior care in a hospital is not required before being eligible for care in a skilled nursing facility.

### **C. Emergency Services**

Emergency medical or hospital services (refer to definition of emergency)

Services must be provided at a contracted facility unless the time requirement to reach a Hometown Health provider would result in a significant risk of permanent health damage. Unanticipated complications of pregnancy or premature delivery are covered outside the service area. Services furnished by a physician, oral surgeon, or hospital or emergency facility personnel for covered services are covered during the emergency. Ambulance services for emergencies are a covered service.

Emergency medical and hospital services (in or outside the service area) are limited to situations that require immediate and unexpected treatment. Routine or follow-up care in an emergency room facility is not covered. Follow-up care should be provided by your PCP.

#### 1. Medical care and notification

Medically necessary medical care is available through participating physicians seven (7) days a week, 24 hours a day.

Medically necessary out-of-area emergency services will be covered. Out-of-area emergency services are provided only if Hometown Health is notified before the receipt of those services or as soon as possible after such emergency services, but no more than 24 hours after onset of the emergency, except as provided in this section.

## **HOMETOWN HEALTH PLAN, INC.**

### **2. Extended notification**

If the member or a family member is unable to contact his or her PCP and Hometown Health before receipt of emergency medical services or within 24 hours of the emergency due to shock, unconsciousness, or otherwise, the member must, at the earliest time reasonably possible, contact Hometown Health to notify the plan of care received.

### **3. Follow-up care (outside the service area / non-contracted facility)**

Continuing or follow-up treatment for an emergency service outside of the service area or from a non-contracted facility is limited to care required before the member can, without harmful or injurious consequences, return to the service area and receive care from participating providers as determined by Hometown Health. Benefits for continuing or follow-up treatment(s) are otherwise provided only in the service area from participating providers, subject to all provisions of this EOC.

## **D. Urgent Care Services**

### **1. Medical care and notification**

Medical care is available through participating physicians seven (7) days a week, 24 hours a day. If injury or illness requires urgent care services, the member is requested to notify his or her PCP before receiving medical services. Medically necessary out-of-area urgent care services will be covered.

Out-of-area benefits and services are limited to situations in which care is required immediately and unexpectedly; elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the service area are not covered. Covered out-of-area urgent care services are covered based on the maximum allowed amount.

### **2. Follow-up care if temporarily outside the service area**

Continuing or follow-up care for urgent care is limited to care required before the member can, without medically harmful or injurious consequences, return to the service area to receive services from participating providers as determined by Hometown Health.

### **3. Limitations**

Urgent care services obtained at a hospital emergency facility may have a maximum benefit limit and/or a higher copayment. Please refer to your Summary of Benefits.

All urgent care services obtained while in the Hometown Health service area must be through a contracted urgent care provider. Urgent care services obtained from a non-contracted, in-service area provider are not covered.

# HOMETOWN HEALTH PLAN, INC.

## PART 4 EXCLUSIONS AND LIMITATIONS

---

### A. Exclusions

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

1. Services of non-participating providers; except in an emergency or urgently needed services or unless prior-authorized by Hometown Health
2. Services not medically necessary or not required in accordance with accepted standards of medical practice (Screening and prevention procedures for disease not specifically endorsed and recommended by the U.S. Health Preventive Services Task Force for the member's specific age group or other specified criteria.)
3. Any services or supplies not specifically listed in this EOC as covered benefits, services, or supplies, including but not limited to charges for missed appointments, telephone calls, travel, transportation, or lodging
4. Any injury or illness that arises out of or in the course of any employment for pay or profit
5. Charges for care or services provided before the effective date or after the termination of coverage
6. Any loss, expenses, or charges resulting from the member's use of illegal substances (including drugs); participation in a riot or criminal act (including the commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation); and losses related to an act of war, insurrection, or terrorism
7. Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation, work hardening programs, and employment training and counseling, including services rendered by or billed by a school or member of its staff
8. Care for military service-connected disabilities and conditions for which the member is legally eligible to receive from governmental agencies and for which facilities are reasonably accessible to the member
9. 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
10. Routine examinations primarily for insurance, immigration, travel, licensing, school sports, adoption purposes, employment, and other third-party physicals
11. Immunizations related to foreign travel or employment
12. Expenses for medical reports, including presentation and preparation

## HOMETOWN HEALTH PLAN, INC.

13. Examinations for court ordered treatment, or in connection with legal processing (Laboratory and other diagnostic testing provided in connection with this exclusion are also excluded.)
14. Medical and psychiatric evaluations, psychological testing, therapy, and other services including hospitalizations or partial hospitalizations that are ordered as a condition of processing, parole, or probation (Laboratory and other diagnostic testing provided in connection with this exclusion are also excluded.)
15. Cosmetic surgery or medical procedures, defined as any plastic or reconstructive surgery, or medical procedures done primarily to improve the appearance of any portion of the body

Excluded cosmetic services or procedures are further defined as:

- Cosmetic surgery exclusions 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
- 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 breast asymmetry will be provided pursuant to coverage as provided in this EOC for mastectomy benefits), treatment of male-pattern baldness, electrolysis, waxing or other methods of hair removal, or hair treatment, keloid scar therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions are additionally not covered under this EOC
- Cosmetics, dietary supplements, anti-aging treatments (even if approved by the FDA for other clinical indications), vitamins, diet pills, health or beauty aids, vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (except as otherwise covered and described within this EOC)

Additional cosmetic surgery or medical procedures exclusions include:

- Complications resulting from excluded cosmetic surgery
- Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function
- Cosmetic treatment or service related complications, insertion, removal or revision of breast implants (including complications) unless provided post mastectomy
- 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

## HOMETOWN HEALTH PLAN, INC.

- Charges which result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by Hometown Health and present significant symptomatic medical problems) or any treatment of obesity
16. Treatment of benign skin lesions that consist of destruction or removal by any surgical technique  
  
Examples of benign skin lesions are capillary hemangiomas (port wine stains), cavernous hemangiomas, dermatofibromas, warts (verruca vulgaris), keloids, skin tags (acrochordon), epidermal inclusion cysts, sebaceous cysts, or benign nevi.
  17. Special formulas, food supplements or special diets including but not limited to total parenteral nutrition (TPN) except for acute episodes and as otherwise set forth in this EOC
  18. Charges exceeding \$2,500 per plan year for special food products medically necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects, or defects arising shortly after birth, or amino acid, organic acid, carbohydrate or fat
  19. Any procedure or treatment designed to alter physical characteristics of the member to those of the opposite sex; and any other services, treatments, drugs, or diagnostic procedures or studies related to sex transformations
  20. Treatment for the removal, ablation, injection, or destruction of varicose veins
  21. Chronic pain therapy and treatment for chronic pain
  22. Spinal manipulation for chronic or recurring conditions
  23. Non-symptomatic foot care such as the removal of warts (except plantar warts); corns or calluses; and including but not limited to podiatry treatment of bunions, toenails, flat feet, fallen arches, and chronic foot strain
  24. Routine foot care
  25. Surgical or invasive treatment for obesity or morbid obesity including but not limited to gastric restrictive services; reversals and complications, unless medically necessary and covered as described within this EOC
  26. All experimental or investigational medical, surgical or other health care procedures and all transplants except as otherwise described within this EOC
  27. Custodial, domiciliary care or homemaker services
  28. In home services provided by Certified Nurse Aides or Home Health Aides
  29. 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
  30. Travel, accommodations, and oxygen provided while traveling on an airline
  31. Any services received outside the United States unless deemed to be urgent or emergent

## HOMETOWN HEALTH PLAN, INC.

32. Personal, beautification, or comfort items for while in a hospital or skilled nursing facility
33. Private duty nursing and private rooms in an inpatient setting
34. Penile implants and injectable services and supplies related to the treatment of impotence, including services for the treatment of sexual dysfunction and enhancement medications
35. DME as well as related supplies and consumables including, but not limited to: dressings, any equipment or supply to condition the air, appliances, ambulatory apparatus, arch supports, support stockings, corrective footwear, orthotics or other supportive devices for the feet, heating pads, personal hygiene, comfort, care, convenience or beautification items, deluxe equipment, cochlear implants, and any other primarily non-medical equipment, except as otherwise covered and described within this EOC
36. Barrier free and other home modifications
37. Prosthetic and orthopedic devices except as otherwise covered and described within this EOC
38. The fitting and cost of hearing aids including both surgical implanted bone conduction hearing aids and externally worn hearing aids regardless of the etiology of the deafness
39. The promotion of fertility including, but not limited to fertility testing (except as otherwise covered and described within this EOC); 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, artificial insemination (including 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 or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval
40. Amniocentesis (except when done in the last trimester for the purpose of determining fetal lung maturity) in the first 16 weeks for genetic testing for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother
41. Non-newborn circumcisions after 8 weeks of age unless medically necessary and prior-authorized by Hometown Health
42. Termination of pregnancy other than medically indicated abortions necessary to save the life of the mother
43. Long-term physical therapy and long-term rehabilitative services for acute conditions evolving into conditions present after 90 days or for chronic conditions unless an acute event has aggravated the chronic condition
44. Charges for cognitive therapy unless related to short term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living
45. Services related to job, vocational retraining or community re-entry

## **HOMETOWN HEALTH PLAN, INC.**

46. Sleep therapy (except for central or obstructive apnea when medically necessary as ordered by a member's PCP and prior-authorized by Hometown Health), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electrosleep therapy, electronarcosis, massage therapy or gene therapy
47. Organ transplant services defined as but not limited to:
  - Services of a member where the member serves as the organ donor
  - Transplants utilizing any animal organs
  - Any transportation of the donor (as opposed to transportation of the donor organ only)
  - Any expenses associated with an organ transplant where an alternative remedy is available
  - Any human organ transplant not covered or described within this EOC, or transplants which, consist of the installation of a non-human device or artificial organ
  - Any expenses for transportation, lodging, and meals for services associated with the transplant including evaluations and the transplant and post transplant periods for the donor, donor's family, recipient, or recipient's family
48. Kidney dialysis or artificial kidney treatments when covered by the Medicare program or other federal or state programs, other than the Medicaid program
49. Tissue transplants (whether natural or artificial replacement materials or devices are used) or oral implants, including the treatment for complications arising from tissue or organ transplants or replacement unless covered and described within this EOC
50. Therapies, psychological services, counseling or tutoring services for developmental delay or learning disability
51. Treatment of mental retardation, down syndrome, and autism (unless covered and described within this EOC) for which a federal or state law mandates that coverage be provided and paid for by a school district or other governmental agency
52. Treatment of hyperactivity and attention deficit disorder for a member over the age of 18 years unless otherwise covered and described within this EOC
53. Care or treatment of chronic marital or family problems, occupational, religious, or other social maladjustments, chronic behavior disorders, chronic situational reactions and hypnotherapy
54. Birth control drugs, devices and implants except as set forth in a prescription drug rider or in this EOC

## HOMETOWN HEALTH PLAN, INC.

55. Prescription drugs except as otherwise set forth in this EOC or in a prescription drug rider

Exclusions for prescription drugs include but are not limited to:

- a. Over-the-counter drugs
- 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 this EOC
- 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](http://www.bop.nv.gov).)

