Hometown Health

Administrative Guidelines and Requirements 2025

(Provider Manual)

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Welcome to the Hometown Health Provider Network!

Thank you for choosing to participate as a network provider with Hometown Health. We are very pleased to have you as a valuable member of our expansive health care delivery team which offers the highest quality care in the areas we serve.

To enhance the health and well-being of our members, Hometown Health is committed to building strong, positive relationships with our participating physicians, hospitals and ancillary providers. We continually seek new ideas for strengthening this relationship. Our goal is to minimize the challenges that you face practicing medicine so you can focus on what matters most – caring for your patients. If you have suggestions for improving our operations, please share them with a Hometown Health representative.

To assist in the administration of Hometown Health services, we are pleased to present our Administrative Guidelines and encourage you and your staff to use this reference source to answer your questions about Hometown Health and our products and familiarize you with our policies and procedures. For purposes of this guideline, "we" means Hometown Health, and "you", means you, the provider.

This guideline was developed as a guide to assist our contracted providers when providing services to Hometown Health members. While we have tried to cover a broad range of topics, this guide is not all encompassing and subject to change without notice.

If there is a conflict between the topics within this guide and the terms of your Provider Contract, the Provider Contract will govern.

This guide dictates the Program Requirements that Hometown Health has established for its provider network. Program Requirements or Requirements means the rules and procedures that establish conditions to be followed by Participating Providers with respect to Programs. The term "Program Requirements" also includes the programs, protocols and administrative procedures adopted by Hometown Health or an affiliated Payer to be followed by the physician, ancillary, provider or hospital in providing services and doing business with Hometown Health and other affiliates Payers. These Requirements may include, among other things, credentialing and re-credentialing processes, utilization management, and care management processes, quality improvement activities, peer review, participant's

grievance, concurrent review, or other similar Hometown Health or affiliated Payer programs and processes, and these Requirements may change from time to time.
To make it easier for you to care for your Hometown Health patients, our convenient web-based option, EpicCare Link, saves you time by offering online access to many Hometown Health services including claims, referrals, authorizations and eligibility.

If you have not already registered for EpicCare Link, visit the provider page at https://ecl.renown.org/EpicCareLink/common/epic_login.asp for instructions on how to register. There is also information included in the guide regarding the use of EpicCare Link.

We appreciate you joining with Hometown Health to provide great service to our members. We will always strive to provide great service to you, and we look forward to a long and mutually productive relationship.

Introduction to Hometown Health

Hometown Health is a proud member of the Renown Health Integrated Delivery System and network. Hometown Health provides health insurance products for employer groups, individuals, and families. Hometown Health was established in 1988 as a Northern Nevada-based, multi-service health care company serving members throughout Nevada.

Hometown Health Plan, Inc.
Health Maintenance Organization (HMO)

Hometown Health Plan, Inc. entered the market as a not-for-profit, community-based Health Maintenance Organization (HMO) in February 1988.

With the HMO plan, members will utilize Hometown Health Plan's Renown HMO Network. Members must use a Primary Care doctor included in the Renown HMO Network. In addition, in network community pediatricians may be used. All services except for urgent, emergent, and prior authorized higher level of care must be done within Washoe, Carson, Lyon, Douglas and Storey counties (except for certain ancillary providers like DME, and diabetic suppliers). PCPs include family practice, internal medicine, general practice, and geriatric medicine.

Hometown Health Plan recognizes the importance of women having direct access to OB/GYN care. Although these services are not considered primary care within Hometown Health's delivery system, a woman may see her OB/GYN for obstetrical and gynecological needs without a referral from her PCP. Some procedures, however, may require a referral.

For Small Groups, Association Health Plan Groups (Builders and Carson City Chamber) and Large Group HMO plans, PCP referrals are not required for a patient to see a specialist. You should be prepared to see patients from these plans without the need for referrals. Individual and Family (IFP) members on the HMO plan require a referral for all services except OB/GYN and Emergency services. Please contact Hometown Health's Customer Service Department for specific information.

Hometown Health Plan, Inc.
Exclusive Provider Organization (EPO)

With the EPO plan members will utilize the open access Nevada EPO Network. Providers are limited to the state of Nevada excluding ancillary specialty types (ancillary providers such as DME and diabetic suppliers outside of the state of NV can still be used, benefit authorizations as required by each plan still apply).

This plan does not provide for out-of-state benefits unless the services are rendered as part of an emergency room visit, an urgent care visit received Out-of-Area, or have been approved by Hometown Health to be paid at the EPO benefit level.

Hometown Heath Providers Insurance Company, Inc.
Preferred Provider Organization (PPO)

Hometown Health Providers Insurance Company, Inc., offers fully insured employers a Preferred Provider Organization (PPO) and plans.

Hometown Health Providers Insurance Company, Inc. provides coverage throughout the state of Nevada through our Hometown Health Network. In addition, we partner with Cigna, a national network of health care providers that allows coverage of certain employees in any city or state nationally, except within the state of Nevada.
Hometown Health Providers Insurance Company, Inc., is a licensed third-party benefit administrator "TPA" which provides services such as claims adjudication, eligibility verification, and a provider network to self-funded employer groups and other Nevada Insurers. For these clients we also perform utilization review and case management.

Hometown Health Individual & Family Plans

While the majority of Hometown Health's non-Medicare products are employer-based, we offer Individual & Family plans that meet the requirements of the Affordable Care Act. These plans are available on and off the Nevada Health EpicCare Link Exchange.

These plans utilize either Hometown Health Plan's Renown HMO Network, the Nevada EPO Network, or the Hometown Health (PPO) Network.

Hometown Health offers Employer based HMO, EPO and PPO plans.

Employer Based Health Plans

- Small Group (SG)
- Large Group (LG)
- Association Health Plans (AHP)

Members enrolled through a large group plan (the plan name has "LG" as a plan prefix), a small group plan (the plan name has "SG" prefix), and Association Plan (the plan name has "AHP" prefix).

Self-funded Health Plans and other Nevada Insurers

Self-funded employers and other Nevada Insurers may access the Hometown Health Network but choose to assume the risk and fund their members' medical expenses themselves.

We serve these self-funded entities and their participants through Hometown Health Providers Insurance Company, Inc., which offers third-party administrator (TPA) services. These members have access to the Hometown Health Network and may also have access to the Multiplan provider network outside of Nevada.

Self-funded entities may choose to purchase all third-party administrator services from Hometown Health Providers Insurance Company, Inc., or to combine our services with those offered by other third-party administrators. For example, self-funded entities may use another third-party administrator to pay claims and choose to incorporate the Hometown Health Network in their health plan.

Hometown Health Providers Insurance Company, Inc., third-party administrator services may include claims payment, plan administration, utilization review, case management, pharmacy administration, peer review, pre-certification services and preferred provider networks. All self-funded entities that contract with us to provide preferred provider network services utilizes our Hometown Health Network.

Most self-funded entities use a Hometown Health Providers Insurance Company, Inc. identification card to explain the program to which their participants belong. The identification card will vary based on the employer group, but may include the member's out-of-pocket costs, the preferred provider network, pre-certification information and claims address. Please ask to see the identification card during each office visit to ensure that you have the participant's current information. However, possession of the insurance card does not guarantee coverage.

Senior Care Plus
Medicare Advantage Plan

Senior Care Plus, a product of Hometown Health Plan, Inc., is contracted with the Centers for Medicare & Medicaid Services (CMS), the U.S. government agency that administers Medicare, to offer a Medicare Advantage Plan without prescription drug coverage (MA), and a Medicare Advantage Plan with prescription drug coverage (MA-PD). MA-PD plans are available to anyone with both Medicare Parts A and Part B. Open enrollment and the opportunity for Medicare beneficiaries to change to Senior Care Plus occurs in the fall of every year during the Annual Election Period (AEP) October 15 through December 7.

Senior Care Plus coordinates Medicare benefits and offers additional coverage, including Routine Dental, Routine Vision and Hearing Aid benefits.

Senior Care Plus members will obtain care either through the SCP Renown Network (in which a Renown, Alpine Family Medicine, Virginia Family Care Center, Reno Family Physician or Geriatric Specialty Care provider must be used), the SCP Network, or the P3 Network.

CMS currently pays Medicare Advantage Organizations (MAOs), like Senior Care Plus, per member, per month amount to cover the cost of Medicare and medical group approved services. The CMS payment amount is based on a risk adjustment component that considers the health status and demographic characteristics of each member.

To implement the various statutes on which the CMS contract is based, CMS issues regulations under authority granted by the Secretary of the Department of Health and Human Services and related provisions of the Social Security Act. CMS also issues various manuals, memoranda and statements necessary to administer the programs. Each MAO and PDP must comply with these requirements. CMS conducts routine regulatory audits to review MAOs and PDP's procedures to ensure compliance with federal regulations.

Dual Eligible Special Needs Plan

D-SNP stands for Dual Eligible Special Needs Plans, which are designed to help coordinate benefits and care for people who are eligible for both Medicare and Medicaid. D-SNPs can provide benefits that aren't available through traditional Medicare and usually don't charge a premium.

In 2025, Senior Care Plus allows QMB and FBDE Members to enroll. Members have a 20% coinsurance for most services with SCP and have Nevada Medicaid for the remainder of their cost share. Providers can find cost-share information by using the EpicCare Link Portal or by calling Customer Service.

Hometown Health Contact Information

Eligibility, Claims, Pre-Authorizations and Reconsiderations:

- **EpicCare Link**
  - This free service is available 24 hours-a-day, 7 days a week
    - For assistance with EpicCare Link please contact the Help Desk at 775-982-4042
- **Customer Service:**
  - Office Hours:
    - 8:00 a.m. – 5:00 p.m., Monday-Friday Year-Round (excluding holidays)
  - Telephone Hours:
    - **October 1st through March 31st:** Monday-Friday 7:00 a.m. – 8:00 p.m.
    - **April 1st through September 30th:** Monday-Friday, 7:00 a.m. – 8:00 p.m.
    - **October 1st through March 31st:** Open weekends 8:00a-8:00p - Senior Care Plus Only
  - 775-982-3232 or 800-336-0123
  - TTY 711
  - Fax: 775-982-3741
- **Healthcare Utilization Management:**
  - Monday – Friday, 8:00 a.m. – 5:00 a.m.
  - 775-982-3232 or 800-336-0123
  - TTY 775-982-3240
  - If you do not have access to the Internet we do accept fax requests for pre-certification: 775-982-3744
- **Pharmacy Pre-Authorization requests:**
  - Senior Care Plus: OptumRx (24 hours a day, 7 days a week)
  - Phone: 844-368-3139 or Fax: 844-403-1028

- Hometown Health: Monday – Friday, 8:00 a.m. – 5:00 p.m. PST
  Phone: 844-373-0970 Fax: 866-521-9916

- **Claims Mailing Address and Mailing Address for general correspondence:**
  Hometown Health
  10315 Professional Circle
  Reno, NV 89521
- **Email:** Customer_Service@HometownHealth.com

Escalation Policy

We empower our entire staff to find solutions that meet your needs. If you have called the Customer Service Department and you still do not have the answers that you need, please contact Hometown Health leadership in the order shown below.

By following this sequence, you will ensure that you speak with the staff member who has the most complete and current information about your request.

This same process continues up through the organization:

1. Email CEC_HTH_Leadership@hometownhealth.com
2. Customer Service Supervisor at 775-982-3173 or 775-982-2622
3. Customer Service Manager at 772-982-5212

Hometown Health Departments

Appeals & Grievances:

The Appeals & Grievances Department investigates all escalated complaints from our members and collaborates with related parties to identify a solution. This Department is also responsible for the processing of all appeals to Hometown Health, both provider and member.

Compliance

The Compliance Department oversees the health plan to detect, correct, and prevent non-compliance.

Customer Service

The Customer Service Department provides information on benefits, authorizations, claims, eligibility and other questions from members, providers, and employers via telephone, e-mail, live chat, personal contact and correspondence.

