

**Health Maintenance Organization  
(HMO)  
Evidence of Coverage**

**OPEN ACCESS**

*Hometown*  
 *Health*  
Plan



HOMETOWN HEALTH PLAN  
HEALTH MAINTENANCE ORGANIZATION (HMO)

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

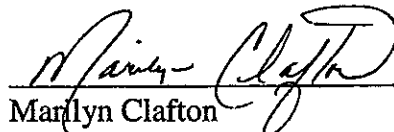
Effective July 1, 2008, the Evidence of Coverage (EOC) for Hometown Health's HMO is hereby amended in the following manner:

- 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.

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### **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>
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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.

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***Hometown Health Plan, Inc.***  
***("Hometown Health Plan")***  
***HMO Evidence of Coverage***

**PART 1                      DEFINITIONS**

**Acupuncture** – piercing of peripheral nerves with needles:

- a. To relieve the discomfort of painful disorders; or
- b. For therapeutic purposes.

**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 over time.

**Adverse Benefit Determination** – A decision by the plan to deny, in whole or in part, a member's Claim for Benefits. Receipt of an Adverse Benefit Determination entitles the member or his/her Authorized Representative to appeal the decision, utilizing Hometown Health Plan's Appeal Procedures.

**Alternative Medicine** – Approaches to medical diagnosis and therapy that have not been developed by use of generally accepted scientific methods, including but not limited to acupressure, acupuncture, aromatherapy, herbal medicine and holistic medicine.

**Appeal** – the formal process a member can use to request review of a plan decision (e.g., typically addresses benefits or service issues).

**Authorized Representative** – a person designated by the member to act on his/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/her Authorized Representative.

**Benefit Period** – the period of time (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 the following:

- a. The last day of the calendar year in which it was established; or
- b. The day coverage under this EOC ends; or
- c. The day 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 twelve months that begins January 1, and concludes December 31, of the same year.

**Centers for Medicare and Medicaid Services (CMS)** – (formerly HCFA) The federal agency responsible for administering Medicare.

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

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

**Chronic** – an illness or injury that is, or is expected to be, six (6) months or longer, and/or with frequent recurrences and is always more or less present. Chronic conditions may have acute episodes.

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

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

**Cognitive Therapy** – treatment given 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.

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

**Copayment** – the specific amount payable by the member to a provider of care upon receipt of certain covered services.

**Cosmetic or Reconstructive Surgery** – any surgical procedure performed primarily:

- a. To improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- b. To prevent or treat a mental or nervous disorder through a change in bodily form.

**Covered Services** – those benefits, services, and supplies which Hometown Health Plan must provide or arrange for a member.

**Criminal Act** – any event where an individual is convicted of a misdemeanor or felony and any event where an individual is not charged or convicted but there is clinical evidence or statement in a Police Report that indicates a law has been broken.

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

- 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.

**Denied Prior-authorization** – a prior-authorization request that has been submitted to Hometown Health Plan and has *not* been approved.

**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:** – facilities that, within the Hometown Health Plan network provide services on favorable financial terms to Hometown Health Plan for our members.

**Elect Providers:** – providers that, within the Hometown Health Plan network provide services on favorable financial terms to Hometown Health Plan for our members.

**Eligible Employee** – a permanent employee who has a regular workweek 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.

**Emergency** – health care services that are provided to an insured by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in: (a) Serious jeopardy to the health of a 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, which 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 Plan shall determine are emergencies.

**Employer** – the group shown on the face page of the Group Subscription Agreement.

**Evidence of Coverage (EOC)** – the entire document which describes the member's benefits, exclusions, limitations and applicable administrative policies, rights, responsibilities and procedures.

**Exclusion** – an item or service that is not a covered benefit under this Evidence of Coverage (EOC). Refer to Part 3, Exclusions and Limitations.

**Expedited Appeal** – if a member appeals a decision regarding a denied authorization (pre-service) and the member or his/her doctor believe 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 are generally made within 72 hours. This may 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 the service or supply is received. Expense **does not include** any charge:

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

**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:

- a. If there is insufficient outcome data from controlled clinical trials and from medical literature to show that the procedure or treatment is safe, effective and superior to existing therapy;
- b. If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institute of Health, the Food and Drug Administration, or the Medicare program;
- c. When a nationally recognized medical society states in writing that the procedure or treatment is experimental, or
- d. When the written protocols used by a facility performing the procedure or treatment state that it is experimental.

**Family Dependents** – members of the subscriber's family who meet the eligibility requirements of this EOC set forth in Part 7, Eligibility, and Enrollment and have been enrolled by the subscriber.

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

**Gastric Restrictive Services** – includes various surgical interventions to accomplish weight loss reduction 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 issues 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, perform risk assessments, and review testing options, where available.

**Grace Period** – a period that begins the first day a member's premium becomes due and extending for 30 days. The plan coverage remains in force during the grace period.

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

**Group Open Enrollment Period** – those periods of time established by the group and Hometown Health Plan pursuant to the Group Subscription Agreement, during which eligible persons may enroll with Hometown Health Plan.

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

**Health Maintenance Organization (HMO)** – a company approved by the Nevada Division of Insurance to offer a capitated (prepaid) health plan through a network of exclusive medical providers.

**Hometown Health Plan** – a Nevada company, licensed as a Health Maintenance Organization, responsible to arrange and/or administer the Schedule of Benefits as set forth herein.

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

**Hospital** – a legally operated facility defined as an acute care or tertiary hospital which is licensed by the State and may be approved by the Joint Commission on Accreditation of Healthcare Organizations ("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. A disorder or disease of the body or mind; or
- b. An accidental bodily wound.
- c. 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 the body chemistry of a person.

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

**Late Enrollee** – an eligible subscriber and/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, which are benign.

**Medical Assessment Form** – a questionnaire used by Hometown Health Plan to establish medical risk for an employer group or subscriber seeking coverage under Hometown Health Plan.

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

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

**Medical Pharmacy** – distribution, administration, and/or supply of pharmaceuticals in a non-retail setting.

**Medically Necessary / Medical Necessity** – the use of services or supplies as provided by a hospital, skilled nursing facility, Primary Care Physician or other health care provider required to identify or treat a member's illness or injury and which, as determined by Hometown Health Plan, are:

- a. Consistent with the symptoms or diagnosis and treatment of the member's condition, disease, illness or injury;
- b. Appropriate with regard to standards of medical practice within the service area's medical community;
- c. Not primarily for the convenience of the member, member's family, member's Primary Care Physician, hospital, or other health care provider; and

d. The most appropriate supply or level of service, which can be safely provided to the member.

The fact that a service is prescribed or recommended by a Primary Care Physician or other health care provider does not mean that the service is medically necessary or prior-authorized by Hometown Health Plan.

***Not all medically necessary services are covered by this plan.***

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

**Member** – subscriber and eligible family dependents who are covered under this EOC.

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

**Out-of-Area Services** – those services provided outside the Plan's service area.

**Out-of-Pocket Maximum** – the maximum amount the member or family is responsible to pay for copayments/coinsurances in a calendar year for covered services. Refer to the Summary of Benefits.