Prescription drugs may be covered under a separately purchased prescription drug rider.

56. Physician services supplies and equipment relating to the administration or monitoring of prescription drugs unless the prescription drug is a covered benefit or covered in a prescription drug rider

57. Experimental, ecological or environmental medicine 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 specifically approved by the FDA as effective for such treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns, replacement of metal dental fillings, laetrile, and gerovital

58. 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

59. Charges related to the acquisition or use of medical marijuana

60. Over-the-counter support hose or compression socks 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.)

## HOMETOWN HEALTH PLAN, INC.

61. Dental or medical care including but not limited to treatment to the teeth; extraction of teeth; repair of injured teeth; general dental services; treatment of dental abscesses or granulomas; treatment of gingival tissues (other than for tumors); dental examinations; restoration of the mouth, teeth, or jaws because of injuries from biting, chewing, or accidents; artificial implanted devices; braces; periodontal care or surgery; teeth prosthetics and bone grafts regardless of etiology of the disease process; repairs and restorations appliances that are medically necessary to stabilize or repair sound and natural teeth after an injury as described within this EOC; other supplies and services including but not limited to cosmetic restorations, implants, cosmetic replacements of serviceable restorations, and materials (such as precious metals)

Exclusions apply even if the condition is due to a genetic, congenital, or acquired characteristic.

62. Dental and or medical care including mandibular or maxillary surgery, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, and any other dental product or service except as otherwise covered and described within this EOC (Exclusions apply even if the condition is due to a genetic, congenital, or acquired characteristic)

63. Treatment to the gums and treatment of pain or infection known or thought to be due to dental or medical cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis, including the replacement of metal dental fillings

64. Temporomandibular joint syndrome (TMJ) or dysfunction services and supplies (including night guards) except as covered and described within this EOC

65. 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); surgical correction of near or far vision inefficiencies such as laser and radial keratotomy (PK)

## HOMETOWN HEALTH PLAN, INC.

66. Services for the following clinical trial services:
- a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry
  - b. Coverage for a drug or device described above which is paid for by the manufacturer, distributor or provider of the drug or device
  - c. Health care services that are specifically excluded from coverage under Hometown Health, regardless of whether such services are provided under the clinical trial or study
  - d. Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the member in the trial or study
  - e. Extraneous expenses related to the member in the clinical trial or study including but not limited to travel, housing and other expenses that a member may incur
  - f. Any expenses incurred by a person who accompanies the member during the clinical trial or study
  - g. Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the member
  - h. Any costs for the management of research relating to the clinical trial or study
67. Cryopreservation or storage charges for collection and storage of biologic materials for any purpose
68. Payment for exercising equipment, vibratory equipment, swimming or therapy pools, spas, whirlpools, personal trainers or gym or health club memberships, exercise programs, exercise physiologists
69. Stress reduction therapy, cognitive behavior therapy for sleep disorders
70. Coverage for human growth hormone or equivalent unless specifically covered and described within this EOC
71. Services related to psychosocial rehabilitation or care received as a custodial inpatient
72. Religious or spiritual counseling

### **B. Limitations**

If the provision of covered services provided under this EOC is delayed or rendered impractical due to circumstances not within the control of Hometown Health including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of significant part of provider's personnel or similar causes, Hometown Health shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Hometown Health and providers shall render the covered services provided under this EOC insofar as practical and according to their best judgment; but Hometown Health and its 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.

# HOMETOWN HEALTH PLAN, INC.

## **PART 5 UTILIZATION MANAGEMENT PROGRAM**

---

The Managed Care/Utilization Management program evaluates and determines the appropriateness of medical care resources utilized by our members. The focus of the program is based on providing our members with access to quality care and monitoring the appropriate utilization of services at the most cost-effective level.

### **A. Scope of the Program**

The Utilization Management program applies to healthcare services utilized by eligible members. A referral from a member's PCP and prior-authorization from Hometown Health is required for all referrals to other physicians and providers for the following services. Covered services are subject to this Utilization Management program including the following:

- All inpatient stays and services in any facility type, including acute and skilled care, mental health care, drug or alcohol detoxification, or rehabilitation (This requirement includes stays for partial or day hospitalization services.)
- Surgical services as inpatient, or same day surgery
- All specialty physician services, and follow-up visits unless other wise noted in the EOC
- Most inpatient office surgical procedures
- Mental health and substance abuse services greater than 12 visits per plan year
- Home health care
- Healthcare services and supplies including but not limited to oxygen, oxygen-related equipment and all DME greater than \$100
- Prosthetic and orthopedic devices greater than \$100
- Transplant services
- Services of all non-participating providers except in the case of an emergency or urgently needed service
- Gastric restrictive services
- Medications specified by Hometown Health
- All out of area services
- Anesthesiology and physiatry services including pain management
- Genetic counseling and testing
- Second-opinion services

It is the obligation of the member to comply and cooperate with the Managed Care and Utilization Management program. Prior-authorization by Hometown Health does not guarantee that all charges are covered under the policy. Charges submitted for payment are subject to all of the terms of the policy.

Hometown Health must be notified upon confirmation of pregnancy.

# HOMETOWN HEALTH PLAN, INC.

## B. Authorization and Prior-Authorization Process

### 1. Hospital admissions

Contracted providers are responsible for notifying Hometown Health of a hospital stay at least five (5) business days before elective admission to a hospital. Hometown Health will review the physician's recommendation to determine level of care and place of service. Admission and services may be approved and an expected length of stay assigned, using InterQual®, Milliman USA or other recognized criteria. If authorization for hospital admission is denied as not covered or it is determined not to meet Hometown Health's criteria and protocols, benefits will not be paid for hospital or related charges.

### 2. Inpatient and outpatient surgery

Contracted providers are responsible for making sure Hometown Health is notified at least 5 business days before inpatient or outpatient surgery is performed. Hometown Health will review the physician's recommended course of treatment. Surgery and services may be approved using InterQual®, Milliman USA or other recognized criteria. Benefits will be paid only for authorized inpatient/outpatient surgery. Benefits will not be paid for inpatient or outpatient surgery or related charges determined not a covered benefit or not meeting Hometown Health's criteria and protocols.

### 3. Emergent and urgent hospital admissions

For an emergent or urgent hospital admission (including all complications of pregnancy), the member is responsible for making sure their PCP or Hometown Health is notified within 24 hours, the next business day or as soon as reasonable after admission. If the member is incapacitated and he or she (or a friend or relative) cannot notify Hometown Health within the above stated times, notification must be received by Hometown Health as soon as reasonably possible.

### 4. Healthcare services and supplies review

Contracted physicians and providers are responsible for making sure Hometown Health is notified to obtain prior-authorization for the services listed in Scope of the Program (part A above). InterQual®, and Milliman USA or other recognized criteria and internal medical policy guidelines, reviewed periodically by the Utilization Management and Quality Improvement Committee, are utilized as the standard measurement tool.

Non-contracted physicians and providers may not know or attempt to notify Hometown Health to obtain prior-authorization for services. The member should verify Hometown Health's referral requirements to prevent use of non-covered services.

Benefits for the health care services and supplies listed above will be paid only if authorized as outlined. No benefits will be paid for healthcare services or supplies determined not a covered benefit or not meeting Hometown Health's criteria and protocols.

## C. Concurrent Review and Case Management

After admission to a facility, Hometown Health will continue to evaluate the patient's progress to monitor appropriate level of care and services. If after consulting with the physician, Hometown Health determines a lower level of care is appropriate or service(s)

## **HOMETOWN HEALTH PLAN, INC.**

does not meet criteria standards, continued authorization will not be extended. InterQual® ISD or Milliman USA or other recognized criteria and internal medical policy guidelines are utilized as the standard measurement tool for this process for acute care facilities.

InterQual® and Milliman USA or other recognized criteria are utilized as the standard assessment tool for skilled and rehabilitation facilities.

Case Management is a service provided by Hometown Health to coordinate ambulatory services or alternate methods of medical care or treatment instead of hospital confinement. Hometown Health case managers will work in coordination with the attending physician and community resources to develop a plan of treatment per the benefit level of the plan.

Discharge planning may be initiated at any stage of the process, and begins immediately upon identification of post discharge needs during prior-authorization or concurrent review.

The planning and coordination of short term and long term plans of care are considered important among a variety of case management functions.

Hometown Health will also evaluate the patient's progress under authorized Psychological Disorder Benefits, Alcohol and Drug Abuse Services, Healthcare Services and Supplies Review.

### **D. Retrospective Review**

Hometown Health evaluates the medical records of those members whose medical treatment or hospital stay was not reviewed under authorization, prior-authorization or concurrent review as described above.

If Hometown Health is unable to authorize any portion of the stay or treatment, the attending, facility, or PCP will be contacted to provide additional information.

Benefits will be paid only for those days or treatment, which would have been authorized under the Utilization Management Program, and Scope of the Program, Prior-Authorization/Authorization Process or Concurrent Review/Case Management.

### **E. Expedited Appeal Process**

Hometown Health offers an appeals process to reconsider denials of authorization for inpatient stays based upon lack of medical necessity. A member or an authorized representative, including a physician, must file an appeal and a decision will be made within seventy-two (72) hours. During the appeal, the course of care or proposed care will not be interrupted and, if the appeal prevails, the care will be covered, subject to the other provisions of this EOC. If the appeal does not prevail, the member or the subscriber, in the case of an underage member, will be financially liable for that care and member and/or subscriber agree to pay for such care as a condition of receiving the disputed care. Should a member or representative desire to appeal a denial he or she can do so by calling Customer Services. If a member fails to pursue such an appeal, this will conclude any obligations that Hometown Health may have to him or her regarding that care. Grievance procedures can be found in Member Appeal Procedure section of this EOC.

