Hometown Health Plan, Inc. is a Health Maintenance Organization (HMO) licensed by the State of Nevada to provide or arrange for the provision of health care services on behalf of its Members. This Policy is an open access Health Maintenance Organization health care plan that provides access to a large a network of Providers, with the ability to see most Specialty Care Physicians without a referral.

This Summary of Benefits describes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures. Refer to your Evidence of Coverage (EOC) for Policy-specific cost sharing information not described within this Summary of Benefits. In case of conflicts between the EOC and Summary of Benefits, the EOC shall be the document that determines the benefits or interpretation of those documents.

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

Copies of EOCs, Summaries of Benefits, attachments, riders, and other associated documents are available online at www.hometownhealth.com in the Members section under "View My Benefits." We will provide you with paper copies of these documents without charge upon your request to our customer services department. This document contains summary information for your reference. It does not contain all of the prior authorization requirements and specific restrictions, exclusions and limitations associated with this benefit plan. Refer to the Hometown Health Providers Insurance Company (Hometown Health) PPO Evidence of Coverage (EOC) for a more comprehensive list of prior-authorization requirements and specific restrictions, exclusions and limitations.

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

Benefit plan – the specific health insurance policy outlined in this Summary of Benefits

Coinsurance means the percentage of covered charges that is due and payable by the Member to a Provider upon receipt of certain covered services. Coinsurance is presented in the Summary of Benefits as a percentage of the maximum allowable amount that is due and payable by the Member to a Provider upon receipt of covered services. Coinsurance applies after all deductibles have been paid, unless otherwise stated within the Summary of Benefits or EOC.

Copayment – the specific amount payable by the member to a provider of care at the time of service for certain covered services. If the benefit plan has a deductible for a service, the copayment and the deductible both apply to the service. Once the deductible has been satisfied the copayments for a particular service apply until the Out of Pocket maximum for the plan is reached. If there is no deductible for a particular service, and a copayment is listed, the member's cost sharing for that service will be that copayment. Copayments apply to the out of pocket maximums.

Deductible- the set amount that must be paid by a member before Hometown Health pays for covered services, other than preventive care, or other named copayment specific benefits, before benefits are payable by Hometown Health. There may be separate deductibles for pharmacy and medical benefits according to the benefit plan that is in place, or they may be combined. Services subject to the deductible will be named in the benefit grid.

Deductibles are based on calendar years (CYD). A calendar year begins January 1 and ends December 31 of that year. A member must satisfy the individual deductible for some benefits and plans before benefits other than those noted earlier in this section are payable, unless the Family has met the family deductible.
A Family deductible is set at two to three times the individual deductible. One individual family member cannot contribute more than 50% of the family deductible amount. The Family deductible continues to be applied to the benefits of other family members until the total Family deductible has been met.

Health Savings Account (HSA) a bank account owned by an individual used exclusively to pay for current and future medical expenses, HSAs are used in conjunction with qualified health insurance policies as defined by the United States Department of the Treasury. HSA qualified health insurance policies cannot cover medical expenses before deductibles or coinsurance except for preventive care services.

Medically Necessary means health care services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an Illness, Injury or disease, or any symptoms thereof, that are:

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

For purposes of this EOC, the phrase "generally accepted standards of medical practice" is defined as standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, endorsed through national Physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas with regard to a patient's condition.

Non-preferred Providers (Out-of-Network)-Healthcare Providers with whom Hometown Health has not contracted to provide discounted covered healthcare services to its members.

Out-of-Pocket Maximum (OOP) -the maximum payment amount for which the Member or Family is responsible for deductible, copayments, or coinsurance in a calendar year for covered services. Out of pocket maximums may be different for pharmacy and medical benefits. For plans, that have an out of pocket maximum that is aggregated from all benefits, all out of pocket maximums for these benefits will be aggregated to determine the out of pocket maximum total for that calendar year. In no instance will the out of pocket maximum amount for covered services provided at the in-network benefit level that a member pays be greater than the amount stated in the benefit plan. Some plans will have out of pocket maximums that are separate for medical and pharmacy.