**Outpatient Observation** – continuous evaluation and monitoring of a medical condition in a facility. Limited to 24 hours.

**Partial Hospitalization** – continuous treatment for at least four hours, but not more than 12 hours in any 24 hour consecutive period of time. Services can be performed in a hospital or treatment center/facility.

**Participating Provider** – a physician, medical group, hospital, skilled nursing facility, home health agency or any other licensed institution or health professional who is both listed in the Hometown Health Plan Provider Directory, as updated, and who is under contract with Hometown Health Plan to provide covered services to members. A participating provider's agreement with Hometown Health Plan 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 Plan are participating providers. ***Hometown Health Plan does not guarantee the continued availability of any particular participating provider. Participating providers cannot determine whether a service is a covered benefit on behalf of Hometown Health Plan.***

**Physical Therapy** – treatment given to improve the physical capabilities of a member in an attempt to restore such individual to a previous level of good health or to the level of health the individual obtained prior to an acute incident that required the therapy.

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

**Policy** – the Group Subscription Agreement, this Evidence of Coverage, and any Riders.

**Premium** – money paid to Hometown Health Plan for this insurance.

**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, who has primary responsibility for providing, arranging and coordinating all aspects of a member's health care. 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.

**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. It would include specific information such as your name, address, date of birth, Social Security number, gender, marital status and information on your dependents. Protected health information also includes your medical information as reflected in records of your medical history; past medical claims and payments; and information from consumer or medical reporting agencies, medical providers or third parties. Hometown Health Plan is required by law to protect this information for all of our members. The law prevents us from communicating this information to any family member, including spouses, without your consent. Please refer to IMPORTANT INFORMATION in Part 1, of this EOC.

**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 with this group plan within 31 days of becoming eligible, when he or she is first eligible for this group plan.

**Qualified Late Enrollee** – an eligible subscriber and/or dependent who becomes eligible and enrolls with this group plan 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 plan; or
- d. A change of status from not being an eligible employee to being an eligible employee, subject to any waiting period.

**Qualifying Life Events** – an event in a subscriber's or dependent's life that would allow the subscriber and/or dependent to enroll in this group medical plan outside of the open enrollment period. In all cases of qualifying life events, the subscriber and/or dependent must enroll within 31 days of the date of the qualifying life event and the dependent may only enroll if the subscriber enrolls or is already enrolled in this group medical plan. The following constitutes the only events that will be considered as a qualifying life event:

- a. The subscriber and/or eligible dependent:
  - i. 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; or
  - ii. 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.
- b. The eligible dependent:
  - i. 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** – a PCP's approval to see a certain specialist or to receive certain covered services.

**Rehabilitative Therapy** – physical, speech, occupational, cardiac and pulmonary therapy.

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

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

**Skilled Nursing Care** – services that can only be performed by, or under the supervision of, licensed nurses.

**Skilled Nursing Facility** – a facility which is duly licensed by the State and/or Federal Government which provides inpatient skilled nursing care, rehabilitation services or other related health services.

**Special Food Products** – a food product that is 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 who provides medical care in a specific branch of medicine.

**Subrogation** – a legal process whereby Hometown Health Plan may seek reimbursement from a third party that is legally responsible (at fault) for claims.

**Subscriber** – a person who meets all applicable eligibility requirements of Part 7, Eligibility, and Enrollment and whose enrollment form has been accepted by Hometown Health Plan in accordance with the requirements of this EOC.

**Tertiary Care** – the highest and/or the 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 in an expedited manner because the member could be seriously harmed by waiting too long for a decision. If the request for coverage was originally 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 which is less severe than an emergency admission but requires care within a short time. This includes complications of pregnancy.

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

**Waiting Period** – the length of time an eligible employee must continuously work for the employer before he or she is eligible for insurance.

# IMPORTANT INFORMATION

## 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. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact Hometown Health Plan Customer Services at 775-982-3232.

### **WHO WILL FOLLOW THIS NOTICE**

This notice describes the practices of Hometown Health Plan, Inc. (referred to as "Hometown Health") and their subscribers.

### **OUR PLEDGE REGARDING 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 and 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 providing healthcare services to Hometown Health Plan 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 we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

### **INFORMATION ABOUT OUR MEMBERS**

In the course of providing healthcare benefits, we may receive the following information about you:

- 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.
- Information provided by your employer, benefits plan sponsor or association regarding any group product you may have.
- 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.
- Information from consumer or medical reporting agencies, medical providers or third parties, such as medical information and demographic information.

### **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 we maintain electronically through the use of 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 safeguard medical information against inappropriate access, use and disclosure, consistent with applicable law.

## **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:

- ~ **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.
- ~ **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. Here are some examples of the ways that we use your medical information for our healthcare operations:
  - Newsletters that offer members information on various healthcare issues such as asthma, diabetes, and breast cancer.
  - Administration of Hometown Health or 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.
  - 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.
  - Quality assessment and improvement activities, such as peer review and credentialing of participating providers; program development; and accreditation by independent organizations, where applicable.
  - 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.
  - Transitioning of policies or contracts from and to other health plans.

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 and qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.

- ~ **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.
- ~ **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.
- ~ **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.

## **SPECIAL SITUATIONS**

- ~ **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.
- ~ **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report the abuse or neglect of children, elders and dependent adults;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - 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; and
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- ~ **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, 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.
- ~ **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 may also 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.
- ~ **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct; or
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- ~ **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.
- ~ **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.
- ~ **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- ~ **Inmates.** If you are an inmate of a correctional institution or under 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 (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

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

- ~ **Right to Inspect and Copy.** 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.

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 Plan 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.

We may deny your request to inspect and copy in certain very 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.

- ~ **Right to Amend.** If you feel that medical information 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.

To request an amendment, your request must be made in writing and submitted to Hometown Health Plan Customer Services, 830 Harvard Way, Reno, NV 89502. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Hometown Health;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

- ~ **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than (1) our own uses for treatment, payment and healthcare operations, as those functions are described above, (2) to you based upon your authorization and (3) for certain government functions.

To request this list or accounting of disclosures, you must submit your request in writing to Hometown Health Plan Customer Services, 830 Harvard Way, Reno, NV 89502. Your request must state a time period that may not be longer than six years and 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.

- ~ **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 we disclose about you to someone who is involved in your care or the payment for your care, like 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.

To request restrictions, you must make your request in writing to Hometown Health Plan Customer Services, 830 Harvard Way, Reno, NV 89502. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

- ~ **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.

To request confidential communications, you must make your request in writing to Hometown Health Plan Customer Services, 830 Harvard Way, Reno, NV 80502. 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.

- ~ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a 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, [hometownhealth.com](http://hometownhealth.com)

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

## **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 Plan Web site at [hometownhealth.com](http://hometownhealth.com). The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you enroll in a Hometown Health Plan health plan, we will offer you a copy of the current notice in effect. We also may publish the current notice in our newsletter on at least an annual basis.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Hometown Health Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Hometown Health Plan, contact Hometown Health Plan 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.