# HOMETOWN HEALTH PLAN, INC.

## **PART 6 DELIVERY OF AND RESTRICTIONS TO SERVICES AND BENEFITS**

---

Each member shall select, or have selected on his or her behalf, a PCP, who will provide certain covered primary services. The PCP also will coordinate the other covered services that the member receives from other participating providers.

Hometown Health considers services provided by a non-participating provider (except in an emergency or if the member needs services urgently) a covered benefit if all of the following conditions apply:

- The member's PCP orders the services
- Hometown Health authorizes the services from the specific non-participating provider prior to the date of the services
- The conditions of this EOC and Summary of Benefits provide for coverage of those services

A member may change his or her PCP by contacting Hometown Health.

A member shall be entitled to receive medically necessary medical care and services from PCPs and other participating providers as specified in the Summary of Benefits and this EOC. These include medical, surgical, diagnostic, therapeutic and preventive services. These services generally and customarily are:

- Provided in the service area
- Performed or ordered by the member's PCP
- Prior authorized by Hometown Health according to the Hometown Health UM/QA protocols, if applicable.

When Hometown Health determines that two (2) or more courses of treatment are substantially equivalent, Hometown Health has the right to substitute less costly services or benefits for those that Hometown Health would otherwise cover under this EOC. This applies regardless of whether Hometown Health otherwise would cover such less costly benefits.

Example: If both inpatient care in a skilled nursing facility and intermittent, part-time nursing care in the home would be medically appropriate, and if inpatient nursing care would be less costly, Hometown Health could limit coverage to the inpatient care. Hometown Health could limit coverage to inpatient care even if this means extending the inpatient benefit beyond the quantity provided in this EOC.

To qualify as a covered service, services must comply with the requirements of this EOC and with the Hometown Health UM/QA protocols. The fact that a participating provider prescribed, ordered, recommended or approved a service or supply does not necessarily make it a covered service or medically necessary.

Coverage for any services ends on the date that Hometown Health terminates the member's eligibility. Coverage ends even if the member has begun to receive a covered service.

A member will be liable for certain copayments to participating providers of service for the services specified in the Summary of Benefits.

# HOMETOWN HEALTH PLAN, INC.

## **PART 7 RELATIONSHIP OF PARTIES**

---

### **A. Independent Contractors**

The relationship of Hometown Health, participating physicians and participating providers is that of an independent contractor relationship. Providers are not agents or employees of Hometown Health, nor is Hometown Health, or any employee of Hometown Health, an employee or agent of the providers. Hometown Health shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the member while receiving care from any provider or in any provider's facilities.

### **B. Provider Relationship with Patient**

Hometown Health is not responsible for and shall not intervene in the provision of medical services by a provider to his or her patient. The traditional relationship between a provider and a patient will be maintained and the provider retains full control of and authority of all medical decisions and recommendations regarding medical treatment. A determination by Hometown Health that a particular course of medical treatment is not a covered service or is inconsistent with Hometown Health Protocols shall not be considered a medical determination. The provider maintains full authority and responsibility for all medical determinations regardless of the availability of coverage for any such medical treatment.

**HOMETOWN HEALTH PLAN, INC.**

**PART 8 BLANK**

---

Part 8 intentionally left blank

# HOMETOWN HEALTH PLAN, INC.

## PART 9 ELIGIBILITY AND ENROLLMENT

---

### A. Eligibility

No person can be refused coverage due to his or her race, color, economic status, creed, marital status, age, gender or national origin.

The employer's eligibility provisions must be fully described within the GSA as of the effective date of the group's current contract. Any subsequent eligibility modification requests will be evaluated and either accepted or denied at Hometown Health's sole discretion.

#### 1. Employee

An employee may enroll as a subscriber in his or her employer's health benefit plan if the employee meets all of the following requirements:

- a. The employee is eligible to participate in his or her employer's health benefit plan as defined by the employer's eligibility provisions
- b. The employee has satisfied any probationary or waiting period as defined by the employer's eligibility provisions
- c. The employee completed and submitted all enrollment forms and other documents as required by Hometown Health

#### 2. Dependents

A subscriber may enroll dependants if the dependent is listed on the enrollment application completed by the subscriber, all other required documents are completed and submitted to Hometown Health, the dependent meets all of the dependent eligibility criteria as defined in the employer's eligibility provisions, and meets one or more of the following requirements:

- a. The dependent is the subscriber's lawful spouse
- b. The dependent is the subscriber's lawful domestic partner and the following requirements are met:
  - i. The group for which the subscriber is an employee has authorized the inclusion of domestic partners as an eligible dependant as defined in the employer's eligibility provisions; and
  - ii. The Nevada Office of the Secretary of State has issued a Domestic Partnership Certificate where both the subscriber and the subscriber's dependent domestic partner are listed as domestic partners; and
  - iii. The Nevada Domestic Partnership Certificate is current and is submitted to Hometown Health as evidence of domestic partnership

## HOMETOWN HEALTH PLAN, INC.

- c. The dependent is an unmarried natural child, stepchild, or legally adopted child of either the subscriber, the subscriber's spouse or the subscriber's domestic partner, provided that the child is under age 19 and a dependent of the subscriber, or who must be provided with coverage due to court order subject to the other eligibility provisions of this EOC

Special provisions for newborn children and newly adopted children:

- i. A newborn natural child falling under this provision will be eligible for coverage effective on the child's date of birth. Coverage for a newborn child will cease after 31 days unless the subscriber submits an enrollment application to Hometown Health within 31 days from the child's birth.
  - ii. A newly adopted child falling under this provision will be eligible for coverage effective on the effective date of the child's adoption and placement of the child in the subscriber's home, subject to certification of the child's placement by the placement agency. Coverage for a newly adopted child will cease after 31 days unless the subscriber submits an enrollment application to Hometown Health within 31 days from the effective date of the child's adoption.
- d. The dependent is an unmarried full-time student and meets all of the following requirements:
    - i. The dependent is under 25 years of age
    - ii. The dependent is financially dependent upon the subscriber
    - iii. The subscriber is able to provide documentation acceptable to Hometown Health that the child is a full time student in a postsecondary educational institution recognized by the United States Department of Education as an accredited institution

Special medical leave of absence provisions for full-time student dependents:

An unmarried full-time student dependent may apply for a medical leave of absence that exempts the dependent from having to attend a postsecondary educational institution for up to one year provided that all of the following requirements are met:

- The dependent's treating physician must provide a written certification to Hometown Health that states the dependent is suffering from a serious illness or injury and the leave of absence is medically necessary.
- Dependents applying for a medical leave of absence must have had coverage under the employer group's health benefit plan on the day immediately prior to the application of the leave of absence.

A medical leave of absence begins on the date of the dependent's injury or the date of the beginning of the dependent's illness.

Any change in the dependent's medical status that results in the medical leave of absence no longer being necessary must be reported to Hometown Health. Failure to report a change could result in loss of coverage for the dependent, at which point the dependent may be eligible for continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

## HOMETOWN HEALTH PLAN, INC.

- e. The dependent is an unmarried disabled child if all of the following requirements are met:
  - i. The dependent child is unable to support themselves and cannot engage in any substantial gainful activity because of a physical or mental condition
  - ii. The dependent child is primarily dependent upon the subscriber for support and maintenance
  - iii. The dependent child was claimed by the subscriber as a dependent on the form for income tax returns which the subscriber filed with the Internal Revenue Service for the previous fiscal year
  - iv. The dependent child's physician provides written certification that the dependent child's condition has lasted at least a year, can be expected to last continuously for at least a year, or could reasonably be considered a terminal illness (Written certification must be provided to Hometown Health before the dependent child is enrolled and each year thereafter prior to the group's renewal date.)
  - v. The dependent child's condition originates before the child reaches the age of 19
- f. The dependent is a grandchild of the subscriber if the following requirements are met:
  - i. The grandchild is born to an unmarried dependent child (dependent parent) covered by the subscriber under this plan; and
  - ii. The grandchild's birth date occurred after the effective date of coverage of the dependent parent; and
  - iii. The dependent parent continues to be covered by the subscriber as an active non-COBRA dependent member; and
  - iv. Both the covered dependent parent and grandchild, prior to and after birth, reside with the subscriber;
- g. The dependent is a legal ward (pursuant to court order) permanently placed in the subscriber's home and meets the other eligibility provisions of this EOC.

Foster children, legal wards not permanently placed in the subscriber's home, children placed in the subscriber's home, emancipated minors under Nevada law, or any other person not defined within this section are not eligible dependents.

### **B. Enrollment**

#### 1. Open enrollment

An eligible employee may be entitled to apply for coverage during his or her employer's open enrollment period provided he or she has satisfied any probationary or waiting period requirements as defined by the employer's eligibility provisions. To apply for coverage an employee must complete a Hometown Health enrollment application and may be required to submit a medical assessment form and other necessary documentation as determined by Hometown Health. Applications may be accepted up to 31 days after the employer's effective date.

## **HOMETOWN HEALTH PLAN, INC.**

An eligible employee may also apply for coverage for qualified family dependents during an open enrollment period by listing the dependents on the employee's enrollment application and may be required to submit a medical assessment form and other necessary documentation as determined by Hometown Health on behalf of the dependent.

Any misrepresentations provided by an employee applying for coverage for himself or herself and or dependent(s) may lead to denial of coverage. If any misrepresentations are discovered after coverage was initially granted, the employee's and his or her dependent's coverage may be retroactively terminated back to their initial enrollment date and the employee may be responsible for any claims submitted for care provided to them.

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

### **2. Newly eligible employees**

A new employee may be eligible to apply for coverage after satisfying any probationary or waiting period as defined by the employer's eligibility provisions. To apply for coverage an employee must complete a Hometown Health enrollment application and may be required to submit a medical assessment form and other necessary documentation as determined by Hometown Health within 31 days after becoming eligible.

A new employee may also apply for coverage for a qualified family dependent at the time the new employee becomes eligible for coverage by listing the dependent on the employee's enrollment application and may be required to submit a medical assessment form and other necessary documentation as determined by Hometown Health on behalf of the dependent.