Different Out-of-Pocket coinsurance maximums apply for individuals and families. Different Out-of-Pocket coinsurance maximums apply for In-Network Providers and for Out of Network Providers, where the benefit plan provides coverage for Out of Network Providers. Deductibles count towards the Out-of-Pocket maximum for in-network benefits. Deductibles for out of network benefits apply to out of network out of pocket maximums. When a member goes outside the network, and seeks care from an Out of Network provider, the difference between the Provider's bill and the usual and customary allowable as determine by Hometown Health, does not count towards the out of pocket maximum for the non-preferred benefit.

Prior authorization means our determination of medical necessity and benefit coverage using utilization management and quality assurance protocols prior to the services being rendered. All benefits listed in this Summary of Benefits may be subject to prior authorization requirements and concurrent review depending upon the circumstances associated with the services. Refer to your plan-specific summary of benefits for services that require prior authorization. You may find a full list of services that require prior authorization by visiting our website at www.hometownhealth.com.

Preferred or Participating Provider -Physician, organization or association of Physicians, Hospital, skilled nursing facility, any organization licensed by a state to render home health services, or any other licensed institution or Professional who is listed in our current health directory and who is directly or indirectly under contract with us to provide Covered Services to Members. A Participating Provider provides services within our Network. Participating Providers are only located in the Licensed Area or out-of-state within 30 miles from the Licensed Area. Unless a Provider is a Participating Provider, services are rendered for a life threatening emergency, or we have issued a prior-authorization for an in-network service, we will cover services by a non-Participating Provider at the non-preferred benefit level of the Policy, if a non-preferred benefit is available.

Usual and Customary means the lesser of:

a. A Provider's usual charge for furnishing a treatment, service, or supply;
b. The charge we determine to be the general rate charged by others who render or furnish such treatment, service, or supply to person who reside in the same geographic area and whose condition is comparable in nature and severity; or
c. What Medicare would pay for such treatment, service, or supply.

The benefits outlined in the Benefit Summary Table are not a complete listing of the medical services covered under this benefit plan. Benefits for services not listed can be found in the EOC. Copayments for services not shown in the Benefit Summary Table are determined by the location in which services are provided (such as emergency rooms, urgent care centers or physicians' offices). The copayment or coinsurance amounts listed in the Benefit Summary Table are applicable for covered services received as described in the EOC and the

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Summary of Benefits. All charges associated with non-covered services or denied claims are the member's responsibility.

Benefit Summary Table		
Benefit Category	Member Responsibility	
Deductibles – ***- Subject to CYD***	In-Network	Out-of-Network
Individual Overall Deductible	N/A	N/A
Family Overall Deductible	N/A	N/A
Individual Medical Deductible *[if separate]*	N/A	N/A
Family Medical Deductible *[if separate]*	N/A	N/A
Individual Annual Out-of-Pocket Maximum –	$2,500	N/A
Family Annual Out-of-Pocket Maximum	$5,000	N/A
During a calendar year, individuals are responsible for paying copayments, coinsurance, and deductibles for certain benefits up to the individual, annual Out-of-Pocket maximum. However if coverage is extended to qualified dependents and the family, annual Out-of-Pocket maximum has been paid, no further payment is required for benefits to be paid on the member's behalf. Out of pocket maximums are different for In-Network and Out-of Network benefit levels if an Out of Network option is offered on the plan.		
Physician Office Visits –***- Subject to CalendarYear Deductible (CYD)***	Member Responsibility	
Primary care (PCP)	$25	
Primary care - wellness visit PPACA covered	$0	
Obstetrics and gynecology for PPACA services	$0	
Specialist care	$50	
No referral is required for these visits. All necessary wellness visits are covered for children less than two years of age. One wellness visit per year is covered for members older than two or as frequently as mandated by ACA.		
Preventive Screenings – ***- Subject to CYD***	Member Responsibility	
Mammography screening	$0	
Papanicolaou (Pap) test	$0	
Prostate Specific Antigen (PSA) screen	$0	
Colorectal screening	$0	
Counseling for sexually transmitted infections (STI) HIV counseling and testing	$0	
Breastfeeding support, supplies and counseling	$0	
Screening for interpersonal and domestic violence	$0	
Contraceptives and Counseling for FDA approved in office including injections, implants, and contraceptive devices not covered under pharmacy benefits	$0	
Screening for Gestational Diabetes	$0	