## **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 provide 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.

## PART 2 SCHEDULE OF BENEFITS

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

### COVERED SERVICES

The following is a description of covered services. All covered services must be medically necessary and ordered by a member's Primary Care Physician (PCP). Prior-authorization is required for many services. Refer to Part 4, Utilization Management Program. Limitations may apply. Please read Part 3, Exclusions and Limitations for more information.

#### A. PROFESSIONAL SERVICES

##### 1. Alcohol and Substance Abuse Services (inpatient and outpatient)

- 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:

A facility for the treatment of abuse of alcohol or drugs which is certified by the Health Division of the Department of Human Resources.

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 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 Primary Care Physician and prior-authorized by Hometown Health Plan

##### 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 Plan 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; or
  - 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:
    - 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 Plan.
  - 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.

Refer to Part 3, Exclusions and Limitations #56.

## 7. **Colorectal Screening**

Refer to the Summary of Benefits

## 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

- a. The purchase, rental, repair or maintenance of durable medical equipment (DME) for other than for kidney dialysis. DME includes, but not limited to:
  - Oxygen equipment (all oxygen and oxygen related equipment). Oxygen while traveling on an airline is not covered. Refer to Part 3, Exclusions and Limitations, #26.
  - Wheelchairs
  - Hospital beds
  - Glucose monitors
  - Warning or monitoring devices for infants (defined as a child 24 months old or less) suffering from recurrent apnea (**limited to 90 days**)
- b. Hometown Health Plan'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 Plan's liability, Hometown Health Plan will be guided by nationally established standards of the rental or purchase of such equipment.  
Refer to Part 3, Exclusions and Limitations, #31.

## 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**). Refer to Part 3, Exclusions and Limitations, #14.

## 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)
- Respiratory diseases;
- Diabetes;
- Hypertension;
- Hypothyroidism;
- Disorders of the pituitary gland and its hypothalamic control;
- Disorders of the adrenal glands;
- Cushing's syndrome

## 13. Genetic Counseling/Testing

- a. Genetic Counseling and Testing (**limited to issues of pregnancy management only**). Genetic Testing may only be done after consultation with an appropriately certified Genetic Counselor. **Lifetime benefit maximum is \$2,500**. Refer to Part 3, Exclusions and Limitations regarding amniocentesis, #35.
- b. Genetic counseling will be covered in connection with pregnancy management in the following circumstances:
  - Parents of a child born with a genetic disorder, birth defect, inborn error of metabolism, or chromosome abnormality
  - Parents of a child with mental retardation, autism, Down syndrome, trisomy conditions, or fragile X syndrome
  - 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
  - Parents affected with an autosomal dominant disorder, contemplating pregnancy
  - 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 Primary Care Physician 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 \$5,000 per calendar year)**. **Certified Nurse's Aides and Home Health Aides are not covered.** Refer to Part 3, Exclusions and Limitations, #24.

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 Primary Care Physician. **(limited to 185 days)**.

- 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:
  - i A licensed psychiatrist;
  - ii A licensed psychologist; or
  - iii 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 Plan 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 calendar year)**. Refer to Part 3, Exclusions and Limitations, #49 and #50.

#### 17. Infertility Services

Medical services to diagnose problems of infertility (refer to Part 1, Definitions) **(limited to \$2,500 per lifetime)**. Refer to Part 3, Exclusions and Limitations, #34.

- 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 not covered by the Medicare program **(limited to \$60,000 in any 12 consecutive months)**. Refer to Part 3, Exclusions and Limitations, #41.

## 19. Lab and Diagnostic Services

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

- Diagnostic X-rays (Radiological/Cardiological/Neurological)
- Mammograms
- Fluoroscopy
- 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 Plan and the mastectomy is paid for by Hometown Health Plan, subject to all the terms and conditions of this EOC, Hometown Health Plan 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.

Refer to Part 3, Exclusions and Limitations, #11.

## 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. Refer to Exclusions and Limitations, Part 3, #1.

## 22. Medical Care and Preventive Services

Medical care and services, including:

- Office visits and consultations
- Hospital and Skilled Nursing Facility services
- Periodic physical examinations and routine immunizations in accordance with Hometown Health Plan's Medical Practice Guidelines
- Routine gynecologic examination (1 per calendar 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.

Refer to Part 3, Exclusions and Limitations #33 and #54.

### 23. Medical Pharmacy

The distribution, administration, and/or supply of pharmaceuticals in a non-retail setting. This includes items such as injectables, or other special pharmaceuticals and a 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 Plan. Special pharmaceuticals exclude drugs administered for chemotherapeutic purposes.

**Special pharmaceuticals have a separate out-of-pocket maximum. Copayment(s) for special pharmaceuticals do not apply toward Plan out-of-pocket maximum. Refer to your Summary of Benefits.**

### 24. Mental Health Services

#### a. General Mental Health:

Outpatient evaluation, crisis intervention and short-term psychotherapy which will lead to significant clinical improvement and achieve treatment goals. All mental health conditions not listed in paragraph b., Severe Mental Illnesses, will be considered general mental health conditions.

- Outpatient general mental health services are limited to 10 visits of 50-minute duration or 10 group visits of 50-minute duration, or any combination **(limited to 10 visits per calendar year)**.
- Attention Deficit Disorder (ADD/ADHD) treatment for members under 18 years old **(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/or obsessive-compulsive disorder, excluding medication management.

- Outpatient severe mental illness services **(limited to 40 visits per calendar year)**.
- 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.

### 25. Oral Surgery, Dental Services, and Temporomandibular Joint Disorder (TMJ)

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

- 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)**;
- Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, and roof and floor of the mouth.
- 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 \$2,500.00).*** Refer to Part 3, Exclusions and Limitations, #52 and #53.

Dental Anesthesia procedures will be provided (inpatient or outpatient) related to the following:

- a. 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 5.
- b. 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.

## 26. Orthopaedic Devices and Prosthetic Devices

- a. Orthopaedic 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; and

- i First pair of eyeglasses or contact lenses (up to the Medicare allowable) immediately following cataract surgery.

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. Refer to Mastectomy Reconstructive Surgery in Part 2, Schedule of Benefits and Part 3, Exclusions and Limitations, #11 and #32.

## 27. 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.

## 28. 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 hours, observation status will become an inpatient admission.

## 29. 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. Refer to Part 3, Exclusions and Limitations, #20.

## 31. Radiation Therapy

Please see the Summary of Benefits

### 32. Second Opinions

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

### 33. 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 calendar year)**.
- b. Outpatient services for cardiac rehabilitation and pulmonary rehabilitation **(limited to 40 visits/sessions per calendar 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 Plan. **(limited to 30 days per calendar year)**.

### 34. Skin Lesions

Removal of suspicious lesions for pathological analysis.

### 35. Spinal Treatment (Non Surgical)

Spinal manipulations and adjustments **(limited to \$1,000 per calendar year)**.  
Refer to Part 3, Exclusions and Limitations, #19.