Finance

The Finance Department services include asset protection, regulatory reporting, underwriting and financial statement reporting. It also houses member eligibility, accounts receivable, accounts payable, and assists in the development of financial information systems to meet business needs and regulatory requirements.

Healthcare Utilization Management

The Healthcare Utilization Management Department coordinates requests for referral authorization and clinical utilization management of members to promote medically necessary high-quality care in an optimal setting. National guidelines provided by MCG (formerly Milliman Care Guidelines) are used to determine medical necessity for services. CMS policies are used to review requests for Senior

Care Plus products. National Committee for Quality Assurance, (NCQA) who accredits Hometown Health and certified medical review companies are consulted on a case-by-case basis for questions or appeals that require same specialty review. Providers may request to review Hometown Health Utilization Management Criteria by calling 775-982-2725.

Utilization management functions performed by Healthcare Utilization Management consist of prior authorizations, concurrent review of inpatient admissions, discharge planning, transitional care management and large case management. Healthcare Utilization Management is staffed by Nevada licensed Medical Directors, registered nurses, licensed therapists, licensed social worker, and pre-certification specialists.

Information Resources

The Information Resources Department provides systems analysis, technical support, computer operations, web site development and reporting and analysis to meet the informational needs of Hometown Health. Information Resources also assists in maintaining the security and integrity of Hometown Health information.

Network Services

The Network Services Department includes contracting, credentialing, provider relations, and contract reimbursement rate configuration. The staff develops and maintains the participating provider networks throughout Nevada.

Pharmacy and Medical Drugs

The Pharmacy Department coordinates administration of the pharmacy benefit and medical-drug benefit for the members of Hometown Health and Senior Care Plus. The department works closely with the Pharmacy Benefit Manager (PBM), providers, and the Hometown Health staff to administer the benefit within the Formularies.

Quality Improvement

The Quality Improvement Department combines quality assurance activities (such as retrospective monitoring and problem solving associated with the quality of care delivered) and continuous quality improvement (such as the trending and analysis of ongoing aggregate data for planning).

The department uses standard measurement sets (HEDIS and CAHPS) developed for health plans to monitor quality indicators for care and service.

The Quality Improvement Department also oversees **NCQA (National Committee for Quality Assurance) accreditation**, demonstrating our commitment to meeting the highest national standards in healthcare. By achieving and maintaining a 99% compliance score, we ensure that Hometown Health consistently delivers top-quality care that aligns with rigorous industry benchmarks.

Reimbursement Services

The Reimbursement Services Department provides accurate and timely processing of claims, delivers coordination of benefits and subrogation services and assists in the resolution of customer complaints, appeals and grievances regarding claims. The department also performs quality audits of claims and works with other departments to ensure that Hometown Health reports accurate data to internal and external agencies.

Risk Adjustment Department

The Risk Adjustment Department ensures the integrity and accuracy of data submitted to CMS through data quality review, medical chart review and Risk Adjustment education/training for providers and other healthcare professionals focusing on compliant documentation and diagnosis coding.

Sales and Retention

The Sales and Retention Department sells new commercial business, works to retain existing business and responds to Requests for Proposals (RFPs). In addition, the Sales and Retention Department serves our self-funded employer clients by coordinating third-party administrator services, including proposals, benefit set-up, and reporting. The Department serves as a consultant to our clients on benefit design, plan provisions and changes that require action by our clients. Sales and Retention develops partnerships with brokers, agents, consultants, and employer groups.

Senior Care Plus

Senior Care Plus is a Medicare Advantage Plan with prescription drug coverage, available to anyone with both Medicare Parts A and B. A member must be a resident of Washoe, Carson City, Clark, or Nye Counties in Nevada and continue to pay his or her Medicare Part B premium.

Through a contract with CMS, the U.S. government agency that administers Medicare, Senior Care Plus coordinates Medicare benefits and offers additional coverage.

Underwriting

The Underwriting Department establishes standard guidelines for new and renewing employer groups. They determine premium levels appropriate for each risk, based on medical underwriting and claims experience of the groups. The department conforms to state and federal regulation and provides the Division of Insurance with regulatory and compliance filings.

Hometown Health Network Logos

Health Maintenance Organization (HMO)

Preferred Provider Organization (PPO)
Third Part Administration (TPA)
Dental Plans

Individual and Family Plans

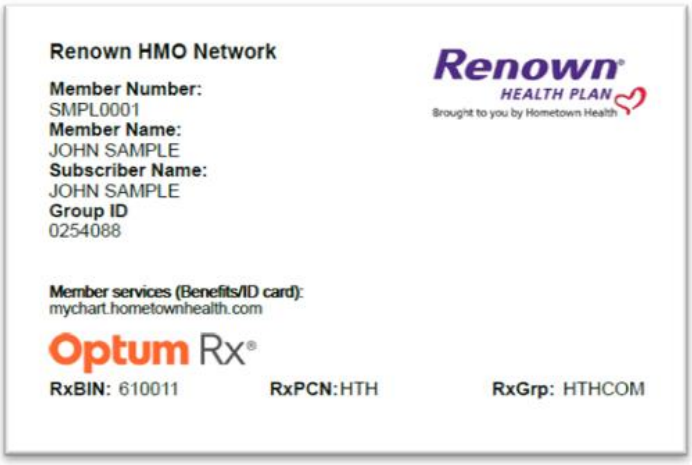
Senior Care Plus

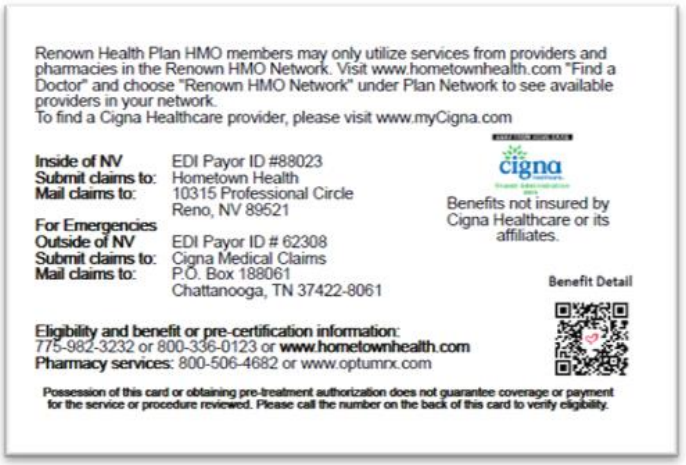

Renown
PREFERRED PLAN
Brought to you by Senior Care Plus

Member Identification Cards

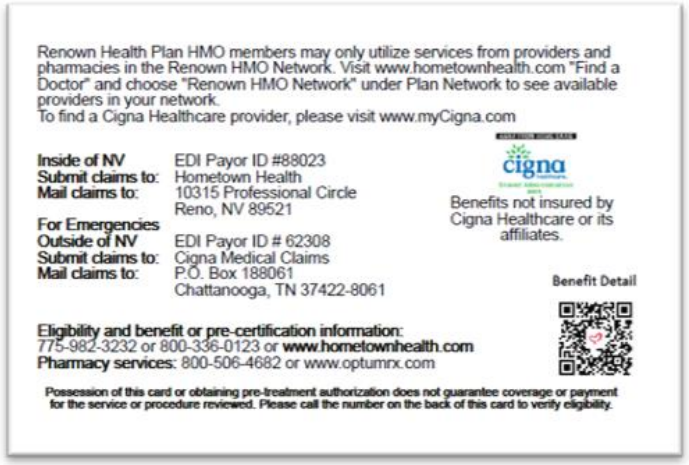
Hometown Health issues an identification card to each member enrolled in the Plan. Member numbers are randomly assigned to each enrolled member and possession of a Hometown Health identification card does not guarantee eligibility or claims payment. We recommend that eligibility for all members are verified using our free and confidential web-based application EpicCare Link (please see the EpicCare Link section of this guide for more information). The back of every Hometown Health ID card contains the claims mailing address as well as the EDI Payer ID number for claims submission. Our current ID cards include:

Commercial HMO - Renown HMO Network

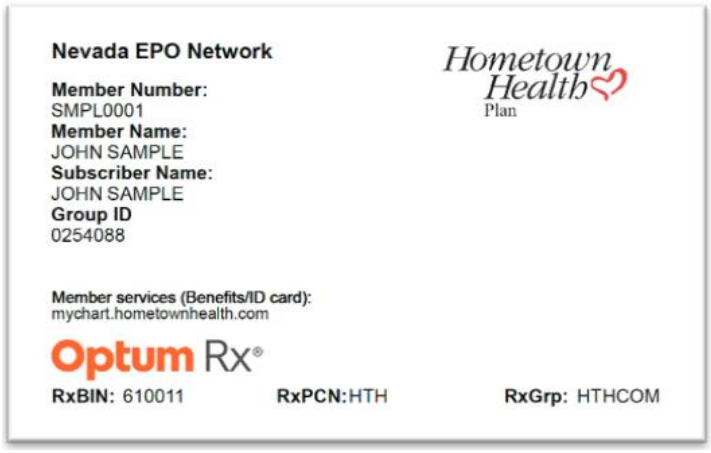




Commercial HMO HDHP - Renown HMO Network



Commercial EPO – Nevada EPO Network



Nevada EPO Network

Member Number:
SMPL0001
Member Name:
JOHN SAMPLE
Subscriber Name:
JOHN SAMPLE
Group ID
0254088

Hometown Health Plan

Member services (Benefits/ID card):
mychart.hometownhealth.com

Optum Rx®

RxBIN: 610011 **RxPCN:** HTH **RxGrp:** HTHCOM

The preferred provider networks for members residing in **Nevada**: Nevada EPO Network. Visit **www.hometownhealth.com**
To find a Cigna Healthcare provider, please visit www.myCigna.com

Inside of NV
Submit claims to: EDI Payor ID #88023
Hometown Health
Mail claims to: 10315 Professional Circle
Reno, NV 89521

For Emergencies
Outside of NV
Submit claims to: EDI Payor ID # 62308
Cigna Medical Claims
Mail claims to: P.O. Box 188061
Chattanooga, TN 37422-8061

cigna

Benefits not insured by Cigna Healthcare or its affiliates.

Benefit Detail

Eligibility and benefit or pre-certification information:
775-982-3232 or 800-336-0123 or **www.hometownhealth.com**
Pharmacy services: 800-506-4682 or www.optumrx.com

Possession of this card or obtaining pre-treatment authorization does not guarantee coverage or payment for the service or procedure reviewed. Please call the number on the back of this card to verify eligibility.

Commercial EPO HDHP – Nevada EPO Network

Nevada EPO Network

Member Number:
SMPL0001
Member Name:
JOHN SAMPLE
Subscriber Name:
JOHN SAMPLE
Group ID
0254088

Hometown Health Plan

Member services (Benefits/ID card):
mychart.hometownhealth.com

Optum Rx®

RxBIN: 610011 **RxPCN:** HTH **RxGrp:** HTHCOM
Qualified High Deductible Health Plan

The preferred provider networks for members residing in **Nevada**: Nevada EPO Network. Visit **www.hometownhealth.com**
To find a Cigna Healthcare provider, please visit www.myCigna.com

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For Emergencies
Outside of NV
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Cigna Medical Claims
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Chattanooga, TN 37422-8061

cigna

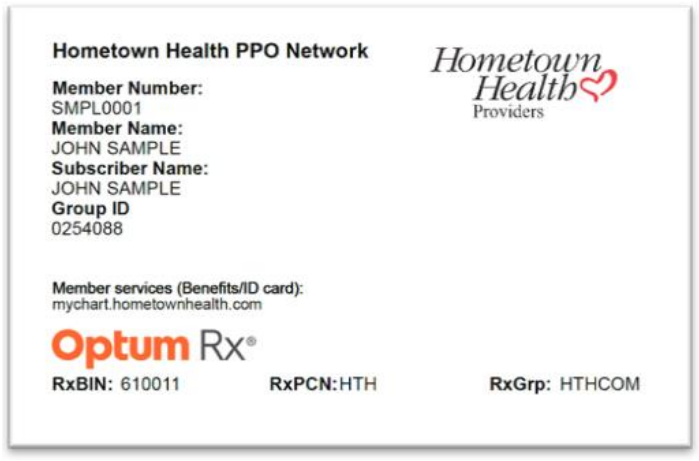
Benefits not insured by Cigna Healthcare or its affiliates.