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High-risk human papillomavirus (HPV) testing	$0
See: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/guide-clinical-preventive-services.pdf For A &B recommendations for screenings and coverage under the ACA.	
Hospital Facility Services –* - ***Subject to CYD***	Member Responsibility
Acute care hospital admission	$1,000 copay/admit
Outpatient observation	$1,000 copay/admit
Skilled nursing facility (limited to 100 days per calendar year)	$1,000 copay/admit
Rehabilitation facility (limited to 60 days per calendar year)	$1,000 copay/admit
Inpatient hospital services include a semiprivate room, physician services, meals, operating room charges, imaging services and laboratory services. Inpatient hospital services require Prior Authorization. *In emergencies in which a member is admitted to a hospital for an inpatient stay, in order to satisfy the Prior Authorization requirement, Hometown Health must be notified on the first business day following the admission date or at the earliest possible time when it is reasonable to do so.*	
Urgent Care and Emergency Services –* - ***Subject to CYD***	
Urgent Care Center Services	$40 copay/visit
Emergency Room Services	$100 copay/visit
Ambulance (ground)	$100 copay/visit
Ambulance (air and water)	$200 copay/trip
Imaging and Diagnostic Testing –* - ***Subject to CYD***	Member Responsibility
Computer Tomography (CT) scan	$225
Positron Emission Tomography (PET) scan	$225
Magnetic Resonance Imaging (MRI)	$225
General nuclear medicine	$225
All other imaging services	Depends upon site of service
Service Provided in a primary care physician office	$25 copay
Services provided in a specialty care physician office	$50 copay
Service Provided in a hospital outpatient setting	$50 copay
Diagnostic mammography	$50 copay
High-Technology imaging services require Prior Authorization, CT, CTA, MRI, MRA, PET, Cardiac Nuclear Medicine, for consideration to be paid under the terms of the plan	
Laboratory Services – * - ***Subject to CYD***	Member Responsibility
General laboratory services unless covered under ACA preventive guidelines	$0
Outpatient Therapy and Rehabilitation Services – * - ***Subject to CYD***	Member

	Responsibility
Speech therapy (Limited to 90 visits per calendar year all modalities combined.)	$25 copay/visit
Occupational therapy (Limited to 90 visits per calendar year all modalities combined.)	$25 copay/visit
Physical therapy (Limited to 90 visits per calendar year all modalities combined.)	$25 copay/visit
Coverage for these therapies is provided with these limits for both habilitative and rehabilitative services as a limit of 60 visits per calendar year for each habilitative and rehabilitative services as per the medical necessity of these services.	
Wound therapy in a physician's office	$25 copay/visit
Wound therapy in an outpatient hospital setting	$25 copay/visit
Rehabilitation services require Prior Authorization.	$25 copay/visit
Chemotherapy in an outpatient hospital setting	$50 copay/visit
Chemotherapy in a physician office	$50 copay/visit
Infusion therapy in an outpatient hospital setting	$50 copay/visit
Infusion therapy in a physician office	$50 copay/visit
Home infusion therapy	$50 copay/visit
Port Wine Stain Removal	Depends upon site of service
Radiation therapy outpatient hospital/physician's office	$50 copay/visit
Surgical Services – ***<u>* - Subject to CYD</u>***	Member Responsibility
Performed in primary care physician's office	$25 copay
Performed in specialty care physician's office	$50 copay
Performed in outpatient facility	$500
Performed in same-day-surgery facility	$500
Diagnostic and therapeutic endoscopy	$150
Bariatric Surgery Limited to one Medically necessary gastric restrictive surgery per lifetime	Depends on site of service for cost-sharing
Medical Supplies, equipment and prosthetics - ***<u>* - Subject to CYD</u>***	Member Responsibility
Durable medical equipment. One purchase of specific item of DME, including repair and replacement every 3 years. Rental of DME to cover Medicare guidelines concerning rental to purchase criteria	$0
Orthopedic and prosthetic devices Limited to a single purchase of a type of prosthetic device including repair and replacement once every 3 years	$25 copay
Ostomy supplies (Limited to 30 days worth of therapeutic supplies per month)	$25 copay
Special Food Products limited to a maximum benefit	$25 copay