Any misrepresentations provided by an employee applying for coverage for himself or herself and or dependent(s) may lead to denial of coverage. If any misrepresentations are discovered after coverage was initially granted, the employee's and his or her dependent's coverage may be retroactively terminated back to their initial enrollment date and the employee may be responsible for any claims submitted for care provided to them.

Coverage for newly eligible employees and any dependents meeting the necessary requirements for enrollment will be effective on the employee's initial effective date.

Newly eligible employees that did not complete and submit a Hometown Health enrollment application and any other necessary documentation as determined by Hometown Health within 31 days after becoming effective will not be allowed to enroll until the employer's next open enrollment period.

### **3. Special enrollment**

A subscriber may also be eligible to apply for coverage for a dependent if a qualifying life event as defined within this EOC allows the subscriber to apply for coverage. To apply for coverage a subscriber must complete a Hometown Health enrollment application and may be required to submit a medical assessment form and other necessary documentation as determined by Hometown Health within 31 days after the qualifying life event.

## HOMETOWN HEALTH PLAN, INC.

Coverage for dependents meeting the necessary requirements for special enrollment will be effective on either the date of the qualifying life event or the first of the month in which the qualifying life event occurred as defined by the employer's eligibility provisions. Dependents for which the subscriber did not complete and submit a Hometown Health enrollment application and any other necessary documentation as determined by Hometown Health within 31 days after the qualifying life event will not be allowed to enroll until the employer's next open enrollment period.

#### 4. Notice of ineligibility

It is the subscriber's responsibility to notify his or her employer and Hometown Health of any changes that can or will affect the subscriber's eligibility or that of his or her dependents. Failure to notify Hometown Health of any changes affecting the eligibility of the subscriber or his or her dependents may lead to retroactive termination of coverage back to the date for which the event took place that caused the subscriber or his or her dependents to be ineligible for coverage and the subscriber may be responsible for any claims submitted for care provided to them from the event date forward.

Provisions for eligibility and ineligibility may also be defined within the employer's eligibility provisions or a benefit plan document. Subscribers are encouraged to ask their employer for a complete description of additional eligibility requirements that his or her employer may require.

#### 5. Documentation requirements

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

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

- a. Hometown Health medical assessment form
- b. Notice of Creditable Coverage
- c. Student Status Verification Form
- d. Coordination of Benefits Form
- e. Birth Certificate
- f. Marriage Certificate
- g. Domestic Partnership Certificate
- h. Court order
- i. Proof of the subscriber's legal right to work in the U.S.
- j. Valid Social Security Number

Requested forms or documents must be provided to Hometown Health by the subscriber no later than 30 days after the subscriber is requested to provide them. Failure to provide any requested forms or documents may result in the termination of coverage for the subscriber or his or her dependents.

# HOMETOWN HEALTH PLAN, INC.

## PART 10 TERMINATION OF COVERAGE

---

### A. Equality

A member's coverage can not be denied or terminated due to his or her age, health status, economic status, health care needs, or prospective health care costs.

### B. Termination for Cause

A member's coverage can be denied or terminated if there is any evidence of the following actions:

1. A subscriber materially misstates information about himself or herself on his or her enrollment application or any other document provided during the coverage application process, or
2. A subscriber materially misstates information about his or her dependent on his or her enrollment application or any other document provided during the coverage application process, or
3. A member knowingly allows someone else to use their identity for the purpose of seeking medical care under the member's hometown health policy, or
4. A member knowingly engages in an activity to defraud hometown health or any organization that hometown health has engaged to provide services under its policies, or
5. An employer erroneously or purposefully allows a member to enroll without meeting the eligibility requirements as defined in the GSA.

Termination of a member's coverage may be retroactively applied, and in some cases the member's coverage may be retroactively terminated back to the member's initial enrollment date. The subscriber and or the member will be responsible for the claims submitted for care provided to the member after the termination date.

Coverage for members terminated for cause as a result of the member's fraudulent actions will not be eligible for reenrollment.

Hometown Health has sole discretion to determine the materiality and intent of a member's actions and to apply any and all legal remedies.

### C. Cancellation

1. If a grandchild is covered as a dependent of a dependent and the grandchild's parent's coverage terminates for any reason, the grandchild's coverage will also terminate at that time.
2. If the group falls below two (2) eligible employees, a sixty-day (60) written termination notice will be given.
3. If the GSA is canceled or terminated, a member's coverage under this policy shall also be canceled on the effective date of the GSA's termination.
4. If any required payment on behalf of a member is not received by the premium due date and payment is not made and accepted within the grace period, all rights of such member will terminate. Hometown health shall not be liable for any health care services incurred

## **HOMETOWN HEALTH PLAN, INC.**

by any member, jointly and severally, for all services provided or arranged for members by hometown health during the grace period and thereafter.

5. Subject to the provisions outlined under the individual conversion privilege and transfer section, the coverage of any member who ceases to be eligible shall terminate on the last day of the month on which eligibility ceased or on the date of event as determined by the GSA. This provision also applies to dependents of a subscriber who has lost his or her eligibility as a member of the group, for whatever reason, including the death of the subscriber.

### **D. Refunds**

If the coverage of a member is terminated, premiums received on account of the terminated member applicable to periods after the effective date of termination shall be refunded within 30 days, less any medical costs incurred by Hometown Health for that period. Neither Hometown Health nor providers shall have any further liability to such member. Any claims for refunds must be made within 90 days from the effective date of termination of the member's coverage or otherwise right to such refunds shall be deemed waived.

# HOMETOWN HEALTH PLAN, INC.

## **PART 11 INDIVIDUAL CONVERSION PRIVILEGE AND TRANSFER**

---

This section outlines under what conditions coverage can be converted to a non-group plan.

### **A. Who May Obtain Conversion Coverage**

You have the right to convert to the non-group conversion program available from Hometown Health at the time of application, without furnishing a medical assessment form if:

- You are a subscriber or an enrolled dependent leaving an employer group with a federally qualified plan and would otherwise no longer be eligible for membership in Hometown Health; and
- You have been enrolled under this plan or a preceding plan that Hometown Health has replaced, for three (3) consecutive months

The provision above also applies if you have continuation of coverage from a federally qualified plan under federal or Nevada law and that coverage is ending.

Conversion rights are subject to all terms and conditions that Hometown Health has in effect on the date of your application for conversion coverage. A member must apply for conversion in writing and pay any applicable premiums within 31 days of the date of ineligibility for coverage herein. Hometown Health will provide further details of the conversion coverage if you submit a request in writing. Individual conversion plans are available only to members of Hometown Health who were enrolled in a federally qualified plan.

### **B. Who May Not Obtain Conversion Coverage**

A member is not eligible to convert to a non-group plan if:

1. The member is eligible for other health coverage within 31 days of termination.
2. The member is eligible for Medicare.
3. The GSA is discontinued in its entirety or with respect to an insured class.
4. The group replaced this plan with another insured or self-insured health care program within 31 days after termination of the GSA.
5. The member would be considered over-insured.

### **C. Overinsurance**

A person is considered over-insured if:

1. Such person's insurance under this plan is replaced by similar group coverage within 31 days of termination.

## **HOMETOWN HEALTH PLAN, INC.**

2. The benefits under the conversion policy, combined with similar benefits, result in excess insurance based on hometown health's underwriting standards for individual policies. Similar benefits are:
  - a. Those for which the person is covered by another hospital, surgical or medical expense insurance policy, a hospital or medical service subscriber contract, a medical practice or other prepayment plan;
  - b. Those for which the person is eligible, whether or not covered, under any other plan or program; and
  - c. Those available for the person by or through any local, State or Federal law.

# HOMETOWN HEALTH PLAN, INC.

## PART 12 CONTINUATION OF COVERAGE

---

### A. Federal Continuation of Coverage

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

A member must be allowed to continue with the same medical insurance that was in force at the time of a qualifying event. All policy provisions applicable to the medical insurance elected still apply under continuation.

The member must elect continuation during an election period and pay the required premium. The member's medical insurance must have ended due to one of the following qualifying events:

- Death of subscriber
- Termination of subscriber's employment for reasons other than gross misconduct
- Reduction of subscriber's working hours resulting in loss of coverage
- Divorce or legal separation of subscriber from subscriber's spouse
- Eligibility of subscriber for Medicare
- Loss of a child's dependent status under requirements of the plan

#### 1. Notice of Continuation of Coverage

- a. The group must provide written notice, at the time coverage commences under this plan, to each subscriber and spouse of subscriber of their right and their dependent children's right to elect continuation of coverage when eligible.
- b. The group must provide written notice of continuation of coverage to the plan administrator (if the plan administrator is not the group) within 31 days from the date of subscriber's:
  - i. Death; or
  - ii. Termination of employment; or
  - iii. Reduction of work hours resulting in loss of coverage; or
  - iv. Eligibility for Medicare benefits.
- c. The member must provide notice to the group (or the plan administrator if different from the group) of the following:
  - i. Member's divorce or legal separation; or
  - ii. Member's loss of eligibility as a dependent child under this plan because of age or marriage.

## HOMETOWN HEALTH PLAN, INC.

- d. The group (itself or by its plan administrator) must provide notice of continuation of coverage to the member within 14 days of the date of receipt of notice of any qualifying event.
- e. The member must provide notice to the group (or plan administrator if different from the group) of the member's intention to elect continuation of coverage within 60 days from the date of notice.
- f. In order for a member to be entitled to continuation of coverage, the group must provide notice of that member's election of continuation of coverage to Hometown Health together with payment of appropriate premiums within 45 days following, but in no event later than the end of a period of 150 days after the occurrence of a qualifying event.
- g. The group must provide notice to the member, within 180 days before termination of this continuation of Coverage, of the member's right to elect conversion coverage provided under this plan.
- h. In no event will Hometown Health be the plan administrator. The term "Plan Administrator" refers to a person or entity, other than Hometown Health, engaged by the group to perform or assist the group in performing, administrative tasks in connection with the group's health plan(s). In providing notices and otherwise performing under these provisions for continuation of coverage, the group is not acting as the agent of Hometown Health; but rather, the group is fulfilling statutory obligations imposed on it by Federal Law and where applicable, acting as the agent of the member.