Benefit Detail

Eligibility and benefit or pre-certification information:
775-982-3232 or 800-336-0123 or **www.hometownhealth.com**
Pharmacy services: 800-506-4682 or www.optumrx.com

Possession of this card or obtaining pre-treatment authorization does not guarantee coverage or payment for the service or procedure reviewed. Please call the number on the back of this card to verify eligibility.

Commercial PPO – Hometown Health Network



Hometown Health PPO Network

Member Number:
SMPL0001
Member Name:
JOHN SAMPLE
Subscriber Name:
JOHN SAMPLE
Group ID
0254088

Hometown Health Providers

Member services (Benefits/ID card):
mychart.hometownhealth.com

Optum Rx®

RxBIN: 610011 **RxPCN:** HTH **RxGrp:** HTHCOM

Preferred provider networks for members residing in Nevada is Hometown Health.
Visit **www.hometownhealth.com**
To find a Cigna Healthcare provider, please visit www.myCigna.com.

Inside of NV
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For Emergencies
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Cigna Medical Claims
Mail claims to: P.O. Box 188061
Chattanooga, TN 37422-8061

cigna

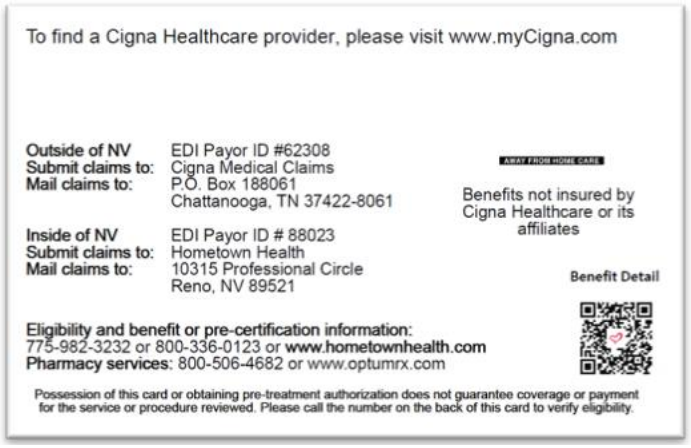
Benefits not insured by Cigna Healthcare or its affiliates.

Benefit Detail

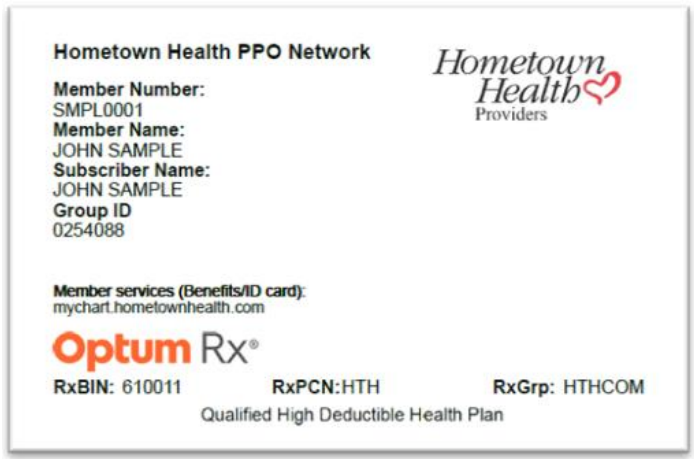
Eligibility and benefit or pre-certification information:
775-982-3232 or 800-336-0123 or **www.hometownhealth.com**
Pharmacy services: 800-506-4682 or www.optumrx.com

Possession of this card or obtaining pre-treatment authorization does not guarantee coverage or payment for the service or procedure reviewed. Please call the number on the back of this card to verify eligibility.

Commercial PPO National - Hometown Health Network



Commercial PPO HDHP - Hometown Health Network



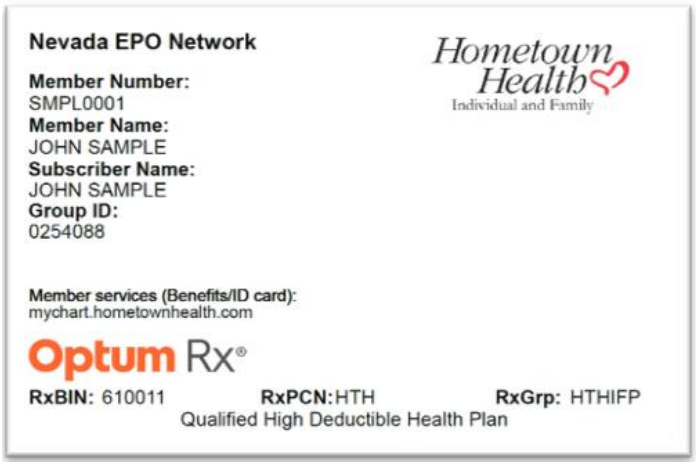
Commercial PPO HDHP National - Hometown Health Network

Individual & Family HMO – Renown HMO Network

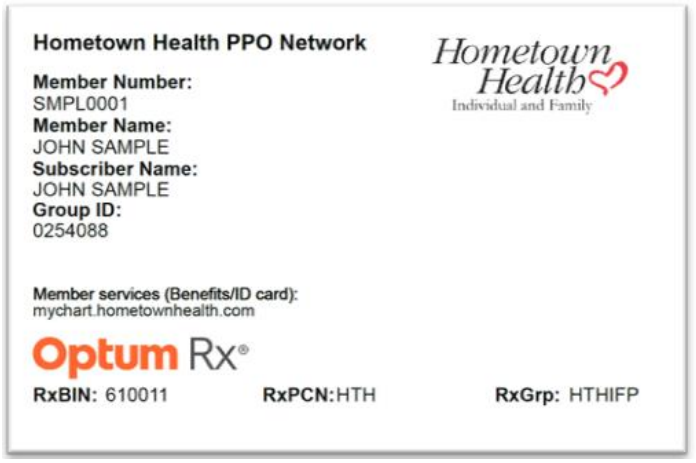
Individual & Family HMO HDHP – Renown HMO Network

Individual & Family EPO – Nevada EPO Network

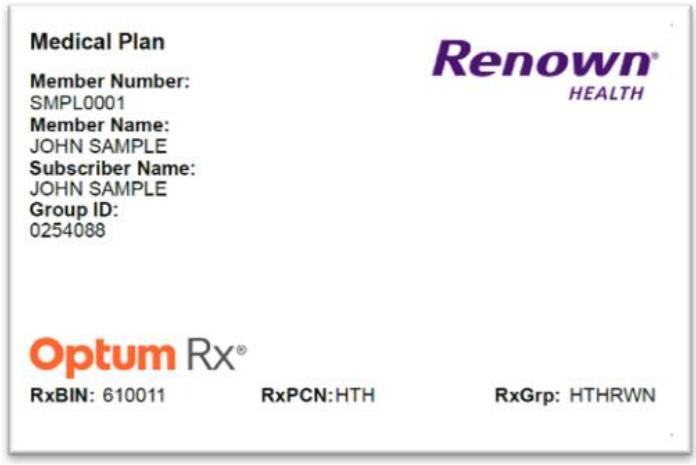
Individual & Family EPO HDHP – Nevada EPO Network



Individual & Family PPO – Hometown Health Network



Renown Health - Self-Funded Plan



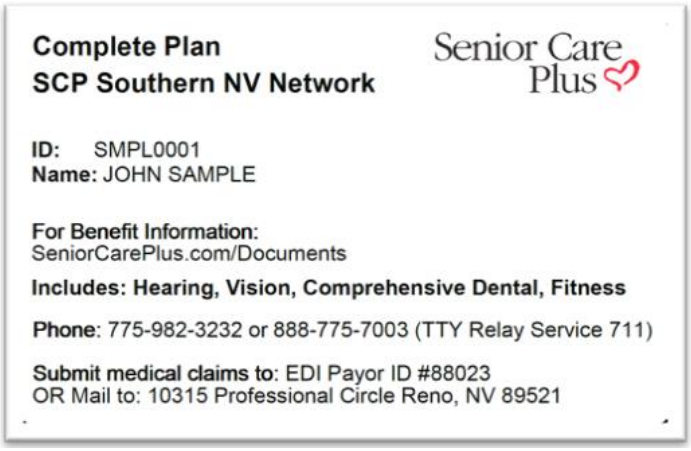
Renown Health National - Self-Funded Plan

Senior Care Plus Patriot Plan – SCP Network

Senior Care Plus Essential Plan – SCP Network

Senior Care Plus Select Plan – SCP Network

Senior Care Plus Complete Plan – SCP Southern NV Network

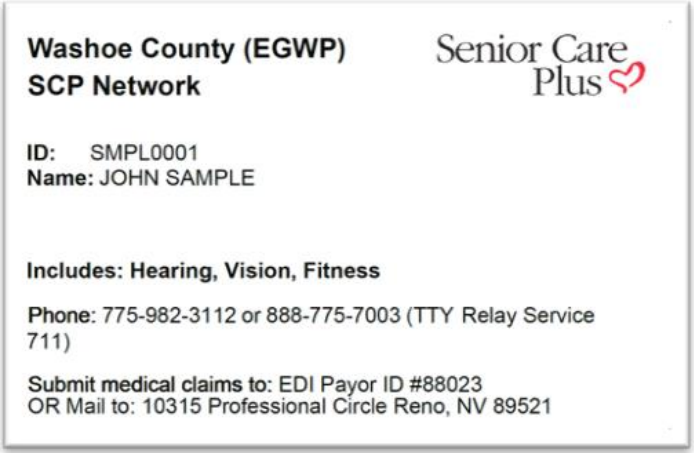


Senior Care Plus Renown Preferred Plan – SCP Renown Network

Senior Care Plus Extensive Duals (HMO D-SNP) – SCP Renown Network

Senior Care Plus Enriched Duals (HMO D-SNP) - SCP Southern NV Network

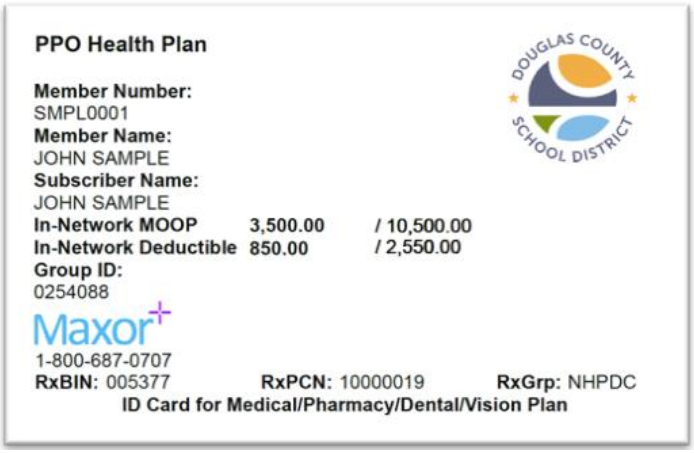
Senior Care Plus Washoe County (EGWP) – SCP Network