### 36. 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**.

- 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)**.

Refer to Part 3, Exclusions and Limitations, #40 and #42.

## B. HOSPITAL, SKILLED NURSING AND SERVICES IN AN OUTPATIENT SURGICAL CENTER

### 1. Inpatient Services

- Hospital services include, but are not limited to:
- Semi-private room and board (private room when medically necessary)
- Unlimited prior-authorized days, except where limits or exclusions are specified elsewhere in this EOC
- 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).
- 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 Plan. **(Inpatient short-term rehabilitative services are limited**

*to 30 days per calendar year*). Refer to Part 2, Schedule of Benefits, Short-term Rehabilitative Therapy.

- Surgical and obstetrical procedures, including the services of a surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care.
- Inpatient alcohol and substance abuse rehabilitation services in a hospital, hospital residential treatment facility, or day treatment program (*limited to \$9,000 per calendar year*). Refer to Part 2, Schedule of Benefits, Alcohol and Substance Abuse Services.
- Inpatient severe mental health services (*limited to 40 days of hospitalization per calendar year*). Two visits for partial hospitalization may be substituted for each one day of hospitalization. Refer to Part 2, Schedule of Benefits, Mental Health Services.

## 2. **Outpatient Hospital or Outpatient Surgical Center Services**

Hospital services such as radiation therapy, chemotherapy (including chemotherapy drugs) and outpatient surgery.

## 3. **Skilled Nursing Facility**

Skilled nursing facility services (*limited to 30 days per calendar year*) for non-custodial care. Prior care in a hospital is not required before being eligible for care in a skilled nursing facility. Refer to Part 3, Exclusions and Limitations, #24 and #28.

# C. **EMERGENCY SERVICES**

Emergency medical or hospital services. ***Services must be provided at a contracted facility unless the time requirement to reach a Hometown Health Plan provider would result in a significant risk of permanent health damage.*** 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. Refer to Part 2, Schedule of Benefits.

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 Primary Care Physician.

Unanticipated complications of pregnancy or premature delivery are covered outside the service area. Refer to Part 2, Schedule of Benefits, Maternity Care and Care of Newborns. Refer to Exclusions and Limitation, Part 3, #1.

## 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 Plan 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.

## 2. **Extended Notification**

If the member or a family member is unable to contact his or her Primary Care Physician and Hometown Health Plan 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 Plan 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 Plan. 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. Refer to Part 3, Exclusions and Limitations, #1, and #26

#### 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 Primary Care Physician 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 Plan.

##### 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 Plan 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.***

#### E. SUMMARY OF BENEFITS

Refer to the Summary of Benefits insert in your benefit material for specific cost-sharing information.

## PART 3

## EXCLUSIONS AND LIMITATIONS

### A. EXCLUSIONS

Except as provided in a Rider, if any, the following services and benefits are excluded from coverage.

1. Services of non-participating providers, except in an emergency or urgently needed services or unless prior-authorized by Hometown Health Plan.
2. Services that are not medically necessary or not required in accordance with accepted standards of medical practice.
3. Any services or supplies not specifically listed in this EOC as covered benefits, services, or supplies.
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 under this EOC.
6. Any loss, expenses or charges resulting from the member's participation in a riot and/or criminal act, use of recreational drugs, or any act of war or terrorism.
7. Testing and treatment for educational disorders; non-medical ancillary services such as vocational rehabilitation and employment counseling.
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 physical examinations primarily for insurance, licensing, school sports, adoption purposes, employment, as well as other third-party physicals; immunizations related to foreign travel, expenses for medical reports, including presentation and preparation; examinations for court ordered treatment, or in connection with legal processing.
11. 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. Cosmetic surgery exclusions include but are not limited to, surgery for sagging or extra skin, any augmentation or reduction procedures, rhinoplasty and associated surgery, epikeratophakia surgery, 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 or hair treatment, keloid scar therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions. Complications resulting from excluded cosmetic surgery or medical procedures are not covered. For the purpose of this EOC, psychological factors (for example, for self-image, difficult social or peer relations) do not constitute a physical bodily function or medical necessity.
12. Treatment of benign skin lesions, which 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.
13. Cosmetics, dietary supplements, 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, laxatives, except as otherwise provided in this EOC. 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 Plan and present significant symptomatic medical problems) or any treatment of obesity.

14. Special formulas, food supplements or special diets including, but not limited to, Total Parenteral Nutrition, (TPN) except for acute episodes, except as otherwise set forth in this EOC.
15. Charges exceeding *\$2,500 per calendar year* for special food products medically necessary 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.
16. Any procedure or treatment designed to alter physical characteristics of the member to those of the opposite sex, and any other treatment or studies related to sex transformations.
17. Treatment for the removal of varicose veins.
18. Chronic pain therapy and treatment for chronic pain. Refer to Part 1, Definitions.
19. Spinal manipulation for chronic or recurring conditions.
20. 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. Routine foot care is not covered.
21. 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 stated in the EOC.
22. Body recontouring to remove excess skin on any part of the body from gastric restrictive services, including but not limited to tummy tucks, belt lipectomies, breast reductions or lifts is excluded.
23. All experimental and/or investigational (as defined in Part 1, Definitions of this EOC) medical, surgical, or other health care procedures and all transplants, except as otherwise provided in Part 2, Schedule of Benefits, of this EOC.
24. Custodial, domiciliary care or homemaker services, rendered by an individual related to, or a part of, member's family. Certified Nurse's Aides (CNA's) in the home and Home Health Aides services.
25. Any services or supplies furnished in an institution, which is primarily a place of rest, a place for the aged, or custodial facility, or any similar institution.
26. Travel, accommodations, and oxygen provided while traveling on an airline.
27. Any services received outside the United States, unless deemed to be urgent or emergent.
28. Personal, beautification, or comfort items for inpatients in a hospital or skilled nursing facility.
29. Private duty nursing and private rooms in an inpatient setting.
30. Penile implants and injectable services and supplies related to the treatment of impotence. Services for the treatment of sexual dysfunction, including enhancement medications.
31. Durable Medical Equipment (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 care or beautification items, deluxe equipment, cochlear implants, and any other primarily non-medical equipment, except as otherwise set forth elsewhere in this EOC.
32. Prosthetic and orthopedic devices, except as otherwise set forth elsewhere in this EOC.
33. The fitting and purchase of hearing aids.
34. The promotion of fertility including, but not limited to, fertility testing (except as otherwise defined in this EOC), services to reverse voluntary surgically-induced infertility, reversal of surgical sterilization, attempts to cause pregnancy by hormone therapy, in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm. Maternity services related to a member serving in the capacity of a surrogate mother or prescription (infertility) drugs. GIFT and ZIFT procedures and low tubal transfers.