### 2. Payment of Premiums

The group is responsible to Hometown Health for the timely payment of premiums due on or before the first day of each month for the continuation of any member's coverage under this plan. Hometown Health is allowed to charge 102 percent of the applicable premium during the COBRA period.

### 3. Commencement of Continuation of Coverage

#### a. Subscriber

If Hometown Health receives from the group (within COBRA guidelines) notice of an election of continuation of coverage, together with timely payment of appropriate premiums, a continuation of coverage period not to exceed 18 months for subscriber and/or family dependents for whom continuation of coverage is elected by the subscriber, and who are enrolled under this plan at the time of the qualifying event, will commence upon:

- i. Reduction in subscriber's working hours resulting in loss of coverage; or
- ii. Subscriber's termination from employment for reasons other than gross misconduct.

#### b. Spouse

If Hometown Health receives from the group (within COBRA guidelines) notice of an election of continuation of coverage, together with timely payment of appropriate

## HOMETOWN HEALTH PLAN, INC.

premiums, a Continuation Coverage period not to exceed 36 months (Shorter periods may apply in certain situations, the qualifying event will determine the length of possible continued coverage) for a spouse for whom continuation of coverage is elected and who was enrolled under this plan at the time the qualifying event, will commence upon:

- i. The death of subscriber, or
  - ii. Notice of legal separation, final decree of divorce, annulment or dissolution of marriage between subscriber and enrolled spouse; or
  - iii. Subscriber's eligibility and coverage by Medicare.
- c. Dependent Children

If Hometown Health receives from the group (within COBRA guidelines) notice of an election of continuation of coverage, together with timely payment of appropriate premiums, a Continuation Coverage period not to exceed 36 months (Shorter periods may apply in certain situations, the qualifying event will determine the length of possible continued coverage) for dependent children enrolled under this plan at the time the qualifying event, will commence upon:

- i. Loss of eligibility because of age or marriage; or
- ii. Any one of the conditions listed above (except when children of a divorced or legally separated spouse of a subscriber remain enrolled as family members of that subscriber).

#### 4. Termination of Continuation of Coverage

##### a. Subscriber

Continuation of coverage which commenced under Commencement of Continuation of Coverage above, for a subscriber will terminate when the first of the following events occurs:

- i. A period of 18 months has elapsed; or
- ii. This plan between the group and Hometown Health is canceled; or
- iii. The required premiums for the next period are not paid; or
- iv. The subscriber becomes eligible for Medicare; or
- v. The subscriber becomes covered under any other group health plan (except when the member's new group health plan restricts coverage for a pre-existing condition limitation, then continuation of coverage may continue until the pre-existing condition limitation is satisfied or until another cause for termination of continuation of coverage occurs. The continuation of coverage plan [this EOC] will be secondary in coverage to the member's new group health policy); or
- vi. Hometown Health receives written notice of the subscriber's voluntary cancellation of coverage.

## HOMETOWN HEALTH PLAN, INC.

### b. Spouse and Dependent Children

Continuation of coverage that commenced under Commencement of Continuation of Coverage above, will terminate for the spouse and dependent children when the first of the following events occurs:

- i. A period of 36 months has elapsed; or
- ii. This plan between the group and Hometown Health is canceled; or
- iii. The required premiums for the next period are not paid; or
- iv. The member becomes covered under any other group health plan (except when the member's new group health plan restricts coverage for a pre-existing condition limitation, then continuation of coverage may continue until the pre-existing condition limitation is satisfied or until another cause for termination of continuation of coverage occurs. The continuation of coverage plan [this EOC] will be secondary in coverage to the member's new group health policy); or
- v. Hometown Health receives written notice of the member's voluntary cancellation of coverage.

### 5. Other Provisions Applicable To Continuation of Coverage

- a. A child born during the period the subscriber is receiving continuation of coverage is covered for the first 31 days of life for care of illness and injury. To continue coverage, a newborn must be enrolled as a family dependent within 31 days. Continuation of coverage of the child ends when the parent's continuation of coverage ends.
- b. For the purpose of determining the proper premiums for continuation of coverage:
  - i. A spouse whose continuation of coverage commences under Commencement of Continuation of Coverage above will be considered a subscriber, and
  - ii. A child whose continuation of coverage commences under Commencement of Continuation of Coverage above will be considered a subscriber, and
- c. If a member is covered under another carrier's continuation of coverage when the group changes coverage to Hometown Health, the term of continuation of coverage provided that member by Hometown Health will be reduced by the period coverage was continued under the prior carrier's plan.

### 6. Extension under internal revenue code, due to disability

Section 6707 provides that in case of a member who is determined under Title II (OASDI) or Title XVI (SSI) of the Social Security Act to have been disabled at the time of the qualifying event of termination of employment or reduction in hours of employment, the member is entitled to 29 (as opposed to 18) months of continuation of coverage under COBRA, but only if the member provided notice of such determination before the end of the 18 months. Extended continuation of coverage can be terminated in the month that begins more than 31 days after the date of the final determination, under Title II or Title XVI of the Social Security Act, that the member is no longer disabled.

## **HOMETOWN HEALTH PLAN, INC.**

### **a. Increased Premium**

Hometown Health is allowed to charge 150 percent of the applicable premium for the additional 11 months of coverage provided to disabled members under this section.

### **b. Notification**

Each member who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of a qualifying event (termination of employment or reduction in hours of employment) is responsible for notifying the plan administrator of such determination within 60 days after the date of the determination and for notifying the plan administrator within 30 days of the date of the date of the final determination that the member is no longer disabled.

## **B. Nevada Continuation of Coverage**

Employers who employ less than 20 employees and provide health care coverage for their employees are subject to comply with the continuation of coverage. To qualify under this legislation, the member must have been covered by the employer's group health plan for at least 12 consecutive months before any of the qualifying events.

### **1. Continuation of Coverage**

Qualifying events for continuation of coverage under the plan are:

#### **a. Eligible Employee**

- i. Non-voluntary termination of employment for any reason other than gross misconduct; or
- ii. Reduction in working hours resulting in loss of coverage.

#### **b. Family Dependents**

- i. Eligible employee's non-voluntary termination for any reason other than gross conduct; or
- ii. Reduction in working hours of the eligible employee; or
- iii. Death of the eligible employee; or
- iv. Divorce or legal separation of the eligible employee and spouse; or
- v. Eligibility of eligible employee for Medicare benefits; or
- vi. Loss of child's dependent status under requirements of the plan.

### **2. Notice of Continuation of Coverage**

- a. An eligible employee, spouse, or dependent child must notify the employer that he or she is eligible to continue coverage within 60 days after he or she becomes eligible.
- b. The employer shall provide written notice to the eligible employee, spouse or dependent child within 14 days after receipt of his or her notification regarding the election to continue coverage and the premium required to be paid.

## HOMETOWN HEALTH PLAN, INC.

- c. The eligible employee, spouse or dependent child must notify the insurer of his election to continue coverage within 60 days after receipt of the information provided by the employer above, and pay the required premium to the employer.

### 3. Commencement of Continuation of Coverage

If Hometown Health receives from the group, timely notice of an election of continuation of coverage, together with timely payment of appropriate premiums, a continuation of coverage period not to exceed 18 months for eligible employee and 36 months (Shorter periods may apply in certain situations, the qualifying event will determine the length of possible continued coverage) for spouse and any dependent children for whom continuation of coverage is elected will commence upon:

- a. Eligible employee's non-voluntary termination from employment; or
- b. Reduction in eligible employee's working hours resulting in loss of coverage; or
- c. Death of the eligible employee; or
- d. Notice of legal separation, final divorce decree, annulment or dissolution of marriage between the eligible employee and enrolled spouse; or
- e. Eligible employee's eligibility for Medicare benefits; or
- f. Dependent child's loss of eligibility because of age or marriage.

### 4. Termination of coverage

Continuation of coverage for a subscriber and/or any family members of that subscriber will terminate when the first of the following events occurs:

- a. A period of 18 months has elapsed for the employee or a period of 36 months has elapsed for dependents; or
- b. This plan between group and Hometown Health is canceled; or
- c. The required premiums for the next period are not paid; or
- d. The eligible employee, spouse or dependent child becomes covered under any other policy or group health insurance or Medicare; or
- e. The eligible employee or spouse qualifies for Medicare; or
- f. Hometown Health receives written notice of the member's voluntary cancellation of coverage; or
- g. The spouse remarries and becomes eligible for coverage under his or her new spouse's policy of group insurance.

## **HOMETOWN HEALTH PLAN, INC.**

5. Other provisions applicable to continuation of coverage
  - a. Newborns are covered for the first 31 days of life for care of illness or injury.
  - b. To continue coverage, a newborn must be enrolled as a family member within 31 days. Continuation of coverage of the child ends when the parent's continuation of coverage ends.
  - c. For the purpose of determining the proper premiums for continuation of coverage:
    - i. A spouse whose continuation of coverage starts under Nevada Continuation of Coverage, will be considered a subscriber.
    - ii. A child whose continuation of coverage starts under Nevada Continuation of Coverage will be considered a subscriber.

### **C. Employer Approved Leave of Absence**

Under the Federal Family And Medical Leave Act Of 1993 (FMLA), any employer with 50 or more employees must grant unpaid family care leave to any eligible employee who has at least 12 months continuous service with the employer and 1250 hours of service during the previous year, for any of the following qualifying events:

1. The Birth or Adoption of A Child, By the Eligible Employee (Including Placement of A Child with an Eligible Employee for Foster Care); or
2. Care for an eligible employee's son or daughter who has a serious health condition; or
3. Care of an eligible employee's spouse or parent who has serious health conditions; or
4. A serious health condition that makes the eligible employee unable to perform the function of his or her position.

The following definitions apply to the Federal Family and Medical Leave Act of 1993.

- Parent - a biological parent or an individual whom stood in loco parentis to a child when the child was a son or daughter
- Serious health condition - an illness, impairment or physical condition that involves inpatient care in a hospital, hospice or residential medical care facility of continuing treatment or continuing supervision by a health care provider
- Son or daughter - a biological, adopted or foster child, a stepchild, a legal ward (pursuant to court order), or a child of a person standing "in loco parentis," who is under 18 years of age or 18 years of age and older and is not capable of self-care due to mental or physical disability
- Spouse - a husband or wife

In addition to the above provisions, this EOC allows for an employer approved leave-of-absence in case of the death of a spouse, son or daughter or parent. This approved leave-of-absence may be paid or unpaid.