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of four (4) thirty (30) days of therapeutic supplies per Member per calendar year.	
All medical supplies, including oxygen and oxygen-related equipment, require Prior Authorization. Certain supply orders are limited to a 30-day supply.	
Alcohol and Substance-Abuse Treatment – ***- Subject to CYD***	Member Responsibility
Inpatient treatment	$1,000 copay/admit
Outpatient treatment – specialist	$25 copay/visit
Withdrawal treatment – inpatient	$1,000 copay/admit
Withdrawal treatment – outpatient	$25 copay/visit
Inpatient alcohol and substance- abuse treatment require Prior Authorization. Benefits for inpatient and outpatient withdrawal treatment are combined when determining the annual benefit limit.	
Medical Pharmacy and Immunizations– ***- Subject to CYD***	Member Responsibility
Special pharmaceuticals	$75 copay
Covered immunizations	$0
All other medical pharmacy	$40 copay
Some medications, injection and infusion drugs require Prior Authorization.	
Mental Health –***- Subject to CYD***	Member Responsibility
Inpatient medically necessary services for mental health disorders	$1,000 copay/admit
Outpatient and office visits – Mental health	$25 copay
Applied Behavioral Therapy for the treatment of Autism *Therapy visits limited to five hundred fifteen (515) total hours of therapy per member per calendar year*	$25 or dependent upon the site of service
All outpatient partial hospitalization programs, partial residential treatment programs, and inpatient services for mental health require Prior Authorization.	
Other Medical Services –***- Subject to CYD***	Member Responsibility
Genetic Counseling and testing	Copayment varies by site of service and reason for testing
Spinal manipulation and Chiropractic services *Limited to 20 visits per calendar year and 100 visits per lifetime*	$50 copay/visit
Kidney Dialysis and associated services	$50 copay/visit
Alternative Medicine services including Acupuncture *Limited to 20 visits per calendar year. Homeopathic medications are not covered under this benefit.*	$50 copay/visit
Home health care *Home health care requires Prior Authorization for in-network benefits to be considered* (30 visits per year). *These 30 visits per year may provide for private duty*	$20 copay/visit