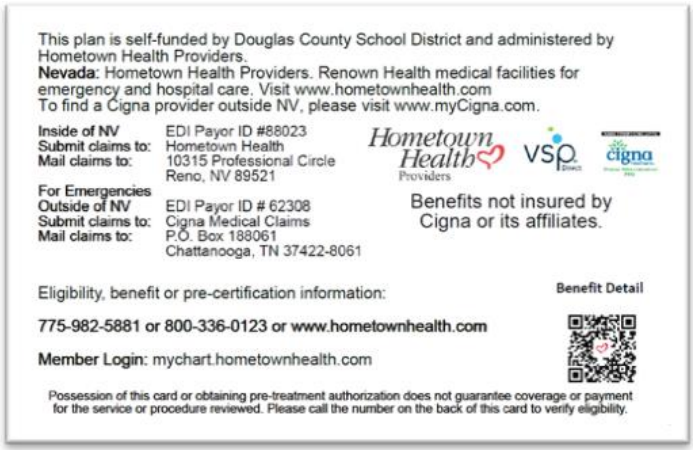


Atlantis PPO - Self-Funded Plan

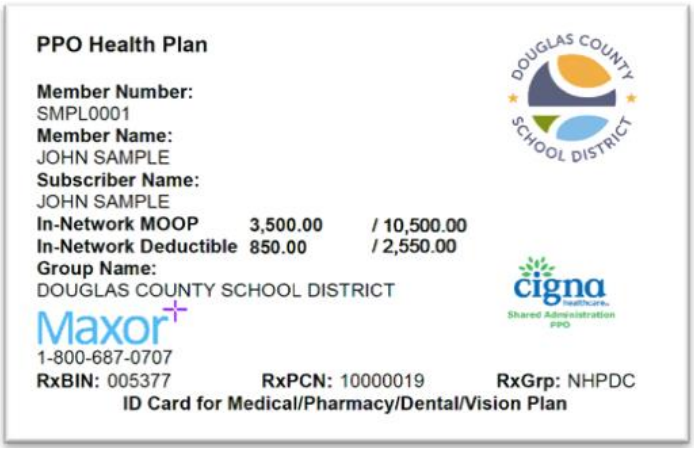
Atlantis PPO National - Self-Funded Plan

DCSD PPO - Self-Funded Plan





DCSD PPO National - Self-Funded Plan



PPO Health Plan

Member Number:
SMPL0001
Member Name:
JOHN SAMPLE
Subscriber Name:
JOHN SAMPLE
In-Network MOOP 3,500.00 / 10,500.00
In-Network Deductible 850.00 / 2,550.00
Group Name:
DOUGLAS COUNTY SCHOOL DISTRICT

Maxor
1-800-687-0707
RxBIN: 005377 **RxPCN:** 10000019 **RxGrp:** NHPDC
ID Card for Medical/Pharmacy/Dental/Vision Plan

This plan is self-funded by Douglas County School District and administered by Hometown Health Providers
Nevada: Hometown Health Providers. Renown Health medical facilities for emergency and hospital care. Visit www.hometownhealth.com
To find a Cigna provider outside NV, please visit www.myCigna.com.

Outside of NV
Submit claims to: EDI Payor ID #62308
Cigna Medical Claims
Mail claims to: P.O. Box 188061
Chattanooga, TN 37422-8061

Inside of NV
Submit claims to: EDI Payor ID # 88023
Hometown Health
Mail claims to: 10315 Professional Circle
Reno, NV 89521

Benefits not insured by Cigna Healthcare or its affiliates

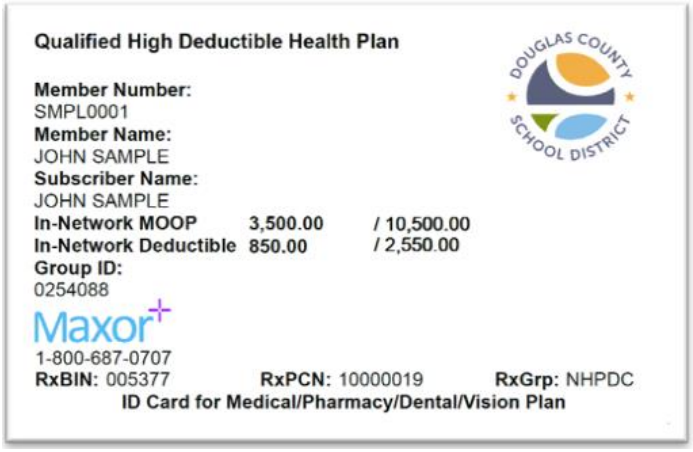
Eligibility, benefit or pre-certification information:
775-982-5881 or 800-336-0123 or www.hometownhealth.com

Member Login: mychart.hometownhealth.com

Benefit Detail

Possession of this card or obtaining pre-treatment authorization does not guarantee coverage or payment for the service or procedure reviewed. Please call the number on the back of this card to verify eligibility.

DCSD HDHP – Self-Funded Plan



Qualified High Deductible Health Plan

Member Number:
SMPL0001
Member Name:
JOHN SAMPLE
Subscriber Name:
JOHN SAMPLE
In-Network MOOP 3,500.00 / 10,500.00
In-Network Deductible 850.00 / 2,550.00
Group ID:
0254088

Maxor
1-800-687-0707
RxBIN: 005377 **RxPCN:** 10000019 **RxGrp:** NHPDC
ID Card for Medical/Pharmacy/Dental/Vision Plan

This plan is self-funded by Douglas County School District and administered by Hometown Health Providers.
Nevada: Hometown Health Providers. Renown Health medical facilities for emergency and hospital care. Visit www.hometownhealth.com
To find a Cigna provider outside NV, please visit www.myCigna.com.

Inside of NV
Submit claims to: EDI Payor ID #88023
Hometown Health
Mail claims to: 10315 Professional Circle
Reno, NV 89521

For Emergencies
Outside of NV
Submit claims to: EDI Payor ID # 62308
Cigna Medical Claims
Mail claims to: P.O. Box 188061
Chattanooga, TN 37422-8061

Benefits not insured by Cigna or its affiliates.

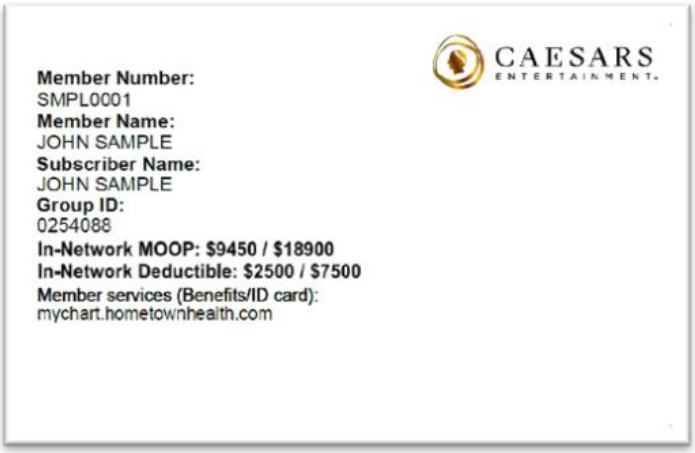
Eligibility, benefit or pre-certification information:
775-982-5881 or 800-336-0123 or www.hometownhealth.com

Member Login: mychart.hometownhealth.com

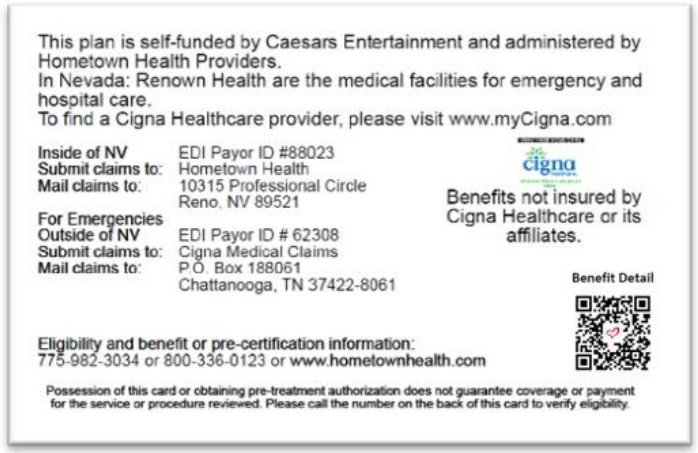
Benefit Detail

Possession of this card or obtaining pre-treatment authorization does not guarantee coverage or payment for the service or procedure reviewed. Please call the number on the back of this card to verify eligibility.

Caesars – Self-Funded Plan



Member Number:
SMPL0001
Member Name:
JOHN SAMPLE
Subscriber Name:
JOHN SAMPLE
Group ID:
0254088
In-Network MOOP: $9450 / $18900
In-Network Deductible: $2500 / $7500
Member services (Benefits/ID card):
mychart.hometownhealth.com



This plan is self-funded by Caesars Entertainment and administered by Hometown Health Providers.
In Nevada: Renown Health are the medical facilities for emergency and hospital care.
To find a Cigna Healthcare provider, please visit www.myCigna.com

Inside of NV
Submit claims to: EDI Payor ID #88023
Hometown Health
Mail claims to: 10315 Professional Circle
Reno, NV 89521

For Emergencies
Outside of NV
Submit claims to: EDI Payor ID # 62308
Cigna Medical Claims
Mail claims to: P.O. Box 188061
Chattanooga, TN 37422-8061

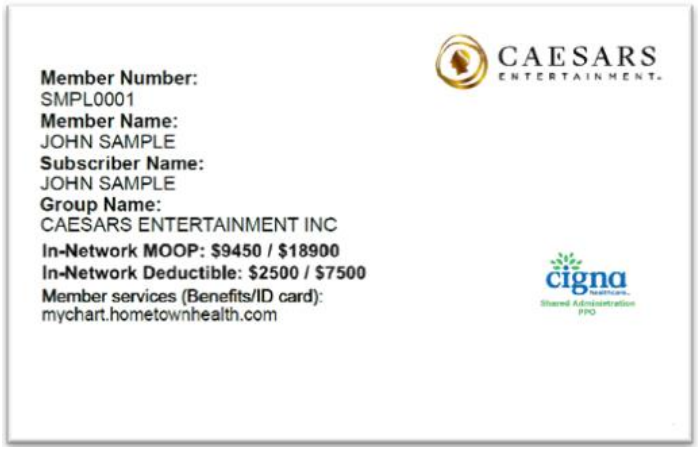
Benefits not insured by Cigna Healthcare or its affiliates.

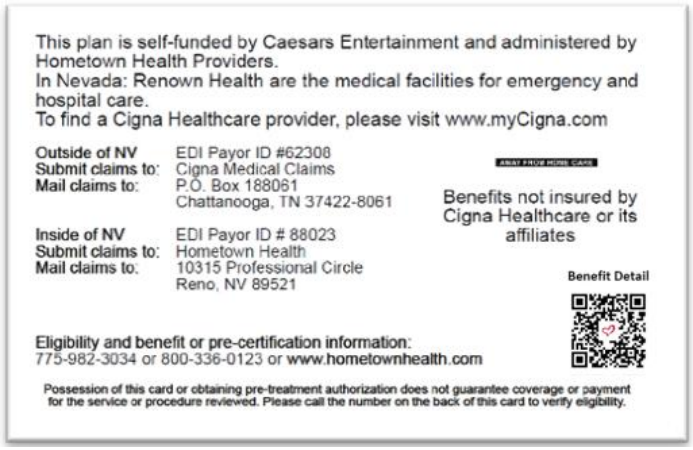
Benefit Detail

Eligibility and benefit or pre-certification information:
775-982-3034 or 800-336-0123 or **www.hometownhealth.com**

Possession of this card or obtaining pre-treatment authorization does not guarantee coverage or payment for the service or procedure reviewed. Please call the number on the back of this card to verify eligibility.

Caesars National – Self Funded Plan





Hometown Health Utilization Management Program Requirements

Physicians, health care professionals and ancillary providers are responsible for prior authorization for certain planned services. These requirements vary by the member's plan. In general, the member's Evidence of Coverage, Summary Plan Description, Summary of Benefits and the authorization matrices are available on EpicCare Link in the Eligibility section and outline the specific plan's prior authorization requirements. Failure to comply with the program requirements that are outlined in this section and in the member's specific benefit plan may result in claims being denied in whole or in part, and as required and specified in your contract, may result in the member being held harmless for all or part of the costs of the services.

The Healthcare Utilization Management Department coordinates requests for authorizations and clinical utilization management of members to promote medically necessary high-quality care in an optimal setting. National guidelines provided by MCG are used to determine medical necessity and the appropriate level of care for services. CMS policies are also used to review requests for Senior Care Plus products. NCQA accredited medical review companies are consulted on a case-by-case basis for questions or appeals that require same specialty review. Copies of specific guidelines or policies are available on request from the Healthcare Utilization Management Department.