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

## **HOMETOWN HEALTH PLAN, INC.**

The coverage required continues until one of the following occurs:

5. The date on which the employment of the employee is terminated; or
6. The date on which the employee obtains another policy of health insurance; or
7. The date on which this policy of group insurance is terminated; or
8. After a total of 12 weeks (consecutive or non-consecutive) during a 12 month period in which benefits would normally be provided to the eligible employee.

### **D. Total Disability Under Nevada State Law**

As used in this part, “Total Disability” and “Totally Disabled” means the continuing inability of the member, because of an injury or illness, to perform substantially the duties related to his or her employment for which he or she is otherwise qualified.

This policy provides continuing coverage for an employee who is otherwise covered by the policy while the employee is on leave without pay as a result of total disability. This coverage is only for an injury or illness suffered by the employee, which is not related to the total disability or for any injury or illness suffered by his or her dependent(s).

The coverage required continues until one of the following occurs:

1. The date on which the employment of the employee is terminated; or
2. The date on which the employee obtains another policy of health insurance; or
3. The date on which this policy is terminated; or
4. After a total of 12 months in which benefits under such coverage are provided to the employee.

# HOMETOWN HEALTH PLAN, INC.

## **PART 13 DOUBLE COVERAGE**

---

### **A. Workers' Compensation**

The benefits herein are not designed to duplicate any benefit to which such members are eligible under Workers' Compensation. It is also understood that coverage herein is not in lieu of, and shall not affect any requirements for coverage under Workers' Compensation.

### **B. Medicare**

Except as otherwise provided by applicable Federal Law, the benefits under this EOC for members otherwise covered by Medicare, do not duplicate any benefit to which such members are eligible under the Medicare Act, including Part B of such Act, except Medicare copayments/coinsurances and deductibles.

## **HOMETOWN HEALTH PLAN, INC.**

### **PART 14 SUBROGATION / RIGHT TO REIMBURSEMENT**

---

Immediately upon paying or providing any benefit under this plan, Hometown Health shall be subrogated to all rights and recovery a member has against any party potentially responsible for making any payment to a member due to a member's injuries or illness. Hometown Health shall have the right to recover the reasonable value of services and benefits provided or to be provided by Hometown Health.

In addition, if a member receives any payment from any potentially responsible party as a result of an injury or illness, Hometown Health has the right to recover from, and be reimbursed by, the member for the reasonable value of services and benefits provided as a result of the injury or illness, up to and including the full amount the member receives from all potentially responsible parties. A "member" includes, for the purposes of this provision, anyone on whose behalf Hometown Health pays or provides any benefit including, but not limited to, the minor child, or dependent of any plan member or person entitled to receive any benefits from the plan.

Hometown Health will automatically have a lien upon all funds subject to its subrogation or reimbursement interest. The lien will be in an amount equivalent to the reasonable value of services and benefits provided.

As used throughout this provision, the term "Responsible Party" means any party potentially responsible for making any payment to a member due to a member's injuries or illness or any insurance coverage.

The member shall do nothing to prejudice Hometown Health's Subrogation and Reimbursement rights and shall, when requested, fully cooperate with Hometown Health's efforts to recover its benefits. It is the duty of the member to notify Hometown Health within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the member. Upon any recovery by the member, the member agrees that any funds received by the member and/or their attorney, if any, from any source for any purpose shall be held in trust until the member's obligation under this provision is fully satisfied.

Except to the extent a statutory lien takes priority, the member acknowledges that Hometown Health's Subrogation and Reimbursement rights are a first priority claim against all potential responsible parties and are to be paid to Hometown Health before any other claims for the member's damages. Hometown Health shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to Hometown Health will result in a recovery to the covered person which is insufficient to make the covered person whole or to compensate the member in part or in whole for the damages sustained. It is further agreed that Hometown Health is not required to participate in or pay attorney fees to the attorney hired by the member to pursue the member's damage claim.

The terms of this entire Subrogation and Reimbursement provision shall apply and Hometown Health is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement of judgment received by the member identifies the medical benefits Hometown Health provided. The plan is entitled to recover from any and all settlements or judgments, any recovery will be deemed as compensation for medical expenses, even those designated as "pain and suffering" or "non-economic damages" only.

## **HOMETOWN HEALTH PLAN, INC.**

In the event any claim is made that any part of this Subrogation and Reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the member and this plan agree that Hometown Health shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

# HOMETOWN HEALTH PLAN, INC.

## PART 15 COORDINATION OF BENEFITS

---

This section explains how other health benefit plans and/or insurance the member may have affect the member's coverage under this EOC.

### A. The Purpose of COB

Many people have health coverage provided by more than one plan at the same time. Each plan has rules for COB if there is double coverage to prevent the total amount of all their benefit payments from exceeding the allowable cost of the covered services. This COB provision helps to contain the cost of health care coverage.

### B. Benefits Subject to COB

All the health benefits provided in this EOC are subject to this section. The member agrees to permit Hometown Health to coordinate its obligations under this EOC with payments under any other group health insurance plan that covers the member. All provisions of this EOC, including but not limited to the use of participating providers and prior-authorization requirements apply whether Hometown Health is primary or secondary.

### C. Definitions

Some of the words used in this section have a special meaning to meet the needs of this section. These words and their meanings when used are:

1. **Plan** - an entity providing group health care benefits or services by any of the following methods:
  - Group insurance or any other arrangement for coverage for individuals whether on an insured or uninsured basis; or
  - Group service plan contracts, group practice, individual practice and other prepayment coverage; or
  - Any group coverage for students which is group sponsored by or provided through school or other educational institutions, other than accident coverage for grammar school or high school students for which the parent pays the entire premium; or
  - Any coverage under labor management trustee plans, union welfare plans, employer organization plans, employee benefits plans, or employee benefit organization plans; or
  - Any group automobile third party insurance required under any law of a state, but only to the extent of benefits required under such third-party no fault law and only to the extent coordination of benefits is permitted under such third-party no fault law; or
  - Coverage under a governmental program, including Medicare and Worker's Compensation plans.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

## HOMETOWN HEALTH PLAN, INC.

2. **Allowable Expense** - the eligible medical expense for medically necessary covered services

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be an allowable expense and a benefit paid.

3. **Primary Plan** - a plan which, in accordance with the rules regarding the order of benefits determination, provides benefits or benefit payments without considering any other plan.
4. **Secondary Plan** - a plan which, in accordance with the rules regarding the order of benefit determination, may reduce benefits or benefit payments and/or recover from the primary plan benefit payments

### D. When COB Applies

COB applies when a member covered under this EOC is also entitled to receive payment for, or provision of, some or all of the same covered services from another plan.

### E. Determination Rules

The rules establishing the order of benefit determination are:

1. Non-dependent/Dependent - The benefits of the plan which covers the person as a subscriber are primary to those of the plan which covers the person as a dependent;
2. Dependent Child/Parents Not Separated or Divorced - When this plan and another plan cover the same child as a dependent of different persons, called "parents":
  - a. The plan of the parent whose birthday falls earlier in the calendar year is primary to the plan of the parent whose birthday falls later in the year;
  - b. If both parents have the same birthday, the benefits of the policy, which covers a parent longer, is the primary policy.
3. Dependent Children/Separated or Divorced Parents - If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - a. First, the plan of the parent with custody of the child;
  - b. Then, the plan of the spouse (stepparent) of the parent with custody of the child;
  - c. Finally, the plan of the parent not having custody of the child;

NOTE: Referring to 1, 2 and 3 above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

## HOMETOWN HEALTH PLAN, INC.

4. **Active/Inactive Employee** - A plan which covers a person who is neither laid off nor retired (or that eligible employee's dependents) is primary to a plan that covers that person as a laid off or retired eligible employee (or that eligible employee's dependents). If the other plan does not have this rule, and if, as a result, the plans do not agree about the benefits, this rule is ignored;

**Longer/Shorter Length of Coverage** – When none of the above applies, the plan in effect for the longest continuous period of time pays first. (The start of a new plan does not include a change in the amount or scope of the plan's coverage, a change in the entity that pays, providers, or administers the plan's coverage, or a change from one type of plan to another).

5. **No COB Provision** - If another plan does not contain a provision coordinating its benefits with those of this plan, then the benefits of such other plan shall be determined before the benefits of this plan.

### F. How COB Works

Plans use COB to decide which health care coverage programs should be the primary plan for the covered service. If the primary plan payment is less than the charge for the covered service, then the secondary plan will apply its allowable expense to the unpaid balance. The member must first file a claim with the primary plan to receive any benefits from the secondary plan.

### G. Right to Receive and Release Information

In order to decide if this COB section (or any other plan's COB section) applies to a claim, Hometown Health (without the consent of or notice to any person) has the right to:

1. Release to any person, insurance company or organization, the necessary claim information;
2. Receive from any person, insurance company or organization, the necessary claim information;
3. Require any person claiming benefits under this policy to give Hometown Health any information needed by Hometown Health to coordinate those benefits.

### H. Right to Recover Payment

If the amount of benefit payment exceeds the amount needed to satisfy Hometown Health's obligation under this Part, Hometown Health has the right to recover the excess amount from one or more of the following:

1. Any persons to or for whom such payments were made;
2. Any group insurance companies or service plans;
3. Any other organizations.

# HOMETOWN HEALTH PLAN, INC.

## PART 16 MEDICARE COORDINATION OF BENEFITS

---

This Medicare COB Rule applies when the member:

- Has health insurance under this policy; and
- Is eligible for insurance under Medicare, Parts A and B,

This Medicare COB Rule applies before any other COB provision of the policy.

### A. Definitions

Some of the words used in this section have a special meaning to meet the needs of this section. These words and their meanings when used are:

**ADEA Employer** - an Employer which:

- Is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
- Has 20 or more employees every working day, in 20 or more calendar weeks, during the current or preceding calendar year.

**Age 65 (as used in this rule)** - is at the age attained at 12:01 a.m. on the first day of the month in which the member's 65th birthday occurs.

**Medicare Benefits** - benefits for services and supplies which the member receives or is eligible for under Medicare, Parts A or B.