35. 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.
36. Non-Newborn circumcisions (after 8 weeks of age), unless medically necessary and prior-authorized by Hometown Health Plan.
37. Termination of pregnancy other than medically indicated abortions necessary to save the life of the mother.
38. Long-term physical therapy and long-term rehabilitative services. Charges for cognitive therapy, by any name.
39. Sleep therapy (except for central or obstructive APNEA when medically necessary, as ordered by a member's Primary Care Physician, and prior-authorized by Hometown Health Plan), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electrosleep therapy, electronarcosis, massage therapy or gene therapy.
40. Organ transplant services:
  - 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 listed in Part 2, Schedule of Benefits, Transplant Services, or transplants which, consist of the installation of a non-human device or artificial organ.
41. Kidney dialysis or artificial kidney treatments when covered by the Medicare program or other Federal or State programs, other than the Medicaid program.
42. Tissue transplants, whether natural or artificial replacement materials or devices are used; any or oral implant; treatment for complications arising from tissue or organ transplants or replacement unless such transplant benefits are provided for in this EOC.
43. Psychological services, counseling, or tutoring services for developmental delay, learning disability, or treatment of mental retardation, Down syndrome, and autism. Testing or treatment, which is the obligation of the school district to provide as mandated by State or Federal Law. Treatment of hyperactivity and Attention Deficit Disorder (ADD) for a member over the age of 18 years.
44. Care or treatment of chronic marital or family problems; occupational, religious, or other social maladjustments; chronic behavior disorders; chronic situational reactions.
45. Services for the treatment of suicide, attempted suicide, or intentionally self-inflicted injury whether the member is sane or insane, including the use of a weapon, any illegal and/or controlled substances, or alcohol.
46. Birth control drugs, devices and implants, except as set forth in a Prescription Drug Rider or in this EOC.
47. Prescription drugs, except as otherwise set forth in this EOC or in a Prescription Drug Rider. Over-the-counter drugs, medicines, and other substances not requiring a prescription, even if ordered by a physician. Drugs consumed in a physician's office, other than immunizations, allergy serum, and chemotherapy drugs, except as otherwise provided in a Prescription Drug Rider. Self-injectables are not covered except as otherwise set forth in this EOC or in a Prescription Drug Rider.
48. 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.
49. Experimental, Ecological or Environmental medicine including, but not limited to, 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.

50. Natural and Herbal remedies that may be purchased "over-the-counter" or at a retail location.
51. Over-the-counter support hose/compression socks, even if ordered by a Physician. Custom hose, which must be measured and made specifically for the patient will be covered only for the treatment of burns or lymphedema.
52. Dental 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, 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 specifically set forth elsewhere in this EOC. Treatment to the gums and treatment of pain or infection known or thought to be due to dental cause and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthosis or prosthesis; replacement of metal dental fillings.
53. Temporomandibular Joint Syndrome (TMJ) or dysfunctional services are covered only where the required services are not recognized dental procedures or supplies, to include night guards.
54. 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 set forth in this EOC. The furnishing or replacing of eyeglasses or contact lenses, except coverage for the first pair of eyeglasses and/or contact lenses following cataract surgery. The surgical correction of near and/or far vision inefficiencies such as Laser and Radial Keratotomy (PK).
55. Charges related to the acquisition or use of medical Marijuana.
56. Services for the following Clinical Trial services:
  - Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
  - Coverage for a drug or device described above which is paid for by the manufacturer, distributor or provider of the drug or device.
  - Health care services that are specifically excluded from coverage under Hometown Health Plan, regardless of whether such services are provided under the clinical trial or study.
  - 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.
  - Extraneous expenses related to the member in the clinical trial or study including, without limitation, travel, housing and other expenses that a member may incur.
  - Any expenses incurred by a person who accompanies the member during the clinical trial or study.
  - 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.
  - Any costs for the management of research relating to the clinical trial or study.

<b>B. LIMITATIONS</b>
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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 Plan 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 Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Hometown Health Plan and providers shall render the covered services provided under this EOC insofar as practical, and according to their best judgment; but Hometown Health Plan 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.

## 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.

### A. SCOPE OF THE PROGRAM

The Utilization Management program applies to healthcare services utilized by eligible members. A referral from a member's Primary Care Physician and prior-authorization from Hometown Health Plan is required for all referrals to other physicians and providers. 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
- Surgical services as inpatient, or same day surgery
- All specialty physician services, and follow-up visits
- Mental health and substance abuse services
- Home health care,
- Healthcare services and supplies, including, but not limited to, oxygen, oxygen-related equipment and all durable medical equipment (DME) over \$100
- Prosthetic and orthopedic devices (DME) over \$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 Plan

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.

Upon confirmation of pregnancy, Hometown Health Plan **must** be notified.

### B. AUTHORIZATION/PRIOR-AUTHORIZATION PROCESS

#### 1. Hospital Admissions

Contracted providers are responsible for notifying Hometown Health Plan of a hospital stay at least (5) business days before elective admission to a hospital. Hometown Health Plan 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 Plan's criteria and protocols, benefits will not be paid for hospital or related charges.

#### 2. Inpatient/Outpatient Surgery

Contracted providers are responsible for making sure Hometown Health Plan is notified at least 5 business days before inpatient/outpatient surgery is performed. Hometown Health Plan 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 Plan'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 Primary Care Physician or Hometown Health Plan 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 Plan within the above stated times, notification must be received by Hometown Health Plan as soon as reasonably possible.

#### 4. **Healthcare Services and Supplies Review**

Contracted physicians and providers are responsible for making sure Hometown Health Plan 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/Quality Improvement Committee, are utilized as the standard measurement tool.

Non-contracted physicians and providers may not know or attempt to notify Hometown Health Plan to obtain prior-authorization for services. The **member** should verify Hometown Health Plan'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 Plan's criteria and protocols.

### **C. CONCURRENT REVIEW / CASE MANAGEMENT**

After admission to a facility, Hometown Health Plan will continue to evaluate the patient's progress to monitor appropriate level of care and services. If after consulting with the physician, Hometown Health Plan determines a lower level of care is appropriate and/or service(s) 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 Plan to coordinate ambulatory services or alternate methods of medical care or treatment instead of hospital confinement. Hometown Health Plan 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 Plan 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 Plan 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 Plan is unable to authorize any portion of the stay or treatment, the attending or Primary Care Physician will be contacted to provide additional information.

Benefits will be paid only for those days or treatment, which would have been authorized under Part 4, Utilization Management Program, and Scope of the Program, Prior-Authorization/Authorization Process or Concurrent Review/Case Management.

### **E. EXPEDITED APPEAL PROCESS**

Hometown Health Plan 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 Plan may have to him or her regarding that care. Grievance procedures can be found in Part 18, Member Appeal Procedure.

## **PART 5 DELIVERY OF AND RESTRICTIONS TO SERVICES AND BENEFITS**

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

Hometown Health Plan 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 Primary Care Physician orders the services
- Hometown Health Plan 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 Primary Care Physician by contacting Hometown Health Plan.

A member shall be entitled to receive medically necessary medical care and services from Primary Care Physicians 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 Primary Care Physician
- Prior authorized by Hometown Health Plan according to the Hometown Health Plan UM/QA protocols, if applicable.