nursing in the home.	
Infertility Services Medically Necessary services to diagnose problems of infertility for a covered individual. *one diagnostic evaluation for infertility every year up to 3 per lifetime and up to 6 artificial inseminations per lifetime. Exclusions apply and are detailed in the Evidence of Coverage (EOC) and the Exclusions portion of this document.*	$50 for office based services; others depend on the site of service
Temporomandibular Joint Services (TMJ) Temporomandibular Joint Disorder (TMJ) and dysfunction services and supplies including night guards are covered only when the required services are not recognized dental procedures. *Limited to annual maximum of one surgery and a lifetime maximum of two surgeries. Full scope of TMJ benefit coverage is detailed in the EOC.*	$50 for office based services; others depend on the site of service
Hospice Services are covered for Members with a life expectancy of six months or 185 days or less as certified by his or her Provider (limited to a lifetime benefit maximum of 185 days): a. Part-time intermittent home health care services totaling fewer than eight hours per day and 35 or fewer hours per week. b. Outpatient counseling of the Member and his or her immediate family (limited to 6 visits for all family members combined if they are not otherwise eligible for mental health benefits under their specific Policy). Counseling must be provided by: i. A psychiatrist, ii. A psychologist, or iii. A social worker. Members who are eligible for mental health benefits under their specific Policy should refer to the applicable description of such benefits to determine coverage. c. Respite care providing nursing care for a maximum of 8 inpatient respite care days per calendar year and 37 hours per calendar year for outpatient respite care services. Inpatient respite care will be provided only when we determine that home respite care is not appropriate or practical. Medically necessary mental health services may be covered under this policy in addition to the outpatient counseling benefits describe above.	$0 for home based services; others varies with site of service

Other Benefit Information –
This is an open access plan which means Hometown Health Plan (HMO) members may self-refer to select specialists contracted with Hometown Health Plan (HMO) without first obtaining a referral from a Primary Care Physician (PCP). Certain services require the member to receive prior authorization from Hometown Health prior to receiving the service. If prior authorization for these services is not received, the member may be responsible for payments related to the unauthorized services that the member received. Refer to the Utilization Management Program, Certification and Prior Authorization sections, in the EOC for a more comprehensive list of services requiring prior authorization.

Notwithstanding anything in this Summary of Benefits to the contrary, Hometown Health will provide:

1. emergency services (as defined within the EOC) without requiring a prior authorization and with the same cost sharing requirement with respect to in-network and out-of-network providers and with respect to providers for which Hometown Health has no contractual relationship, and
2. Preventative services described in the Public Health Service Act, Section 2713(a) (as amended by the Patient Protection and Affordable Care Act) without any cost sharing requirements.

The benefits described in this document and the EOC are available only when services are provided by a participating provider, unless referred by a Primary Care Physician and authorized in advance by Hometown Health. Prior authorization from Hometown Health is required for all services except those services provided by a member's Primary Care Physician unless otherwise noted.

After the member has paid the annual out-of-pocket maximum which includes any applicable deductibles, copayments, or coinsurance, , Hometown Health will pay 100 percent of the charges for covered services up to the maximum allowed amount.

If there is an out of network option associated with the plan offered, members may elect to seek services from non-preferred healthcare providers provided the member pays the additional deductible and coinsurance amounts and any additional charges over a usual and customary charge for the service provided. Members also may be required to obtain prior authorization before seeking services from non-preferred providers. Additional charges paid by the member above the usual and customary amount, penalties for lack of obtaining authorization, or payments for non covered services, are not included in the Out of Pocket maximum calculations.

Exclusions

The following services and benefits are excluded from coverage unless otherwise covered through a separately purchased benefit rider purchased in connection with this Policy or incorporated into the Policy described in this EOC and your Policy-specific summary of benefits. Additional exclusions that apply to only a particular service or benefit are listed in the description of that service or benefit.

1. Services not Medically Necessary or not required in accordance with accepted standards of medical practice or applicable law are excluded.

2. Treatment for any Injury or Illness that arises out of or in the course of any employment for pay or profit is excluded.