### B. Effect on Benefits

If, according to the rules for determining of benefits:

1. Hometown Health has primary responsibility for the member's claims, and then Hometown Health pays benefits first.
2. Hometown Health has secondary responsibility for the member's claims:
  - a. First, Medicare benefits are determined or paid; and
  - b. Then, Hometown Health benefits are paid;

Note, for services payable under both plans, the combined Hometown Health benefits and Medicare benefits will not exceed 100% of the expense incurred.

### C. Rules for Determining Order of Benefits

1. For the Subscriber or the Eligible Employee - If all the following apply, then Hometown Health has primary responsibility for claims.
  - a. The subscriber is age 65 or older; and
  - b. The subscriber is eligible for Medicare, Parts A and B, solely because of age; and
  - c. The subscriber is actively employed by an ADEA employer, which pays all or part of the premium.

If the subscriber is not actively employed by an ADEA employer, which pays all or part of the premium, and when the subscriber is eligible for Medicare, Parts A and B, because of age, Hometown Health has secondary responsibility.

## **HOMETOWN HEALTH PLAN, INC.**

2. For A Dependent Spouse - If all of the following apply, Hometown Health has primary responsibility for a dependent spouse's claims:
  - a. The spouse is age 65 or older; and
  - b. The spouse is eligible for Medicare, Parts A and B, solely because of age; and
  - c. The spouse is actively employed by an ADEA employer, which pays all or part of the premium.

If the subscriber is not actively employed by and ADEA employer which pays all or part of the premium, and when the dependent spouse is eligible for Medicare, Parts A and B, because of age, Hometown Health has secondary responsibility.

3. For a Disabled Person - Hometown Health has primary responsibility for the claims of a member:
  - a. Who is eligible for primary Medicare Benefits because he or she is disabled; even if he or she is also eligible for Medicare, Parts A and B, because of age; and
  - b. Whose employer normally employed 100 or more employees on a typical business day during the previous calendar year;
4. For an Insured Person with End-Stage Renal Disease (ESRD) - Hometown Health has primary responsibility for the claims of a member:
  - a. Who is eligible for Medicare Benefits because of end-stage renal disease; even if he or she is also eligible for Medicare, Parts A and B, because of age; and
  - b. Who is in the Waiting Period (up to 3 months) prior to the coordination period or in the coordination period itself;
5. Hometown Health has secondary responsibility - For the claims of a member who is eligible for secondary Medicare benefits solely because of end-stage renal disease after the coordination period has ended.

### **D. Beginning of Coordination Periods**

1. For members who started a course of maintenance dialysis or who received a kidney transplant before 1989, the coordination period begins with the earlier of:
  - a. The first month of dialysis; or
  - b. In the case of a member who received a kidney transplant, the first month in which the member became entitled to Medicare or, if earlier, the first month for which the individual would have been entitled to Medicare benefits if he or she had filed an application for such benefits.
2. For members other than those specified in Paragraph 1 above, the coordination period begins with the earlier of the first month of entitlement to, or Eligibility for, Medicare Part A, based solely on ESRD.

### **E. End of Coordination Periods**

1. For individuals who started a course of maintenance dialysis or who received a kidney transplant before December 1989, the coordination period ends with the earlier of the end of the 12th month of dialysis or the end of the 12th month of a transplant. The 12th

## HOMETOWN HEALTH PLAN, INC.

month of dialysis may be any time from the 9th month through the 12th month of Medicare entitlement, depending on the extent to which the member was subject to a Waiting Period before becoming entitled to Medicare.

2. The coordination period for the following individuals ends with the earlier of the 12th month of entitlement to or eligibility for Medicare Part A:
  - a. Members, other than those who began dialysis or who received a kidney transplant prior to December 1989, who become entitled to, or eligible for, Medicare Part A solely on the basis of ESRD during December 1989 and January 1990.
  - b. Members who become entitled to or eligible for, Medicare Part A solely on basis of ESRD after January 1995.
3. The coordination period ends with the earlier of the end of the 18th month of eligibility for or entitlement to Medicare Part A, for individuals who become entitled to, or eligible for Medicare Part A solely on the basis of ESRD from February 1990 through July 1994.
4. The coordination period ends January 1, 1996 for members who become entitled to, or eligible for, Medicare Part A solely on the basis of ESRD from August 1994 through January 1, 1995.
5. The coordination period ends with the earlier of the end of the 30th month of eligibility for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who had not completed an 18-month coordination period by July 31, 1997 will have a 30-month coordination period.

# HOMETOWN HEALTH PLAN, INC.

## PART 17 MEMBER APPEAL PROCEDURE

---

Concerns about medical services are best handled at the medical service site level before being brought to Hometown Health. If a member contacts Hometown Health regarding an issue related to the medical service site and has not attempted to work with the site staff, the member may be directed to that site to try to solve the problem there.

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

### A. Definitions

1. **Informal Appeal**- An appeal, which is, directed to the Hometown Health Customer Services Department via phone or in person. If an Informal Appeal is resolved to the satisfaction of the member, the matter ends. The Informal Appeal is a voluntary level of appeal.
2. **1st Level Formal Appeal** - An appeal filed in writing which the Customer Services Department investigates. If a 1st Level Formal Appeal is resolved to the satisfaction of the member, the matter ends.
3. **2nd Level Formal Appeal**- If a 1st Level Formal Appeal is not resolved to the member's satisfaction, a member may then file a 2nd Level Formal Appeal. A 2nd Level Formal Appeal is submitted in writing on a Hometown Health Request for Formal Hearing form and reviewed by the Grievance Committee. The 2nd Level Formal Appeal is voluntary for Urgent Care Claim appeals.
4. **Grievance Committee** - A committee of three or more persons, the majority of which must be members of Hometown Health, chaired by the Vice President of Insurance Services, or his or her designee, and comprised of such other persons as the chairperson deems appropriate.

### B. Procedures

#### 1. Informal Appeal

A member who questions the manner in which a Claim for Benefits is decided may file an Informal Appeal. All Informal Appeals must be made to the Customer Services Department within 60 days of the Adverse Benefit Determination. Informal Appeals not filed in a timely manner will be deemed waived. The Informal Appeal is a voluntary level of appeal.

Upon the initiation of an Informal Appeal, Customer Services will record at least the following information:

- Name of person on whose behalf the appeal is filed (Complainant)
- Complainant's name and Hometown Health membership number
- Name of person(s) involved
- Date(s) of occurrence
- Location

## **HOMETOWN HEALTH PLAN, INC.**

- Nature of appeal
- Name of person filing the appeal

The Customer Services representative will inform the member of the resolution or proposed resolution of the appeal within 20 working days, unless more time is required for fact-finding. If the proposed resolution to the Informal Appeal is not acceptable to the member, the member may file a 1st Level Formal Appeal.

### **2. 1st Level Formal Appeal**

When an Informal Appeal is not resolved in a manner that is satisfactory to the member or when the member chooses not to file an Informal Appeal, the member may file a 1st Level Formal Appeal. The 1st Level Formal Appeal must be submitted in writing to the Customer Services Department within 180 days after the member has been informed of the resolution of the Informal Appeal or within 180 days of the Adverse Benefit Determination if the 1st Level Formal Appeal is the member's initial appeal. There is an exception to the 180 day filing timeframe; if the member is able to demonstrate that he/she was incapacitated and unable to file an appeal within the standard timeframe, a reasonable extension will be granted. 1st Level Formal Appeals not filed in a timely manner will be deemed waived with respect to the Adverse Benefit determination to which they relate. The Formal Appeal shall contain, at least:

- Member's name (or name of Member and Member's Authorized Representative), address, and telephone number;
- Member's Hometown Health membership number and group name; and
- A brief statement of the nature of the matter, the reason(s) for the appeal, and why the member feels that the Adverse Benefit Determination was wrong.

Additionally, the member may submit any supporting medical records, physicians' letters, or other information that explains why Hometown Health should cover the Claim for Benefits.

Hometown Health will investigate the Appeal. When the investigation is complete, the member will be informed, in writing, of the resolution within 15 days of receipt of the 1st Level Formal Appeal for an appeal regarding a denied authorization (pre-service) and within 20 working days of receipt of the 1st Level Formal Appeal for an appeal regarding a denied claim (post-service). Limited extensions may be required if additional information is required.

If the proposed resolution to the 1st Level Formal Appeal is not acceptable to the member, the member is entitled to file a 2nd Level Formal Appeal. The member will be informed of this right at the time the member is informed of the resolution of his/her 1st Level Formal Appeal.

A member may receive, free of charge, reasonable access to, and copies of, all documents and records and other information in the possession of Hometown Health relevant to the Adverse Benefit Determination including, but not limited to, any applicable internal rule or guideline of Hometown Health on which it relied in making the Adverse Benefit determination and, if the Adverse Benefit Determination related to medical necessity, a

## **HOMETOWN HEALTH PLAN, INC.**

statement of the scientific or clinical judgment for the determination applying the terms of the EOC to the member's medical circumstances.

### **Expedited Appeal**

The member can ask for an Expedited Appeal of an Adverse Benefit Determination if the member or his/her doctor believe that the health of the member could be seriously harmed by waiting too long for a decision. This may be referred to as an Urgent Care Claim. (Expedited appeals are not available for appeals regarding denied claims (post-service).) Expedited Appeals must be decided no later than 72 hours after receipt of the appeal, provided all necessary information has been submitted to Hometown Health.

- If the member's physician requests an Expedited Appeal, or supports a member's request for an expedited appeal, and indicates that waiting for 15 days could seriously harm the health of the member or subject the member to unmanageable severe pain, the plan will automatically grant an expedited appeal.
- If a request for an Expedited Appeal is submitted without support of the member's physician, the plan shall decide whether the member's health requires an Expedited Appeal. If an Expedited Appeal is not granted, the plan will provide a decision within 15 days, subject to the above.

### **3. 2nd Level Formal Appeal**

When a 1st Level Formal Appeal is not resolved in a manner that is satisfactory to the member, the member may initiate a 2nd Level Formal Appeal. This appeal must be submitted in writing on a Request for Formal Hearing Form, (a Request for Formal Hearing Form will be attached to the member's 1st Level Formal Appeal decision letter) within sixty (60) days after the member has been informed of the resolution of the 1st Level Formal Appeal.