Prior Authorization Requirements

Providers are responsible for obtaining prior authorization for services that require prior authorization by the plan, regardless of where the services are to be performed. Providers are responsible to follow the prior authorization matrices and medical benefit drug matrix requirements. Facilities are responsible for confirming the prior authorization is on file at Hometown Health prior to the date of the services. The facility is responsible for obtaining prior authorization for services that require an authorization per the member's benefit plan and that are rendered by hospital-based physicians. A minimum of five business days in advance of the service date is required for non-urgent or emergent services to be reviewed for prior authorization. If the service is scheduled less than five business days in advance, the facility will give notice at the time the service is scheduled, so that the service can be reviewed for

coverage. **Hometown Health will not perform retrospective authorization reviews beyond 7 days.**

When a retro-authorization is requested, an explanation must be included with the request as to why the authorization was not requested prior to the services being rendered. Past 7 days, the retro authorization request will need to be submitted as a reconsideration when the claim is completed, unless otherwise noted in the plan document.

When a prior authorization request results in a medical necessity denial, our physicians are available for a peer-to-peer conversation with the requesting provider within one business day of a request, if the request is received within 7 days of the denial. Another option is to submit additional clinical information within 7 calendar days of the denial for a reconsideration review by UM. If the denial is upheld, the provider must follow the appeal process per the member's plan documents. If a prior authorization request is denied, it may not be re-submitted until after the appeal timeframe has expired.

The facility is responsible for providing timely admission notification and obtaining admission authorization even if a prior authorization had been obtained by the physician. This includes any add on services for observation stays or inpatient admissions when the member is kept overnight or longer after same day surgery or other scheduled and prior authorized services.

Admission notification must be made within 24 hours of an emergent or urgent inpatient admission for situations that occur on a weekday or by 5:00 p.m. Pacific time on the next business day for inpatient stays that are initiated on a weekend or federal holiday, even if the patient was discharged over the weekend or the holiday. The facility and physician must be prepared to provide clinical documentation to support the medical necessity of the admission.

Reimbursement Reductions for Lack of Timely Admission Notification

Notification Time Frame	**Reimbursement Reduction**
Admission notification received after it was due, but not more than 72 hours after admission.	100% of the contracted rate for the days preceding notification
Admission notification received after it was due, and more than 72 hours after admission.	100% of the contracted rate (entire stay).
No admission notification received.	100% of the contracted rate (entire stay).

Appropriate clinical documentation that supports the medical necessity for hospital facility services must be supplied with the request for authorization. The Healthcare Utilization Management staff will review this documentation against nationally available criteria to determine whether medical necessity has been met for the facility stay. Hometown Health uses MCG, CMS, or other peer reviewed guidelines to make these determinations for admissions and concurrent reviews. MCG guidelines are available for acute and sub-acute medical, behavioral health and substance use disorder, rehabilitation, skilled nursing facility, home health care, and ambulatory services. For an inpatient stay, an initial length of stay is assigned for each case. Both facilities and physicians must cooperate with Hometown Health's requests for information, documents, or discussions for purposes of concurrent review and discharge planning including, but not limited to, clinical information, treatment plans, patient status, discharge planning needs, barriers to discharge, and discharge date. Facilities and physicians need to cooperate with Hometown Health's requests for information from its Healthcare Utilization Management Department case managers or Medical Director for review to enable coverage to be extended for services.

When the member is ready for discharge, Healthcare Utilization Management staff will be available to work with the facility discharge planning staff as needed to obtain services and supplies that the member may require from Hometown Health contracted network providers.

Experimental/Investigational Procedures

Experimental/Investigational services are defined as (1) a treatment, procedure, facility, equipment, drug, service or supply ("intervention") that has been determined not to be medically effective for the condition being treated; (2)any treatment, therapy, drug/drug usage, or procedure that has not been approved by the FDA, for example, inhaled nitric oxide (iNO) in neonates < 34 weeks, or (3) any treatment, therapy, drug/drug usage, or procedure that has not been recognized by generally accepted medical standards. Services or supplies that are considered to be for experimental procedures or investigational procedures or unproven procedures are not covered.

We evaluate requests for coverage for new treatments on a case-by-case basis. Hometown Health uses internal and external sources including its Clinical Quality Improvement Committee peer-reviewed medical literature, and independent medical experts to assist its medical directors in reaching coverage determinations.If coverage is approved for an experimental/investigational procedure, a letter of agreement is required for reimbursement.

Off-Label Drug Use

Off-label drug use refers to the practice of prescribing an FDA-approved medication for a purpose or condition that differs from its official FDA approved indications in the drug labeling. This occurs when healthcare providers, based on their clinical judgment and patient-specific factors, determine that the drug may be effective and appropriate for a particular condition, even though it has not undergone formal evaluation or approval by the FDA for that specific use. Requests for reimbursement or coverage of off-label drug use must undergo individual review to assess clinical necessity and appropriateness. In some cases, it may still be considered experimental and/or investigational and will not be covered for off-label use.

Retrospective Review

Retrospective review is an initial review of services after services have been provided to a member. This may occur when authorization or (i.e., member was unconscious at presentation, member did not have their Hometown Health ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted within 90 days from the date of explanation of payment unless otherwise outlined in the provider agreement. Provider's failure to submit requests within such time period will result in the request being denied by Hometown Health. A request for retrospective review must also include supporting documentation including the reason/s as to why the authorization request was not submitted prior to services being rendered. If no reasoning is provided the request for retrospective review will be denied.

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

If a retro-authorization is granted, benefits will be paid only for those days or treatment approved by Hometown, under the Utilization Management Program, Scope of the Program, Prior-Authorization Process, or Concurrent Review/Case Management.

Providers should consult EpicCare Link to check for services that require a prior authorization through the Eligibility section in EpicCare Link. The Authorization Matrixes under the Forms tab will show the most current authorization requirements specific to the member's plan.

Site of Care

Choice for physical location of infusion administration. Sites of Care include hospital inpatient, hospital outpatient, physician office, ambulatory infusion suite, or home-based setting.

> Note: In some plans, "level of care," "site of service" or another term such as "setting" or "place of service" may be the term used in benefit plans, provider contracts, or other materials instead of or in addition to "site of care" and, in some plans, these terms may be used interchangeably.

Outpatient hospital facility-based intravenous medication infusion is medically necessary for individuals who meet the following criteria (submission of medical records is required).

Documentation that the individual is medically unstable for administration of the prescribed medication at the alternative sites of care as determined by any of the following:

1. The individual's complex medical status or therapy requires enhanced monitoring and potential intervention above and beyond the capabilities of the office or home infusion setting; or
2. The individual's documented history of a significant comorbidity (e.g., cardiopulmonary disorder) or fluid overload status that precludes treatment at an alternative site of care; or
3. Outpatient treatment in the home or office setting presents a health risk due to a clinically significant physical or cognitive impairment; or
4. Difficulty establishing and maintaining patent vascular access; or
5. To initiate, re-initiate products for a short duration (e.g., 4 weeks) or
6. Documentation (e.g., infusion records, medical records) of episodes of severe or potentially life-threatening adverse events (e.g., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure) that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other pre-medications, thereby increasing risk to the individual when administration is in the home or office setting; or
7. Initial infusion or re-initiation of therapy after more than 6 months; or

8. Homecare or infusion provider has deemed that the individual, home caregiver or home environment is not suitable for home infusion therapy (if the prescriber cannot infuse in the office setting).

Ongoing outpatient hospital facility-based infusion duration of therapy will be no more than 6 months to allow for reassessment via prior authorization review of the individual's ability to receive therapy at an alternative site of care.

Healthcare Utilization Management Department Contact Information

The Healthcare Utilization Management Department may be contacted through EpicCare Link. If your office does not have access to the Internet, we do accept prior authorizations:

- By telephone at 775-982-3232
- By fax at 775-982-3744
  - By mail to 10315 Professional Circle, Reno NV 89521

When faxing or mailing a prior authorization request for a member, please use the Prior Authorization Form located at www.hometownhealth.com to ensure we receive all the information to process your request. This includes the following information:

- Member name
- Member date of birth
- Member number
- Diagnosis
- Procedures, services and items that you are requesting
- Treatment date(s)
- Clinical documentation as necessary to support the request

Claims and Payment Policy Program Requirements

Hometown Health Claims Processing

Hometown Health Reimbursement Services is dedicated to ensuring accurate and timely processing of all claims pursuant to the member's benefit plan and individual provider contracts.

As you know, efficient billing is essential to the successful operation of any physician office, hospital, or ancillary medical provider. By properly completing your claim, your office can minimize the time spent on billing and help speed payment to your office.

Complying with all requirements of Hometown Health's Utilization Management Program and verifying the member's eligibility for benefits will help your claims to be processed timely and accurately.

Claim Filing Time Limits

Hometown Health allows 180 days from the date of service to submit a claim for payment unless otherwise required by law. If the payer is the secondary payer, Hometown Health allows 365 days from the date of service to submit a claim for payment.

Please remember to check EpicCare Link regularly to confirm that we have received your claim and to determine the status.

For all claims submissions, but particularly paper claims, please pay particular attention to the following items:

- Member's name and enrollee identification number exactly as they appear on the member's identification card
- Member's birth date
- Provider's Taxpayer Identification Number – Do not use a signature stamp that in any way obscures the Tax Identification Number (TIN)
- Provider's National Provider Identifier and/or servicing provider's National Provider Identifier (NPI) on the CMS-1500

- Accurate coding of all diagnoses and services in accordance with national coding guidelines will help us accurately determine a member's level of coverage under his or her benefit plan for certain services.

Submitting Electronic Claims

The most efficient and cost-effective way of filing claims is by electronic transmission, or Electronic Data Interchange (EDI). It can reduce your administrative time, improve claim accuracy, and expedite claim payment turnaround time. Your office may submit claims to Hometown Health electronically using our *EDI Payer ID #88023.* If you would like to begin billing electronically please contact your claims clearinghouse for more information.

You can check the status of claims on-line using EpicCare Link. For more information, see the EpicCare Link section.

Submitting Paper Claims

Paper claim submission is not the preferred method of claim receipt and <u>should not</u> be used unless the provider is unable to submit electronically.

To expedite payment to your office, complete and submit a separate claim form for each patient. Hometown Health will only accept claims submitted on the CMS-1500 and the CMS-1450 (UB04) forms. The claim form must either be typed or printed from a computer, preferably red "drop out" ink. Any altered or handwritten claim may result in a denial.

Ensure that the claim form is filled out completely, correctly and legibly. Hometown Health may deny the claim if all necessary information is not included.

International claim submissions will only be accepted if the claim is submitted on the appropriate CMS-1500 and the CMS 1450 (UB04) form. Prior to submission, all claims must be translated into English for accurate review and timely processing. Hometown Health may deny the claim if the claim is not translated.

Please pay particular attention to the following items:

- Member's name and enrollee identification number exactly as they appear on the member's identification card
- Member's birth date
- Provider's Taxpayer Identification Number – Do not use a signature stamp that in any way obscures the TIN

- Provider's National Provider Identifier and/or servicing provider's NPI on the CMS-1500
  Accurate coding of all diagnoses and services in accordance with national coding guidelines

Mail the completed claim form(s) and pertinent documentation to:

Hometown Health
10315 Professional Circle
Reno, NV 89521

Altered Claims

Please submit clean claims with no alterations. Hometown Health will deny altered claims. A clean claim includes no correction fluid, correction tape, or handwritten changes on the claim.

Tracer and Resubmission Claims

A tracer or resubmission claim is a request for the status on a claim. Before submitting a tracer or resubmission claim, your office should allow enough time for your claim to process. Please check the status of the claim on EpicCare Link before submitting a tracer or resubmission. For more information, see the EpicCare Link section.

Submit tracer and corrected claim to Hometown Health within 180 days from the date of service to:

Hometown Health
10315 Professional Circle
Reno, NV 89521
EDI Payer ID: 88023

To facilitate ease of member and service identification and claims payment for Hometown Health and Senior Care Plus members, we have set requirements for what defines a complete claim.