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3. Charges for care or services provided before the effective date or after the termination of coverage are excluded.
4. Any loss, expenses, or charges resulting from the Member's participation in a riot or Criminal Act; and losses related to an act of war, insurrection, or terrorism are excluded.
5. Testing and treatment for educational disorders, non-medical ancillary services such as vocational rehabilitation, work-hardening programs, and employment training and counseling, are excluded, including services rendered by or billed by a school or member of its staff.
6. Care for military service-connected disabilities and conditions for which you are legally eligible to receive from governmental agencies and for which facilities are reasonably accessible to you are excluded.
7. Care for conditions that federal, state, or local law requires be treated in a public facility, care provided under federally or state funded health care programs (except the Medicaid program), care required by a public entity, care for which there would not normally be a charge are all excluded.
8. Routine examinations primarily for insurance, immigration, travel, licensing, school sports, adoption purposes, employment, and other third-party physicals are excluded.
9. Expenses for medical reports, including presentation and preparation are excluded.
10. Medical and psychiatric evaluations, examinations, or treatments, psychological testing, therapy, and other services including hospitalizations or Partial Hospitalizations and residential treatment programs that are ordered as a condition of processing, parole, probation, or sentencing are excluded, unless we determine that such services are independently Medically Necessary. Laboratory and other diagnostic testing provided in connection with this exclusion are also excluded.
11. Cosmetic surgery or procedures are excluded. Cosmetic surgery generally includes any plastic or reconstructive surgery or medical procedure done primarily to improve the appearance of any portion of the body or restore bodily form without materially correcting a bodily malfunction. Cosmetic surgery to treat or prevent mental health or psychological conditions or consequences or socially avoidant behavior is not covered as these do not constitute a bodily malfunction.

    Excluded procedures include:

    a. Cosmetic surgery, including but not limited to surgery for sagging or extra skin; any augmentation or reduction procedures; electrolysis; liposuction; liposculpting; body contouring or recontouring to remove excess skin on any part of the body including but not limited to: tummy tucks, belt lipectomies, breast reductions or lifts;
    b. Any off-labeled use of growth hormone;
    c. Cosmetic laser treatments, rhinoplasty and associated surgery, epikeratophakia surgery, kerato-refractive eye surgery including but not limited to implants for correction of presbyopia, correction of facial or breast asymmetry (except that breast asymmetry will be provided pursuant to coverage as provided in this EOC for mastectomy benefits), treatment of male-pattern baldness, electrolysis, waxing or other methods of hair removal, or hair treatment, keloid scar therapy, any procedures utilizing an implant that cannot be expected to substantially alter physiologic functions are additionally not covered under this Policy; and

d. Cosmetics, dietary supplements, anti-aging treatments (even if FDA-Approved for other clinical indications), vitamins, diet pills, health or beauty aids, vitamin B-12 injections (except for pernicious anemia, other specified megaloblastic anemias not elsewhere classified, anemias due to disorders of glutathione metabolism, post surgery care or other b-complex deficiencies), antihemophilic factors including tissue plasminogen activator (TPA), acne preparations, and laxatives (except as otherwise covered and described within this EOC).

Additional cosmetic surgery or medical procedures exclusions include:

a. Complications resulting from excluded cosmetic surgery;
b. Complications of medical procedures that result in conditions that affect the appearance of the body without commensurate impairment of bodily function;
c. Cosmetic treatment or service related complications, insertion, removal or revision of breast implants (including complications) unless provided post mastectomy;
d. Treatment for the removal, ablation, injection, or destruction of varicose veins;
e. Psychological and physical factors including but not limited to self-image, difficult social or peer relations, embarrassment in social situations, inability to exercise or participate in recreational activities comfortably, or impact on ability to perform one's job duties; and
f. Charges that result from appetite control, food addictions, eating disorders (except documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by us and present significant symptomatic medical problems) or any treatment of obesity, unless otherwise provided in this EOC.

12. Any procedure or treatment designed to alter physical characteristics of you to those of the opposite sex and any other services, treatments, drugs, or diagnostic procedures or studies related to sex transformations are excluded.