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

## **PART 6                      RELATIONSHIP OF PARTIES**

### **A.    INDEPENDENT CONTRACTORS**

The relationship of Hometown Health Plan, participating physicians and participating providers is that of an independent contractor relationship. Providers are not agents or employees of Hometown Health Plan, nor is Hometown Health Plan, or any employee of Hometown Health Plan, an employee or agent of the providers. Hometown Health Plan 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/PATIENT RELATIONSHIP**

Hometown Health Plan 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 Plan that a particular course of medical treatment is not a covered service or is inconsistent with Hometown Health Plan 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.

## PART 7 ELIGIBILITY AND ENROLLMENT

### A. WHO IS ELIGIBLE FOR COVERAGE

1. **The Subscriber** - To be eligible to enroll as a subscriber, a person must:
  - a. Be an eligible employee of the group who is entitled on his or her own behalf to participate in the medical and hospital benefits arranged by the group, including satisfaction of any probationary or Waiting Period established by the group;
  - b. Complete and execute all enrollment forms and such other documents as required by Hometown Health Plan; and
  - c. Pay any and all premium that is due.
2. **Eligible Family Dependents** - To be eligible to enroll as a family member, a person must be listed on the enrollment form completed by the subscriber, and meet all dependent eligibility criteria established by the group, and be:
  - a. The subscriber's lawful spouse; or
  - b. Any unmarried child (limited to a natural child, stepchild, grandchild, and/or a legally adopted child) of either subscriber or subscriber's spouse, who is under age 19, and is a dependent of the subscriber, or who must be provided with coverage due to court order (i.e., divorce) subject to the balance of this Part 7, Eligibility, and Enrollment or;
  - c. A grandchild of the subscriber if the following requirements are met:
    - i. The grandchild must be born to a dependent (hereinafter called the "dependent parent") covered by the subscriber under this plan; and
    - ii. The grandchild's birth date must occur after the effective date of coverage of the "dependent parent"; and
    - iii. The "dependent parent" must continue 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, must reside with the subscriber; or
  - d. Any unmarried child as defined in subsection (b), above, who is between 19 and 25 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. If a dependent is no longer a full-time student and proper notice is not provided to Hometown Health Plan pursuant to Part 7, Eligibility, and Enrollment, E, Hometown Health Plan shall have the right to retroactively terminate coverage on the last day of the month full-time student status actually ceased and to recover an amount from subscriber and/or dependent equal to the maximum allowed amount for services provided after that date; or
  - e. An unmarried child who is and continues to be **both** [1] unable to support themselves due to mental illness, developmental disability, mental retardation, physical handicap **and** [2] chiefly dependent upon the subscriber for support and maintenance. This condition must have occurred **before** the child reaches the age of 19. Proof of incapacity must be furnished to Hometown Health Plan at the time of enrollment and each year thereafter; or
  - f. A legal ward (pursuant to court order) permanently placed in the Subscriber's home.

- g. A newborn or newly acquired child of the subscriber, the subscriber's spouse, or subscriber's dependent, who meets the requirements of section C above, has coverage from the moment of birth or acquisition, subject to all other provisions of this EOC. If the child is adopted or placed for adoption, then coverage shall start on the date the adoption becomes effective pursuant to Nevada law or from the moment of placement in the subscriber's home subject to certification of such placement by the placing agency. Coverage of the newborn, the newly adopted child and/or the child placed for adoption (as shown in 2-B) shall cease after 31 days from birth or acquisition unless the child is enrolled in Hometown Health Plan and all applicable premiums paid within the above time frame. Coverage of an adopted child shall cease 31 days after the adoption proceedings are concluded as certified by the public or private agency making the placement unless the child is enrolled in Hometown Health Plan and all applicable premiums paid.
- h. 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 in Part 7, Section A, 2 (a) through (g) above are not eligible dependents for purposes of this policy. Grandchildren of the subscriber or subscriber's spouse are not eligible dependents unless all requirements in Section C above are met.

## B. ENROLLMENT

1. **Initial Enrollment** - Each eligible subscriber of the group during the initial group open enrollment period shall be entitled to apply for coverage for himself or herself and eligible family dependents (who must be listed on the enrollment form). A medical assessment form must be provided to Hometown Health Plan upon request.
2. **Newly Eligible Employees** - Each new eligible employee of the group entering employment after the group's initial enrollment effective date shall be permitted to apply for coverage for himself or herself and eligible family dependents, within 31 days of becoming eligible, subject to the enrollment regulations in effect with the group.
3. **Newly Eligible Dependents** - The subscriber may enroll anyone attaining qualification as a dependent by completing and submitting to Hometown Health Plan a signed enrollment form and medical assessment form, if required, within 31 days of qualifying as a dependent.
4. **Limitation** - Persons initially or newly eligible for enrollment who do not enroll within 31 days of eligibility or who have previously waived coverage may only be enrolled during the open enrollment period at group's renewal or due to a qualifying event.

## C. ENROLLMENT EFFECTIVE DATE

Only qualifying events will allow a late enrollee to be enrolled on the plan after group's open enrollment.

Coverage for adopted newborns and children will be from the date the adoption is effective pursuant to Nevada law or from placement in the subscriber's home subject to certification by the placing agency.

## D. DELIVERY OF DOCUMENTS

Hometown Health Plan will give a copy of this EOC, Summary of Benefits and any other applicable attachments or Riders to each subscriber after enrollment.

## E. NOTICE OF INELIGIBILITY

It shall be the subscriber's responsibility to notify group of any changes that will affect subscriber's eligibility or that of dependents herein.

**F. RULES OF ELIGIBILITY**

No one is eligible to re-enroll who has been terminated under Part 8, Termination of Member's Coverage, A (2) a. or A (2) b. No person will be refused coverage due to his or her race, color, economic status, and creed, marital status, age, sex or national origin. Member's coverage will not be terminated or renewal refused due to his or her age, health status, economic status, health care needs, or prospective health care costs.

**G. DOCUMENTATION**

Request for birth certificates, marriage licenses, court orders, or other items (e.g. certificates of coverage, US citizenship) must be furnished by subscriber to the plan within 30 days of receipt of request. Failure to furnish the requested documents will result in ineligibility.

**H. NOTICE OF CREDITABLE COVERAGE**

Evidence of creditable coverage will be required to verify continuous coverage. It is the responsibility of the subscriber to supply such documentation to Hometown Health Plan.

## PART 8

## TERMINATION OF MEMBER'S COVERAGE

### A. TERMINATION

Except as expressly provided in this EOC, and subject to the provisions of coverage herein, a member will be terminated or canceled as follows:

#### 1. Cancellation

- a. If the Group Subscription Agreement is canceled or terminated, a member's coverage under this EOC shall also be canceled on the effective date of the Group Subscription Agreement's termination.
- b. 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 Plan shall not be liable for any health care services incurred by any member, jointly and severally, for all services provided or arranged for members by Hometown Health Plan during the grace period and thereafter.