Complete claims requirements include:

- Member's name (enter exactly as it appears on the member's ID card)
- Member's ID number

- Member's address
- Member's gender
- Member's date of birth (mm/dd/yyyy)
- Member's relationship to subscriber
- Subscriber's name (enter exactly as it appears on the member's ID card)
- Subscriber's ID number
- Subscriber's employer group name
- Subscriber's employer group number
- Rendering physician, health care professional, ancillary provider, or facility name
- Rendering physician, health care professional, ancillary provider, or facility representative's signature
- Address where services was rendered
- Physician, health care professional, ancillary provider, or facility "remit to" address
- Phone number of Physician, health care professional, ancillary provider, or facility performing the service (provide this information in a manner consistent with how that information is presented in your agreement with us)
- Physician, health care professional, ancillary provider, or facility NPI and federal TIN
- Referring physician's name and TIN (if applicable)
- Date of service(s)
- Place of service(s)
- Number of services (days/units) rendered
- Current CPT-4 and HCPCS procedure codes, with modifiers where appropriate
- Current ICD-10 diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
- Charges per service and total charges
- Detailed information about other insurance coverage
- Information regarding job-related, auto or accident information, if available
- Retail purchase cost (or a cumulative retail rental cost) greater than $1000 for DME
- Current National Drug Code (NDC) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPPA 837 Professional electronic form.

Additional information needed for a complete CMS-1450 (UB-04) form:

- Date and hour of admission
- Discharge date and hour of discharge
- Member status-at-discharge code
- Type of bill code (4 digits)
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current 4-digit revenue code(s)
- Current principal diagnosis code (highest level of specificity), with the applicable present on admission (POA) indicator on hospital impatient claims per CMS guidelines
- Current other diagnosis codes, if applicable (highest level of specificity), with the applicable present on admission (POA) indicator on hospital inpatient claims per CMS guidelines
- Current ICD-10 procedure codes for inpatient procedures
- Attending physician ID
- For outpatient procedures, provide the appropriate revenue and CPT or HCPCS codes
- For outpatient services, providers specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)
- Submit claims according to any special billing instructions that may be indicated in your agreement with us
- On an inpatient hospital bill type of 011x, the admission date and time should always reflect the actual time the member was admitted to inpatient status

National Provider Identification

The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations, and many state Medicaid agencies mandate the adoption and use of a standardized NPI for all health care professionals. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPI for all identification purposes in standard electronic transactions. In addition, based on state-specific regulations, NPI may be required to be submitted on paper claims. HIPAA defines a covered health care provider who transmits health information in electronic form in connection with a transaction for which standards have been adopted. These covered health care providers must obtain an NPI and use this number in all HIPAA transactions, in accordance with the instructions in the HIPAA electronic transaction x12N Implementation Guides.

To avoid payment delays or denials, we require that a valid billing NPI, rendering NPI and relevant taxonomy code(s) be submitted on both paper and electronic claims. In addition, we strongly encourage the submission of all other NPIs as defined below. It is important that, in addition to the NPI, you continue to submit your TIN. The NPI information that you report to us now and on all future claims is essential in allowing us to efficiently process claims and to avoid delays or denials.

Non-Payments for Sentinel and Never Events

Hometown Health reserves the right to deny claims payment for any encounter related to avoidable errors and mistakes, inclusive of hospital acquired conditions and sentinel and never events as defined by Medicare and the Joint Commission. If such claims are denied patients may not be balanced billed.

Medicare Advantage Benefit Plan Claim Processing Requirements

Section 1833 of the Social Security Act, prohibits payments to any provider unless the provider has sufficient information to determine the "Amounts due such provider." To that end, Hometown Health applies various claims processing edits based on National and Local Coverage Determinations (NCD/LCD), the Medicare Claims Processing Manual, National Correct Coding Initiative (NCCI), and other applicable guidance from CMS, including but not limited to the official ICD-10 Guidelines for coding and reporting. These edits are designed to provide Hometown Health with sufficient information to determine:

- The correct amount to be paid
- Whether the provider is authorized to perform the service
- Whether the provider is eligible to receive payment
- Whether the service is covered, correctly coded, and correctly billed to be eligible for reimbursement
- Whether the service is provided to an eligible beneficiary
- Whether the service was provided in accordance with CMS guidance

Providers participating in our Senior Care Plus network must comply with all CMS guidance regarding coding, claims submission, and reimbursement rules. For example, all participating Medicare providers must report a Serious Adverse Event by populating the POA indicator on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. In the instance that the "Never Event" has not been reported, we will attempt to determine if any changes filed with is meet the criteria, as outlined by the National Quality

Forum (NQF) and adopted by CMS, as a Serious Reportable Adverse Event. To the extent that a provider fails to comply with these requirements, that provider's claim will be denied and be considered a provider liability. Providers cannot bill the customer for these charges.

There may be situations when Hometown Health and Senior Care Plus implement edits and CMS has not issued any specific coding guidance. In these circumstances, Hometown Health and Senior Care Plus will review the available guidance in the Medicare Coverage Center and identify those coding edits that most align with the applicable coverage rules

Effective January 1, 2012: Due to CMS requirements, all physicians and other health care providers, including delegated/capitated claims and encounters, are required to adopt the 837 Version 5010 format for dates of service on and after January 1, 2012. Incomplete submissions including blank data fields will result in rejection of the claim or encounter submission. Note that an NPI is a required data element on all submissions. Rejections will be returned for correction and resubmission.

Hold Harmless Requirements

When an HMO, EPO, PPO, or SCP claim has been denied with a reason of Hold Harmless, meaning that a prior authorization was not obtained before the HMO, EPO or SCP member who received services, a denial of services was issued, or a continued stay was not justified, the provider is obligated to adjust the claim, including removal of any member copayment, deductible or coinsurance as per the provider's contract with Hometown Health.

If you determine that Hometown Health denied a claim incorrectly, please do not bill the patient for the denied claim. Please contact Hometown Health Customer Service at 775-982-3232 or 800-336-0123, for further information. You may also submit reconsideration as outlined in the Requests for Reconsideration section.

Member's Responsibility and Additional Fees for Covered Services

You may not charge our members fees for covered services beyond copayments, coinsurance, or deductibles as described in their benefit plans. You may not charge our members contractual "write-off" amounts, or fees for covered services that are denied or not paid due to your failure to notify or bill Hometown Health timely, for services that you performed that were denied as not medically necessary, or for claims that were denied because of your failure to cooperate with the terms of your contract, including the prior authorization program requirements.

Charging Members for Non-Covered Services

For our Commercial and Senior Care Plus members, you may seek and collect payment from our member for services not covered under the applicable benefit plan, providing that you first obtain the member's written consent for those services on a dated and signed form that is retained in your patient's medical record. These services most often occur when members seek plastic surgery services at the time of a covered medical procedure, or when they have an astigmatism correcting lens implanted at the time of a covered cataract surgery. Hometown Health will not cover physician time, assistant surgeon time, anesthesiologist time, operating room and anesthesia services, and hospital charges (including observation or inpatient services) for services that we determine to be non-covered according to the application of the medical necessity criteria or exclusions in the benefit plan, the use of nationally recognized guidelines, or after physician peer review.

You, as a provider, should contact Hometown Health for prior authorization or a coverage determination for services for a particular member according to the prior authorization program requirements, or if you suspect that the services proposed may not be medical necessary or covered under the benefits.

In addition, for our Senior Care Plus members, Hometown Health will provide a denial of medical coverage to the member to advise them that the service is not covered. The member can then exercise their appeal rights through Senior Care Plus, if they so choose or they can proceed with the service at their expense.

Hometown Health reserves the right to retrospectively review all services billed to Hometown Health for coverage policy benefit eligibility and medical necessity. Prior authorization and benefit eligibility do not guarantee that services and benefits will be paid for that member.

Coverage determinations and benefit availability for our Hometown Health HMO, PPO, and TPA members, are based on the appropriateness of care, the medical necessity of that care, and any other terms as defined in the members' Evidence of Coverage or Summary Benefit Plan Descriptions. Senior Care Plus member are governed by their Evidence of Coverage for the calendar year of service as approved by CMS, and the definition of "reasonable and necessary" within Medicare coverage rules and regulations.

Senior Care Plus Medicare Advantage Risk Adjustment Data

The risk adjustment data you submit to us must be accurate and complete and follow these guidelines:

- Risk adjustment is based on ICD-10 diagnosis codes, not CPT codes. Therefore, it is critical for your office to refer to the correct ICD-10 coding manual and code accurately, specifically and completely when submitting claims.
- Diagnosis codes must be supported by the medical record. Therefore medical records must be clear, complete and support all conditions coded on claims or encounters you submit.
- Be sure to code all conditions that co-exist at the time of the patient visit and require or affect patient care, treatment, or management.
- Never use a diagnosis code for a "probable" or "questionable" diagnosis. Instead, code only to the highest degree of certainty.
- Be sure to distinguish between acute and chronic conditions in the medical record and in coding. Only choose the diagnosis code(s) that fully describe the patient's condition and pertinent history at the time of the visit. Do not code conditions that were previously treated and no longer exist.
- Always carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a 3-digit code if a 5-digit code more accurately describes the patient's condition.
- Please be sure to sign chart entries with credentials.
- CMS or Hometown Health may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner.

Retroactive Eligibility Changes

A member's eligibility under a benefit contract may change retroactively if the member's policy/benefit coverage has been terminated or if the eligibility information we receive is later determined to be incorrect.

If you have submitted a claim(s) that is affected by a retroactive eligibility change, you are welcome to submit a reconsideration for the claim or to contact Hometown Health for more information concerning that claim and any potential former member liability.

Third Party Administrator

Hometown Health Providers also provides TPA services and furnishes a contracted network and other health-insurance services to self-funded employer groups.

When a patient has benefit coverage with a self-funded group, a TPA may have responsibility for eligibility, utilization review and claims payment.

Please refer to the member's identification card to determine the services that are provided by Hometown Health. This information may also be located on EpicCare Link or by contacting Hometown Health Customer Service at 775-982-3232 or 800-336-0123.

Overpayments

"Overpayments" are funds that exceed the amount due and payable under the member's benefit plan and/or terms of the provider contract. In the event Hometown Health identifies an Overpayment, Hometown Health may, at its option, deduct the excess payment from other amounts payable.

If you refund an overpayment, please provide appropriate documentation that outlines the overpayment, including the member name, member ID number, date of service, and the amount paid. Please also include a copy of the EOP. If the refund is due because of coordination of benefits with another carrier, please provide a copy of the other carrier's EOB with the refund.

If you disagree with a claim reconsideration or re-adjudication, you can appeal the determination through our claim reconsideration process.

Over/Under Payments

If claims are being over/under paid according to your contracted fee schedule, please fill out the Over/Under Large Payment Claim Adjustment Form if an adjustment is needed on 10 or more claims.

The form is located at https://www.hometownhealth.com/provider-partners/provider-forms/ and can be submitted via email: HTHProviderRelations@hometownhealth.com.

An email inquiry is not considered a formal request for adjustment. The date Hometown Health receives the Over/Under Large Payment Claim Adjustment Form will serve as the submission date for adjustment of claim.

Please note, for fewer than 10 claims please follow the appeal process as outlined in the Claims Reconsiderations section in these guidelines.

If you disagree with a claim reconsideration or re-adjudication, you can appeal the determination through our provider reconsideration process.

Notification of Claims Determination

A claim determination will result in the issuance of an EOP, or 835 electronic file if payment is submitted through Electronic Funds Transfer (EFT), by Hometown Health. It is important to notify your Provider Services Representative of any address changes to ensure any claims determination information is received in a timely manner.

An EOP will include the following information to help reconcile your payment:

- Check date and number
- Payee number, name and address
- Service date, procedure codes
- Contracted/allowed, and COB amount
- Deductible, co-insurance, and co-pay amount
- Ineligible amount
- Prepaid/Cap amount
- Paid amount
- Remarks
- Member responsibility

The member financial responsibility will reflect in the ineligible, deductible, coinsurance or co-pay fields. The remarks section identifies additional information regarding the adjudication of the claim, such as if a benefit maximum has been met or if the claim has been denied and why.