13. All experimental or investigational medical, surgical, or other health care procedures and all transplants are excluded except as otherwise described within this EOC. We will consider a procedure or treatment as experimental or investigational at our discretion:

    a. If outcome data from randomized controlled clinical trials, recommendations from consensus panels, national medical associations, or other technology evaluation bodies and from authoritative, peer-reviewed US medical or scientific literature is insufficient to show that the procedure or treatment is:

        i. Safe, effective, or superior to existing therapy, or
        ii. Conclusive in that the evidence demonstrates that the service or therapy improves the net health outcomes for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even in the event that the service, drug, biological, or treatment may be recognized as a treatment or service for another condition, screening, or illness;

    b. If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institutes of Health, the Food and Drug Administration, or Medicare;

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c. When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply can not be legally marketed in the United States without the final approval of the Food and Drug Administration or any other state or federal regulatory agency, and such final approval has not been granted for that particular indication, condition, or disease;

d. When a nationally recognized medical society states in writing that the procedure or treatment is experimental; or

e. When the written protocols used by a facility performing the procedure or treatment state that it is experimental.

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

14. Any services or supplies furnished in an institution that is primarily a place of rest, a place for the aged, a custodial facility, or any similar institution are excluded.

    Travel expenses, accommodations, travel insurance are not covered. Oxygen provided while traveling on an airline is excluded as are portable oxygen concentrators that are supplied for purchase or rent specifically to meet airline requirements.
15.
16. Any services received outside the United States are excluded unless deemed to be urgent or Emergency care.

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

18. Except as otherwise provided in this EOC, drugs, medicines, procedures, services, and supplies, for sexual dysfunction (organic or inorganic), inadequacy, or enhancement, including penile implants and prosthetics, injections, and durable medical equipment.

19. Termination of pregnancy is excluded, other than medically indicated abortions necessary to save the life of the mother.
20. Charges for cognitive therapy is excluded unless related to short-term services necessitated by a catastrophic neurological event to restore functioning for activities of daily living.

21. Services related to job, vocational retraining, or community re-entry are excluded.

22. Sleep therapy (except for central or obstructive apnea when Medically Necessary as prior-authorized by us), behavioral training or therapy, milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, electro hypnosis, electrosleep therapy, electronarcosis, massage therapy, and gene therapy are excluded.

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

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

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

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

27. Physician services, supplies, and equipment relating to the administration or monitoring of a prescription drug are excluded unless the prescription drug is a Covered Service or covered in a separately purchased Pharmacy rider.

28. Experimental, ecological, or environmental medicine is excluded, including, but not limited to the use of chelation or chelation therapy except for Acute arsenic, gold, mercury, or lead poisoning; orthomolecular substances; use of substance of animal, vegetable, chemical or mineral origin not FDA-Approved as effective for such treatment; electrodiagnosis; Hahnemannian dilution and succussion; prolotherapy, magnetically energized geometric patterns, replacement of metal dental fillings, laetrile, and gerovital.

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

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

31. Over-the-counter support hose or compression socks are excluded even if ordered by a Physician. (Custom hose that must be measured and made specifically for the patient will be covered only for the treatment of burns or lymphedema.)

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

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

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

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

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

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

    Medically Necessary services to diagnose problems of infertility are covered for one workup per year up to 3 evaluations per lifetime. Up to six cycles of artificial insemination are covered per lifetime for covered members. For the covered female, services include the preparation of the sperm and the insemination, provided that the sperm has not been purchased or the donor compensated for his biological material or services, and that the donor is has benefits under a Hometown Health 2014 individual or small group plan costs related to the actual insemination of a non covered person, are not covered under the terms of this benefit plan. The following services are not covered:

    a. All other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit. This is includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy

    b. The promotion of fertility including, but not limited to, fertility testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos; maternity services related to a Member serving in the capacity of a surrogate mother, sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval;

    c. Any services related to a Member serving in the capacity of a surrogate mother, including, but not

limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the Member's ability to become pregnant or to carry a pregnancy to term, or maternity services; and

d. Any payment made by or on behalf of a Member who is contemplating or has entered into a contract for surrogacy to a Provider or individual related to any services potentially included in the scope of surrogacy services described above.

B. Limitations

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