#### 2. Termination for cause

- a. If the member permits the use of his or her Hometown Health Plan membership card or uses another person's card, Hometown Health Plan may retain the card and coverage of the member shall terminate upon 30 days written notice to the member. The subscriber (and member if different) shall be liable to Hometown Health Plan for all costs incurred as a result of the misuse of the membership card.
- b. If incorrect or incomplete information was furnished to Hometown Health Plan which constitutes a material misrepresentation and/or fraud, then the coverage of the member who either furnished such information and/or on whose behalf such information was furnished may, at Hometown Health Plan's sole discretion, either be terminated immediately, upon 30 days notice, or be voided retroactive to the effective date of coverage. In addition, the subscriber (and member if different) shall be responsible for all costs incurred by Hometown Health Plan as a result of the misrepresentation.
- c. Subject to Part 9, Individual Conversion Privilege and Transfer, 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 Group Subscription Agreement. This paragraph 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. 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.
- e. If the group falls below two (2) eligible employees, a sixty-day (60) written termination notice will be given.

### B. REINSTATEMENT

A member shall not be reinstated automatically if coverage is terminated; reapplication with Medical Assessment Form is required. At Hometown Health Plan's sole discretion, this requirement may be waived.

### C. 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 Plan for that period. Neither Hometown Health Plan 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.

## **PART 9                    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 Plan 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 Plan; and
- You have been enrolled under this plan or a preceding plan that Hometown Health Plan 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.

The non-group conversion coverage provides less extensive benefits than those offered under this plan of benefits from Hometown Health Plan. For example, you might have higher copayments, and any riders attached to this EOC would not be available.

Conversion rights are subject to all terms and conditions that Hometown Health Plan 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 Plan 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 Plan 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 Group Subscription Agreement 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 Group Subscription Agreement.
5. The member would be considered over-insured.
6. The member voluntarily terminated his or her coverage under the plan.

### **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.
2. The benefits under the conversion policy, combined with similar benefits, result in excess insurance based on Hometown Health Plan'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.

## **PART 10 CONTINUATION OF BENEFITS REQUIRED UNDER FEDERAL LAW**

### **A. COBRA**

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:

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

### **B. NOTICE OF CONTINUATION OF COVERAGE**

1. 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.
2. 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:
  - a. Death; or
  - b. Termination of employment; or
  - c. Reduction of work hours resulting in loss of coverage; or
  - d. Eligibility for Medicare benefits.
3. The member must provide notice to the group (or the plan administrator if different from the group) of the following:
  - a. Member's divorce or legal separation; or
  - b. Member's loss of eligibility as a dependent child under this plan because of age or marriage.
4. 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.
5. 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.
6. 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 Plan 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.
7. 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.

8. In no event will Hometown Health Plan be the plan administrator. The term "Plan Administrator" refers to a person or entity, other than Hometown Health Plan, 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 Plan; but rather, the group is fulfilling statutory obligations imposed on it by Federal Law and where applicable, acting as the agent of the member.

#### **C. PAYMENT OF PREMIUMS**

The group is responsible to Hometown Health Plan 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 Plan is allowed to charge 102 percent of the applicable premium during the COBRA period.

#### **D. COMMENCEMENT OF CONTINUATION OF COVERAGE**

##### **1. Subscriber**

If Hometown Health Plan 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:

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

##### **2. Spouse**

If Hometown Health Plan 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 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:

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

##### **3. Dependent Children**

If Hometown Health Plan 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 for dependent children enrolled under this plan at the time the qualifying event, will commence upon:

- a. Loss of eligibility because of age or marriage; or
- b. Any one of the conditions listed under paragraph D-1 or D-2, above (except when children of a divorced or legally separated spouse of a subscriber remain enrolled as family members of that subscriber).

#### **E. TERMINATION OF CONTINUATION OF COVERAGE**

##### **1. Subscriber**

Continuation of coverage which commenced under paragraph D-1, above, for a subscriber will terminate when the first of the following events occurs:

- a. A period of 18 months has elapsed; or
- b. This plan between the group and Hometown Health Plan is canceled; or

- c. The required premiums for the next period are not paid; or
- d. The subscriber becomes eligible for Medicare; or
- e. 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
- f. Hometown Health Plan receives written notice of the subscriber's voluntary cancellation of coverage.

**2. Spouse and Dependent Children**

Continuation of coverage that commenced under paragraph D-2 or D-3, above, will terminate for the spouse and dependent children when the first of the following events occurs:

- a. A period of 36 months has elapsed; or
- b. This plan between the group and Hometown Health Plan is canceled; or
- c. The required premiums for the next period are not paid; or
- d. 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
- e. Hometown Health Plan receives written notice of the member's voluntary cancellation of coverage.

**F. OTHER PROVISIONS APPLICABLE TO CONTINUATION OF COVERAGE**

- 1. 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.***
- 2. For the purpose of determining the proper premiums for continuation of coverage:
  - a. A spouse whose continuation of coverage commences under paragraph D-2, above will be considered a subscriber, and
  - b. A child whose continuation of coverage commences under paragraph D-3, above will be considered a subscriber, and
- 3. If a member is covered under another carrier's continuation of coverage when the group changes coverage to Hometown Health Plan, the term of continuation of coverage provided that member by Hometown Health Plan will be reduced by the period coverage was continued under the prior carrier's plan.

**G. 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.

**1. Increased Premium**

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

**2. 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 final determination that the member is no longer disabled.

## PART 11

# NEVADA CONTINUATION OF COVERAGE UNDER CERTAIN GROUP POLICIES

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.

### A. CONTINUATION OF COVERAGE

Qualifying events for continuation of coverage under the plan are:

#### 1. Eligible Employee

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

#### 2. Family Dependents

- a. Eligible employee's non-voluntary termination for any reason other than gross conduct; or
- b. Reduction in working hours of the eligible employee; or
- c. Death of the eligible employee; or
- d. Divorce or legal separation of the eligible employee and spouse; or
- e. Eligibility of eligible employee for Medicare benefits; or
- f. Loss of child's dependent status under requirements of the plan.

### B. NOTICE OF CONTINUATION OF COVERAGE

1. 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.
2. 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.
3. 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.

### C. COMMENCEMENT OF CONTINUATION OF COVERAGE

*If Hometown Health Plan 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 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.

#### D. TERMINATION OF COVERAGE

Continuation of coverage which commenced under paragraph "C" above for a subscriber and/or any family members of that subscriber will terminate when the first of the following events occurs:

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

#### E. OTHER PROVISIONS APPLICABLE TO CONTINUATION OF COVERAGE

1. Newborns are covered for the first 31 days of life for care of illness or injury.  
***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.***
2. For the purpose of determining the proper premiums for continuation of coverage:
  - a. A spouse whose continuation of coverage starts under paragraph A above, will be considered a subscriber.
  - b. A child whose continuation of coverage starts under paragraph A above will be considered a subscriber.

**PART 12 CONTINUATION OF COVERAGE:  
FEDERAL FAMILY AND MEDICAL LEAVE ACT OF 1993:  
EMPLOYER APPROVED LEAVE OF ABSENCE**

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.