Exhaustion of the 1st Level Formal Appeal procedure is a precondition to filing a 2nd Level Formal Appeal. A 2nd Level Formal Appeal not filed in a timely manner will be deemed waived with respect to the Adverse Benefit determination to which it relates. The 2nd Level Formal Appeal is voluntary for Urgent Care Claim appeals.

The member shall be entitled to receive the same reasonable access to, and copies of documents, referenced above under the 1st Level Formal Appeal.

The Grievance Committee shall determine if a formal presentation is appropriate and, if so, shall make every reasonable effort to schedule one at a time mutually convenient to the parties. Repeated refusal on the part of the member to cooperate in the scheduling of the formal presentation shall relieve the Grievance Committee of the responsibility of hearing a formal presentation, but not of reviewing the 2nd Level Formal Appeal. If a formal presentation is granted, the member will be permitted to have assistance in presenting the matter to the Committee, including representation by counsel. However, Hometown Health must be notified at least one (1) week before the date of the scheduled formal presentation of the member's intent to be represented by counsel and/or to have others present during the formal presentation.

Upon receipt of the Request for Formal Hearing, the request will be forwarded to the Grievance Committee along with all available documentation relating to the Grievance.

## **HOMETOWN HEALTH PLAN, INC.**

The Grievance Committee shall consider the 2nd Level of Appeal, schedule a formal presentation if applicable, obtain additional information from the member and/or staff as it deems appropriate, and make a decision and communicate its decision to the member within 15 days after receipt of the request for a 2nd Level Formal Appeal if the appeal is regarding a denied authorization (pre-service) and within 20 working days after receipt of the request for a 2nd Level Formal Appeal if the appeal is regarding a denied claim (post-service). Limited extensions may be required if additional information is required or a formal presentation is requested.

#### **4. Independent Medical Evaluation**

In the event Hometown Health requires an member to undergo an independent evaluation for any final determination of medical or chiropractic benefits or care, only a participating physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field will conduct the evaluation. The independent evaluation will include a physical examination of the member, unless he or she is deceased, and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of all reports of findings will be sent to the complainant within five (5) working days by certified United States Mail.

# HOMETOWN HEALTH PLAN, INC.

## PART 18 GENERAL PROVISIONS

---

### **A. Assignment**

The coverage and any benefits under this EOC are not assignable.

### **B. Authorization to Examine Medical Records**

The member and the subscriber on behalf of underage members, consents to and authorizes all health care providers including, but not limited to, PCP's, hospitals, skilled nursing facilities, and other providers to permit the examination and copying of any portion of the member's hospital and medical records, when requested by Hometown Health. Information from the medical records of members and information received from providers incidental to the provider-patient relationship shall be kept confidential and except for reasonably necessary use in connection with government requirements established by law, may not be disclosed without the consent of the member.

### **C. Balance Billing**

If the billed charges exceed the contracted amount agreed to by a contracted provider for covered services, this provider is prohibited from billing the member the difference. Because this provider is a contracted provider for the plan, the member is not responsible for the difference between the billed charges and the contracted charges.

### **D. Cancellation**

Except as otherwise provided in this EOC, Hometown Health shall not have the right to cancel or terminate any individual subscriber while he or she remains in the eligible class of employees of the group and his or her premiums are paid according to the terms of this EOC.

### **E. Charge for Service or Purchase**

The charge for service or purchase will be deemed to have been incurred on the date the service is performed or the date the purchase occurs.

### **F. Clerical Error**

Clerical errors or delays in keeping or reporting data relative to coverage will neither invalidate coverage, which would otherwise be validly in force nor continue coverage, which would otherwise be validly terminated. Upon discovery of such errors or delays, an equitable adjustment of premiums will be made. In no event will credits be made retroactive more than two premium due dates prior to the date that Hometown Health is notified in writing in a form satisfactory to Hometown Health of a requested addition/deletion to, or change in, a member's Hometown Health coverage status.

### **G. Entire EOC**

This EOC, the GSA, Summary of Benefits, Riders, the individual applications, questionnaires, and applicable attachments if any, of the subscriber constitute the entire contract between the parties. As of the effective date of coverage, it supersedes all other agreements between the parties. Any statements made to Hometown Health by the group and any subscriber or dependent shall, in the absence of fraud, be deemed representations and not warranties. No such statement, unless it is contained in a written application for coverage, shall be used in defense to a claim under this EOC.

# **HOMETOWN HEALTH PLAN, INC.**

## **H. Form or Content of EOC**

No agent or employee of Hometown Health is authorized to change the form or content of this EOC. Such changes can be made only through endorsement signed by an authorized officer or Director of Hometown Health.

## **I. Gender**

The use of any gender herein shall include the other gender and the use of the singular shall include the plural (and vice versa).

## **J. Membership Card**

Cards issued by Hometown Health to members are for identification only. Possession of a Hometown Health membership card confers no right to services or other benefits under this EOC. To be entitled to such services or benefits, the holder of the card must, in fact be an eligible member on whose behalf all applicable premiums due under this EOC have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to the provisions of this policy and any member assisting such person shall be liable for the actual cost of such services or benefits.

## **K. Interpretation of EOC**

The laws of the State of Nevada shall be applied to interpretations of this EOC.

## **L. Modifications**

By this EOC, group makes Hometown Health coverage available to members who are eligible under Part 7, Eligibility, and Enrollment. However, this EOC shall be subject to amendment, modification, and termination in accordance with any provision hereof or by agreement between Hometown Health and group without the consent or concurrence of the members. This EOC shall automatically be modified to comply with provisions of Nevada law. By electing medical and hospital coverage under Hometown Health or accepting Hometown Health benefits, all members legally capable of contracting, and the legal representative of all members incapable of contracting, agree to all terms and conditions hereof.

## **M. Notice**

Any notice under this EOC may be given by United States Mail, first class, postage prepaid, addressed as follows:

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

Or, if to a member, at the last address known to Hometown Health.

## **N. Notice of Claim**

If submission of a claim is required to receive benefits under this EOC, such claim shall be allowed only if notice of the claim is submitted to Hometown Health within 120 days from the date on which the covered expenses were first incurred. However, if it was not reasonably possible to give notice within the above time limit, and notice was furnished, as

## **HOMETOWN HEALTH PLAN, INC.**

soon as was reasonably possible, the submission date will be extended accordingly. However, in no event will benefits be allowed if notice of claim is made beyond one year from the date on which the expense was incurred.

### **O. Policies and Procedures**

Hometown Health may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this plan.

### **P. Return of Overpayment**

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

### **Q. Claims Procedures**

In accordance with the sections 503 and 505 of the Employee Retirement and Income Security Act of 1974 (ERISA), the following claims procedures were adopted. See also Part 18, Member Appeal Procedure as revised.

#### **1. Authorized Representative**

A member may elect to designate an “authorized representative” to act on their behalf to pursue a benefit claim or appeal of an adverse benefit determination. To designate an authorized representative, a written notice, signed and dated by the member, is required. The notice must include the full name of the representative and must indicate specifically for which Claim for Benefits or appeal the authorization is valid. The notice should be sent to: Hometown Health, Customer Services 830 Harvard Way, Reno, NV 89502

Any correspondence from Hometown Health regarding the specified Appeal will be provided to both the member and their authorized representative.

In the case of an Urgent Care Claim, a health care professional with knowledge of the member’s medical condition shall be permitted to act as an authorized representative of the member without designation by the member.

#### **2. Failure to Obtain Prior Authorization**

If a member fails to follow the plan’s procedures for filing a pre-service claim, the member shall be notified of the failure and the proper procedures to be followed, provided that the communication by a member or an authorized representative is received by a person or department customarily responsible for handling benefit matters and the communication specifically names the member; a specific medical condition or symptom; and a specific treatment, service or product for which approval is requested. This notification shall be provided as soon as possible, but not later than 5 days (24 hours in the case of an Urgent Care Claim) following the failure. Notification may be oral unless specifically requested in writing by the member.

#### **3. Timing of Notification of Benefit Determination**

**Urgent Care Claims:** If the claim involves an Urgent Care Claim, Hometown Health shall notify the member of the benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim, unless insufficient

## HOMETOWN HEALTH PLAN, INC.

information to determine whether, or to what extent, benefits are covered or payable under the plan.

If insufficient information is received, Hometown Health shall notify the member as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The member will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Hometown Health shall notify the member of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

- a. Hometown Health's receipt of the specified information, or
- b. The end of the period afforded the member to provide the specified information.

Concurrent Care Decisions: If Hometown Health has approved an ongoing course of treatment to

be provided over a period of time or number of treatments and reduces or terminates coverage of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments, Hometown Health will notify the member at a time sufficiently in advance of the reduction or termination to allow the member to appeal and obtain an determination before the benefit is reduced or terminated.

Any request by a member to extend the course of treatment beyond the period of time or number of treatments for an Urgent Care Claim shall be decided as soon as possible. Hometown Health shall notify the member within 24 hours after receipt of the claim by the plan, provided that the request is received at least 24 hours prior to the expiration of the authorized period of time or number of treatments.

Requests for Prior Authorization (Pre-Service Claims): Hometown Health shall notify the member of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request by the plan. This period may be extended one time by the plan for up to 15 days, provided that the extension is necessary due to matters beyond the control of the plan and plan notifies the member prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which the plan expects to make a decision. If the extension is necessary due to a failure of the member to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information and the member shall be afforded at least 45 days from receipt of the notice to provide the information.

Submission of Claims for Payment (Post-Service Claims): Hometown Health shall notify the member of any denial within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the extension is necessary due to matters beyond the control of the plan and the plan notifies the member prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. If the extension is necessary due to a failure of the member to submit the information necessary to decide the claim, the notice of extension shall specifically

## **HOMETOWN HEALTH PLAN, INC.**

describe the required information and the member shall be afforded at least 45 days from receipt of the notice to provide the information.

# HOMETOWN HEALTH PLAN, INC.

Hometown Health Plan, Inc. is licensed by:

State of Nevada  
Department of Business and Industry  
Division of Insurance  
788 Fairview Drive, Suite 300  
Carson City, Nevada 89701-5491  
Toll Free No. 1-888-872-3234  
Hours Monday thru Friday 8 am to 5 pm  
Pacific Standard Time (PST)

Hometown Health Plan, Inc.

*Hometown  
Health* 

830 Harvard Way  
Reno, NV 89502



[www.hometownhealth.com](http://www.hometownhealth.com)