Claims Reconsiderations

All reconsiderations must be submitted within 90 days from the date of explanation of payment unless otherwise outlined in the provider agreement or regulated by law. Provider's failure to submit requests within such time period and according to the processes outline below will result in the request being dismissed by Hometown Health. Hometown Health may accept a request for a reconsideration or claim submission after the allotted timeframe if the filing party shows good cause. Good Cause may be established by the following:

• If the claim or reconsideration includes an explanation for the delay in submission (or other evidence which establishes the reason), Hometown Health will determine good cause based primarily on that statement or evidence.

• If the evidence leads to doubt about the validity of the statement, Hometown Health will contact the provider for clarification or additional information necessary to make a Good Cause determination.

If you believe that Hometown Health has not processed your claim correctly for any reason including timely filing or denial for needed medical records, you should submit a provider reconsideration. Reconsiderations must be submitted with the following information:

- Claim number
- Member Name
- Date of Service
- Clear explanation as to why you disagree with the initial determination

For the fastest response to your reconsideration, please use EpicCare Link and complete a Customer Relationship Management (CRM) request. You will be assigned a CRM number for each reconsideration. All supporting documentation can be uploaded into the CRM. If unable to submit additional information to the CRM, you may fax it to 775-982-3741. If faxing supporting documentation, please clearly list the CRM number on the fax cover page. This will enable us to match up your documentation with the correct reconsideration.

For CRM determinations, if the reconsideration was submitted through EpicCare Link your determination would be published in the CRM. If the reconsideration was submitted via mail or fax, your determination would be sent via a mailed letter.

Although the quickest turnaround for reconsiderations is through EpicCare Link, as a last resort reconsiderations may also be submitted by fax to 775-982-3741 or mailed. When faxing your request be sure to use the Hometown Health Reconsideration Request Form located on www.hometownhealth.com and include medical records, if applicable.

Finally, reconsiderations may also be mailed to:

Hometown Health
Attn: Provider Reconsiderations
10315 Professional Circle
Reno, NV 89521

When completing a written request for reconsideration of a completely or partially denied claim please include the completed Hometown Health Reconsideration Form. Indicate the specific reason that you want this claim reprocessed and attach all supporting documentation. The more complete the documentation, the more quickly the reconsideration can be processed.

Hometown Health will respond within sixty (60) days of receipt of the reconsideration request with either an EOP or an explanation advising that the decision has been upheld and why.

Appeals for untimely filing of a claim should include confirmation that Hometown Health received and accepted your claim within the timely filing deadlines set within the provider agreement, or within timely filing requirements set within the Hometown Health Administrative Guidelines and Procedures from the date of service or other supporting documentation if Hometown Health was not sent the claim because of presumed or confirmed other primary insurance coverage for the member.

Dispute Resolution

If you do not agree with the outcome of the provider reconsideration, you may resubmit another reconsideration with additional supporting documentation for review which must include new and material evidence to support a re-opening of the initial reconsideration. If there is no new material evidence, the reconsideration will be dismissed as a duplicate submission. All claim reconsiderations and disputes must be submitted within 90 days from the date of explanation of payment unless otherwise outlined in the provider agreement

Disputes arising between the provider and Hometown Health related to performance or interpretation of the Provider Agreement or the Administrative Guidelines will be attempted to be resolved in good faith by non-legal means. Disputes may be brought to the attention of Hometown Health leadership by emailing HTHProviderRelations@hometownhealth.com. Please include "Provider Dispute" in the subject line.

Coordination of Benefits and Subrogation

Subrogation and Coordination of Benefits

All Hometown Health Benefit Plans are subject to subrogation and Coordination of Benefits rules.

Subrogation means the recovery of benefits paid for a member's health care services when a third party causes the member's illness or injury. Hometown Health reserves the right to subrogate benefits to the extent permitted under applicable state and federal law and the applicable benefit plan.

Coordination of Benefits (COB) means a process by which another group health plan or Medicare may be responsible for claims payment either as the primary or secondary carrier.

When Hometown Health is the secondary payer, the primary carrier must be billed first. Both carriers must be billed the same amount for services performed. All claims must be submitted with the primary carrier's Explanation of Benefits (EOB) in order to be considered for payment. If the primary carrier's EOB is not attached to the claims submission, the adjudication of the claim may be delayed or denied.

Hometown Health coordinates benefits up to the lowest allowable. This is done at the line level. The lowest allowable is determined in many ways such as:

- The primes allowable being lowest
- Hometown Health's allowable being lowest
- A combination of both prime's allowable and Hometown Health's allowable due to multiple lines within the claim

All electronic payment edits still apply if Hometown Health is the secondary payer.
Please submit secondary payer claims to:

Hometown Health
10315 Professional Circle
Reno, NV 89521
EDI Payer: 88023

Paying Claims under Coordination of Benefits

Hometown Health coordinates benefits with other group insurance plans. If Hometown Health determines that another insurance carrier is the primary payer, Hometown Health will deny the claim until we received an EOB statement from the primary insurance carrier.

Below is a guide regarding COB:

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	Primary	Secondary
Group Coverage		
Employee	✓	
Spouse with other coverage		✓
Child-Parents not separated (Birthday Rule)		
Parent with earliest birthday in year	✓	
Child – Separated Parents		
Parent with custody	✓	
Spouse of custodial parent		✓
Non-custodial parent		✓
Court decree	✓	

	Primary	Secondary
Active/Inactive		
Plan covering member as active employee	✓	
Plan covering member as inactive employee		✓
Longer/Shorter		
Plan in effect longer time	✓	
Plan in effect shorter time		✓

Coordination of Benefits for Medicare

Medicare eligible with		
Medigap supplement	✓	
Medicaid		✓
Employer Group Health Plan		
Active employment with 20 or more employees		✓
Active employment with less than 20 employees	✓	
End Stage Renal Disease		
In 30-month coordination period	✓	
36 months following transplant		✓
Disability		
Large group health plan (More than 100 employees)		✓
Fewer than 100 employees	✓	

Claims Payment Policy

Hometown Health's medical claims payment policy incorporates clinical logic based on clinical practice and reimbursement standards. Please note that Hometown Health's payment policy is subject to each payer's payment policies (TPA/self-funded and lease networks), and any or all payment policy edits are subject to change.

Hometown Health reimburses providers according to its standard payment policies. In developing its standard payment policies, we consider current healthcare trends and advances, as well as information from a variety of different sources, including but not limited to: provider questions and comments; guidelines from the Centers for Medicare and Medicaid Services (CMS) including reductions in provider allowables for midlevels and certain behavioral health specialty types; National Correct Coding Initiative (NCCI); CMS's Outpatient Code Editor (OCE); AMA guidelines; CPT Assistant; Optum Supplemental Code Editing and Insight Record Review (TC3) and, specialty medical societies. However, Hometown Health's standard payment policies may differ from policies adopted, endorsed, or recommended by any or all of those sources.

Hometown Health conducts prepayment and post-payment claim reviews to ensure billing and coding accuracy using an automated code-auditing tool in its claims processing system and third party vendors. This code-auditing tool incorporates edits based on Hometown Health's standard payment policies. If a claim submitted for payment is not in accordance with Hometown Health's standard payment policies, we may deny or pend payment on the claim completely or partially.

In the event of a conflict between Hometown Health's standard payment policies and an automated edit, Hometown Health's standard payment policies will control. Additionally, all payment decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to all applicable state and/or federal laws.

If your claim or portion of a claim is denied for any reason or you want to understand the actual payment edits and reimbursement, you may appeal the decision by following the procedures as explained in this Provider Manual.

Reviewing a claim

When our system reviews a claim, it applies edits that may result in non-payment of the entire claim or service lines within the claim. The edits consist of logic that enables the claim review system to select claims containing certain values or combinations of procedure codes. The logic evaluates the codes against accepted standards and Hometown Health's payment policy.

There are thousands of edits in the logic of the claims review system. Below are the most common payment policy edits that are applied to evaluate claims. Providers may always request the rationale of a particular claims payment policy edit or appeal any decision related to an edit that is applied to a claim.

Age Conflicts

An age conflict occurs when the provider assigns an age-specific procedure to a patient whose age is outside of the designated age range. Age conflict edits may include the following:

- Newborn procedure; age should be less than 1 year
- Pediatric procedure; age should be 1-17 years
- Maternity procedure; age should be 12-55 years
- Adult procedure; age should be over 14 years

The edit comment may indicate *"THE CPT CODE USED IS INAPPROPRIATE FOR THE MEMBER'S AGE"*

Assistant Surgeon Edit

As defined by The American College of Surgeons (ACS), CPT codes related to surgery procedures are designated into the following categories:

- Assistant surgeon *always allowed* or
- Assistant surgeon *never allowed*

This rationale is based on the fact that the ACS determines these designations using clinical guidelines versus statistical measures.

In contrast, CMS's assistant reimbursement policy is based solely on the frequency (via a national sample) in which a specific procedure is reported with an assistant surgeon modifier.

Consequently, clinical logic is not used for the CMS determination of designations for assistant surgeons.

As a result, Hometown Health may apply the following edits:

- Assistant surgery reduction – All lines of the assistant surgeon's claim are reduced based on a percentage of the contract allowance.
- Assistant surgeon not allowed – All lines of the assistant surgeon's claims are denied.

Cosmetic Surgery Edits

A cosmetic procedure is usually performed for cosmetic reasons, without a medically indicated purpose. A number of surgical procedures may be performed, in full or in part, for reasons that are primarily "cosmetic" and where medical necessity does not exist. Usually, the procedure is requested by the patient to improve his or her physical appearance.

Cosmetic surgery edits were developed on a procedure-by-procedure basis by clinical consultants. Each CPT code was reviewed to determine whether it was partially or entirely cosmetic.

Hometown Health's claim review system recognizes that cosmetic services are frequently performed and, at time, could be medically necessary. These procedures are flagged as potentially cosmetic procedures and are subject to additional medical review.

Duplicate Charge Edit

The purpose of this edit is to identify claims that have already been processed for the same provider, member number, service date, service code, and modifier.

The edit comment may indicate *"DUPLICATE CHARGE PREVIOUSLY PROCESSED"*

Evaluation and Management (E & M) Services Edit
Established Patient, New Visit Procedure Code Not Allowed

The purpose of this edit is to identify claims for a new patient visit procedure when the provider has performed a previous visit within a specific period that qualifies that patient as an established patient.

Our claims review system's handling of separate reporting for E & M services varies according to the type of procedure performed on the same date of service. Specifically, the differentiation between:

- Initial or new patient
- Follow-up or established patient services

In addition, the claims review system adheres to the "Surgical Package Concept" and does not allow separate reporting of E & M services when a substantial diagnostic or therapeutic procedure is performed. CPT guidelines for E & M services support this medical visit auditing.

E & M guidelines direct the use of modifier 25 to indicate that the patient's condition required a significant, separately identifiable E & M service beyond the usual pre-service or post-service care associated with the procedure that was performed. For example, a claim is billed with CPT code 99213 (Office or other outpatient visit for the evaluation and management of an established patient) with CPT code 90772 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug] subcutaneous or intramuscular). The claims review edit will identify CPT code 99213 as included in procedure 90772. If the claim is billed with modifier 25 attached to the E & M code, the claim will be flagged for review and appropriate billing.

The edit comment may indicate *"NEW VISIT FREQUENCY or MEDICAL VISIT INCLUDED IN PROCEDURE"*

Hospital Outpatient Departments

Hometown Health does not reimburse for separate facility fees billed in conjunction with services rendered by a professional provider in a hospital outpatient department setting as defined in this policy. A facility fee is defined as a separate bill submitted by a facility for facility services provided as part of a professional provider in a hospital outpatient department.

Reimbursement for such facility fees is considered included in the reimbursement to the professional provider's practice, and such services are not reimbursable if billed on a UB -04 claim form. Facility providers should not bill Hometown Health for off-campus clinic charges for any technical component or overhead expenses of a covered service, including use of the space the professional services are provided in.