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.

- a. **"Parent"** - a biological parent or an individual whom stood **in loco parentis** to a child when the child was a son or daughter.
- b. **"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.
- c. **"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.
- d. **"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.

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 of group insurance is terminated; or
4. 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.

## **PART 13 CONTINUATION OF COVERAGE: TOTAL DISABILITY UNDER NEVADA STATE LAW**

This section will start only after the time period, stated in Part 7, Eligibility, and Enrollment has expired, but only if Part 7 is applicable.

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.

## **PART 14 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.

## PART 15 SUBROGATION / RIGHT TO REIMBURSEMENT

Immediately upon paying or providing any benefit under this plan, Hometown Health Plan 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 Plan shall have the right to recover the reasonable value of services and benefits provided or to be provided by Hometown Health Plan.

In addition, if a member receives any payment from any potentially responsible party as a result of an injury or illness, Hometown Health Plan 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 Plan 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 Plan 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 Plan's Subrogation and Reimbursement rights and shall, when requested, fully cooperate with Hometown Health Plan's efforts to recover its benefits. It is the duty of the member to notify Hometown Health Plan 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 Plan's Subrogation and Reimbursement rights are a first priority claim against all potential responsible parties and are to be paid to Hometown Health Plan before any other claims for the member's damages. Hometown Health Plan shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to Hometown Health Plan 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 Plan 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 Plan 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 Plan 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.

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 Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

## PART 16 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 Plan 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 Plan 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"** will mean an entity providing group health care benefits or services by any of the following methods:
  - a. Group insurance or any other arrangement for coverage for individuals whether on an insured or uninsured basis; or
  - b. Group service plan contracts, group practice, individual practice and other prepayment coverage; or
  - c. 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
  - d. Any coverage under labor management trustee plans, union welfare plans, employer organization plans, employee benefits plans, or employee benefit organization plans; or
  - e. 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
  - f. Coverage under a governmental program, including Medicare and Worker's Compensation plans.
2. 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.
3. **"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.
4. **"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.
5. **"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.

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 Plan (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 Plan any information needed by Hometown Health Plan to coordinate those benefits.

#### **H. RIGHT TO RECOVER PAYMENT**

If the amount of benefit payment exceeds the amount needed to satisfy Hometown Health Plan's obligation under this Part, Hometown Health Plan 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.

## PART 17            MEDICARE COORDINATION OF BENEFITS (MEDICARE COB)

This Medicare COB Rule applies when the member:

1. Has health insurance under this policy; and
2. 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

**"ADEA Employer"** - an Employer which:

1. Is subject to the U.S. Age Discrimination in Employment Act (ADEA); and
2. 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.

**"ESRD"** - End Stage Renal Disease

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

Note, for services payable under both plans, the combined Hometown Health Plan 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 Plan 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 Plan has secondary responsibility.
2. **For A Dependent Spouse** - If all of the following apply, Hometown Health Plan 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 Plan has secondary responsibility.

3. **For a Disabled Person** - Hometown Health Plan 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** - Hometown Health Plan 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 Plan 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 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.

## PART 18 MEMBER APPEAL PROCEDURE

Concerns about medical services are best handled at the medical service site level before being brought to Hometown Health Plan. If a member contacts Hometown Health Plan 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 Plan 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. **1<sup>st</sup> Level Formal Appeal** - An appeal filed in writing which the Customer Services Department investigates. If a 1<sup>st</sup> Level Formal Appeal is resolved to the satisfaction of the member, the matter ends.
3. **2<sup>nd</sup> Level Formal Appeal**- If a 1<sup>st</sup> Level Formal Appeal is not resolved to the member's satisfaction, a member may then file a 2<sup>nd</sup> Level Formal Appeal. A 2<sup>nd</sup> Level Formal Appeal is submitted in writing on a Hometown Health Plan Request for Formal Hearing form and reviewed by the Grievance Committee. The 2<sup>nd</sup> 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 Plan, 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 Plan membership number
- Name of person(s) involved
- Date(s) of occurrence
- Location
- 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 1<sup>st</sup> Level Formal Appeal.

#### 2. 1<sup>st</sup> 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 1<sup>st</sup> Level Formal Appeal. ***The 1<sup>st</sup> 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 1<sup>st</sup> 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. 1<sup>st</sup> 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 Plan 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 Plan should cover the Claim for Benefits.

Hometown Health Plan 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 1<sup>st</sup> Level Formal Appeal for an appeal regarding a denied authorization (pre-service) and within 20 working days of receipt of the 1<sup>st</sup> 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 1<sup>st</sup> Level Formal Appeal is not acceptable to the member, the member is entitled to file a 2<sup>nd</sup> Level Formal Appeal. The member will be informed of this right at the time the member is informed of the resolution of his/her 1<sup>st</sup> 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 Plan relevant to the Adverse Benefit Determination including, but not limited to, any applicable internal rule or guideline of Hometown Health Plan on which it relied in making the Adverse Benefit determination and, if the Adverse Benefit Determination related to medical necessity, a 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 Plan.

- 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. 2<sup>nd</sup> Level Formal Appeal**

When a 1<sup>st</sup> Level Formal Appeal is not resolved in a manner that is satisfactory to the member, the member may initiate a 2<sup>nd</sup> 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 1<sup>st</sup> Level Formal Appeal decision letter) within sixty (60) days after the member has been informed of the resolution of the 1<sup>st</sup> Level Formal Appeal.***

Exhaustion of the 1<sup>st</sup> Level Formal Appeal procedure is a precondition to filing a 2<sup>nd</sup> Level Formal Appeal. A 2<sup>nd</sup> 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 2<sup>nd</sup> 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 1<sup>st</sup> 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 2<sup>nd</sup> 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 Plan 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.

The Grievance Committee shall consider the 2<sup>nd</sup> 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 2<sup>nd</sup> 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 2<sup>nd</sup> 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 Plan 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.

## **PART 19            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, Primary Care Physicians, 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 Plan. 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 Plan 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 Plan is notified in writing in a form satisfactory to Hometown Health Plan of a requested addition/deletion to, or change in, a member's Hometown Health Plan coverage status.

### **G. ENTIRE EOC**

This Evidence of Coverage, the Group Subscription Agreement, 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 Plan 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.

### **H. FORM OR CONTENT OF EOC**

No agent or employee of Hometown Health Plan 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 Plan.

**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 Plan to members are for identification only. Possession of a Hometown Health Plan 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 Plan 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 Plan 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 Plan or accepting Hometown Health Plan 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 Plan  
Attention: Customer Services  
830 Harvard Way  
Reno, Nevada 89502

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

**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 Plan 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 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 Plan 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 Plan 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 Plan, Customer Services 830 Harvard Way, Reno, NV 89502

Any correspondence from Hometown Health Plan 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 Plan 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 information to determine whether, or to what extent, benefits are covered or payable under the plan.

If insufficient information is received, Hometown Health Plan 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 Plan 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 Plan’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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 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 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)