Revenue codes 510-519 will not be reimbursed on the associated facility claim.

Facility Treatment Rooms with Office Evaluation and Management Services

Hometown Health requires the reporting of CPT or HCPCS codes for treatment room revenue codes in an outpatient facility setting. Hometown Health does not allow reimbursement for office evaluation and management services when reported along with revenue codes 0760, 0761 or 0769. These revenue codes should be used to bill for the treatment room in which a specific procedure was performed, or a treatment was rendered. The HCPCS for E&M do not qualify as a procedure or treatment.

Incidental Procedures Edit

The purpose of this edit is to identify procedures that are performed at the same time as a more complex primary procedure. The incidental procedure does not require significant physician resources and/or is clinically integral to the performance of the primary procedure. For example, a claim is billed with CPT code 28270 (Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, each joint (separate procedure) and CPT code 28285 for the same date of service. The claims review system will identify CPT code 28270 as incidental to CPT code 28285.

The edit comments may indicate *"INCIDENTAL PX"*

Intensity of Service Edit

The purpose of the edit is to identify claims with excessive utilization of comprehensive and detailed evaluation and management services performed by the same provider for the same patient on the same date of service.

Based upon standard treatment protocols, certain diagnoses typically require limited medical evaluation services. Claims with these diagnoses are audited to detect instances of coding to a higher level of medical evaluation service than is typically indicated. In cases where the intensity of the medical evaluation service is higher than excepted for the diagnosis, the evaluation service is replaced with a lower intensity procedure. For example, if a claim is submitted with a high intensity visit code, such as procedures 99214 or 99215, for a diagnosis form the "Minor Viral Infections" category, then our system may recommend a lower intensity visit code 99213.

The edit comment may indicate *"99214 IS HIGHER THAN EXPECTED FOR DX AND SHOULD BE REPLACED WITH 99213"*

The presence of additional diagnoses may warrant a comprehensive or detailed visit.

Modifier to Procedure Code Edit

The purpose of this edit is to identify claims billed with a procedure code and a modifier that are not appropriate.

The edit comment may indicate *"INVALID MODIFIER/PROCEDURE COMBINATION"*

Mutually Exclusive Edit

The purpose of this edit is to identify claims billed with two or more procedures that are usually not performed during the same patient encounter, on the same date of service.

Mutually exclusive rules may also govern different procedure code descriptions, for the same type of procedure, for which the provider should be submitting only one procedure.

Generally, an open procedure and a closed procedure performed in the same anatomic site will not be both reimbursed. If both procedures accomplish the same result, the clinically more intense procedure is recommended for reimbursement and the comparable procedure is found mutually exclusive. For example, if a claim is submitted with CPT code 62331 (Implantation, revision or repositioning of tunneled intrathecal or epidural catheter) with CPT code 64483 (injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level) for the same date of service.

The edit comment may indicate *"CPT 62331 IS MUTALLY EXCLUSIVE TO CPT 64483."*

New Visit Frequency Edit

The purpose of this edit is to prevent inappropriate reporting of a new patient E & M service and is based on the following CPT guidelines:

- A new patient is one who has not received any professional services from the physician or another physician of the same specialty, who belongs to the same group practice, within the past three years

If the provider attempts to report a new patient E & M service more than once in a three-year period, our claims review system may recommend the CPT code with the corresponding established E & M service, if one is available.

The edit comment may indicate *"NEW VISIT FOR ESTABLISHED PATIENT"*

Obsolete Code Edit

The purpose of this edit is to identify procedure code(s) that has been deleted or no longer performed.

The edit comment may indicate *"INVALID CLAIM BILLING RECODING IS REQUIRED"*

Preoperative and Postoperative Edit

The purpose of this edit is to verify claims submitted for preoperative and postoperative timeframes associated with surgical procedures and certain medical procedures are followed.

Preoperative and postoperative periods are designated in CMS's National Physician Fee Schedule. With regard to medical visits:

- Minor surgical procedures have a zero day preoperative, and a zero to 10 day(s) postoperative timeframe
- Major surgical procedures have a one day preoperative and a 90 day(s) postoperative

The edit comments may indicate *"POST OP PROCEDURE OR PRE OP PROCEDURE"*

Re-bundled or Unbundling Edits

The purpose of the edit is to identify claims submitted with two or more procedure coded to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a provider.

Occasionally, the appropriate procedure is not present on the claim. In these instances, our claims review system may recommend to rebundle the unbundled procedure(s) to the more appropriate CPT/HCPCS procedure. For example, if a claim is submitted with CPT codes 93005 (Electrocardiogram, routine EKG with at least 12 leads; tracing only, without interpretation and report) AND 93010 (Electrocardiogram, routine EKG with at least 12 leads; interpretation and report only) for the same date of service; Hometown Health may recommend to rebundle CPT code 93005 and 93010 to CPT code 9300 (Electrocardiogram, routine EKG with at least 12 leads; with interpretation and report).

The edit comment may indicate *"APPROPRIATE CODE FOR REBUNDLED PROCEDURE"*

Gender Conflict Edit

A gender conflict occurs when the provider assigns a gender specific procedure to a patient of the opposite gender.

The edit comment may indicate *"PROCEDURE XXXXX IS NOT INDICATED FOR A MALE" or "PROCEDURE XXXXX IS NOT INDICATED FOR A FEMALE"*

Medicare Sequestration

In 2011 and 2012, Congress passed laws requiring a reduction in federal government spending under Title I of the Budget Control Act of 2011 (Public Law 112-25) and Title IX of the American Taxpayer Relief Act of 2012 (Public Law 112-240), 2 U.S.C. §§ 901, 901a. On May 1, 2013 The White House Office of the Press Secretary issued a Presidential Sequestration Order for Fiscal Year 2013 Pursuant to Section 251A of the Balanced Budget and Emergency Deficit Control Act, As Amended.

On March 22, 2013, CMS released sequestration guidance notifying MAOs (and other groups) that beginning April 1, 2013, payments made to those groups would be reduced by 2% in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985.

On May 1, 2013, MCS issued a second sequestration memorandum explaining the impact of the Sequestration Law on MAOs.

On July 12, 2013 Hometown Health d/b/a Senior Care Plus notified providers of the implementation of sequestration payment adjustments. This payment policy will apply to payments made by Hometown Health d/b/a Senior Care Plus for covered items and services supplied to members covered by Senior Care Plus a Medicare Advantage plan. The 2% sequestration payment adjustment will be applied at the final payment level after all other edits, rules and adjustments have been applied.

Unlisted or Unclassified CPT Codes

An unlisted code may be submitted for a procedure or service that does not have a valid, more descriptive CPT or HCPC code assigned. If you must bill one of these codes, it is important to give us a complete description of the service provided such as: what the code is being used for; procedure report for unlisted surgical/procedure; invoice for unlisted DME/supplies codes and NDC #; or dose and route of administration for unlisted drug codes. Documentation will be reviewed for appropriate coding, existence of a more appropriate code, coverage and

reimbursement allowance. Reimbursement for these codes is based on individual consideration of the service that is rendered. Unlisted or unclassified CPT codes that do not have documentation will be denied.

Quality Improvement Program Requirements

Hometown Health works to continuously improve the services offered to our members through our formal Quality Improvement Program. Federal and state regulatory agencies establish stringent quality standards for all health plans and monitor to ensure that the plans and their providers meet these standards.

Hometown Health's Quality Improvement Program provides the framework to ensure positive clinical outcomes and the optimization of member health, along with the formulation of strategies for improvement in non-clinical areas, such as improvement in customer service, improved claims reimbursement accuracy and timeliness, the enhancement of efficiencies, and the maximization of member satisfaction.

To meet these responsibilities, the Hometown Health Quality Improvement Department continually monitors specific quality indicators and activities within Hometown Health and among our providers.

The department's activities include:

- Performing quality improvement studies, along with developing and implementing initiatives and programs designed to improve the quality of services provided to our members;
- Monitoring member complaints for quality-of-care and service issues;
- Coordinating member satisfaction surveys and other regulatory research;
- Conducting medical record reviews;
- Reporting quality-related information as required to regulatory agencies; and
- NCQA, HEDIS/Stars reporting and management.

As a contracted provider and/or facility, you are obligated to comply with Hometown Health's quality programs and consent to the utilization of your practitioner quality performance data for quality improvement activities. This data can be used to determine your network status with Hometown Health and will be made available to Hometown Health membership.

Measuring Quality

CMS requires that Hometown Health meets certain standards to retain our contract for Senior Care Plus, a Medicare Advantage Plan, as well as maintain our Plan Ratings with NCQA

Our performance is monitored through healthcare quality measures known as the Healthcare Effectiveness Data and Information Set, or HEDIS. Hometown Health's processes for reporting HEDIS quality indicators are audited by our external NCQA-certified vendor annually.

Hometown Health's HEDIS data is reported to a number of regulatory and accreditation agencies, including: CMS; NCQA; and the State of Nevada Health Division.

The annual collection of HEDIS data in support of regulatory requirements will necessitate cooperation on the part of our providers, which may entail reviews by teams of our registered nurses, through onsite medical record review, or requests for records via fax.

Access to Records

Hometown Health may request copies of medical records or specific information as contained in any medical, financial or administrative records, to include, but not limited to: utilization/care management, quality improvement activities, HEDIS data collection, quality-of-care or complaint investigations, and other administrative obligations such as compliance with the terms provisions of the network participation agreement, contracts, appropriate billing practices, and other regulatory obligations. All requests for information will be made in accordance with applicable federal and state laws.

Additionally, our providers must provide access to any medical, financial, or administrative records related to the services you provide Hometown Health, Senior Care Plus, or third party administrated members, within fourteen (14) calendar days of our request, or sooner, as pertaining to fraud, waste, or abuse investigations; member grievance or appeals; or regulatory accreditation requirement. Note that the fourteen (14) day requirement may be superseded by any regulatory or accreditation requirements, or at the discretion of Hometown Health. Such records must be maintained in accordance with the more stringent federal or state guidelines as applicable, even after termination of any agreement with Hometown Health. Access to these records will be granted, even after termination with any agreement with Hometown Health, for the period in which the agreement was in place.

Preventive and Clinical Health Guidelines

Hometown Health is dedicated to optimizing our members' health. In the pursuit to achieve the highest quality of care, Hometown Health has adopted Preventive and Clinical Health Guidelines. These guidelines, based on the most current guidelines as published by benchmark institutions as the Centers for Disease Control and Prevention, the US Preventive Health Task Force, the American Academy of Family Physicians, ACA and others, offer the provider evidence-based guidelines to assist in the rendering of preventive services and clinical health services specific to certain disease states, including:

- Diabetes
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Hypertension (HTN)

Hometown Health encourages the use of these commonly-accepted guidelines through educational opportunities for your provider network.

Managing Disease

To help our members improve their quality of life and reduce their need for hospitalization, Hometown Health had developed disease management programs. The diseases we are currently targeting are diabetes, respiratory ailments (asthma and COPD), and congestive heart failure.

Providers who participate in a disease management program agree to follow the standards set by the program. Hometown Health relies on cooperation from our providers in treating our members according to these standards. For example, members with diabetes must have a dilated eye exam annually by an eye care professional, to examine for evidence of diabetic retinopathy (the dilated eye exam is an example of just one of the measures identified during a medical record review for HEDIS measures).

Our disease management program goals are to provide a collaborative approach with the member's personal physician in order to prevent acute exacerbation and long-term complications associated with the disease, and to ultimately promote the optimal health of the member.

Medical Record and Documentation Standards

Medical records and related documentation must contain the information necessary to support claims submitted by the provider for services rendered and in support of quality improvement activities. Medical information and documentation must meet the industry standards as established by federal and state regulatory agencies, as well as accrediting organizations. Providers must:

- Maintain a single, permanent medical record that is detailed, legible, organized, current, and comprehensive, and available for each patient visit
- Providers must establish policies and procedures for the protection, storage and maintenance of medical records, whether paper or electronic. Safeguards must be implemented to prevent unauthorized access or alteration, loss, destruction, or tampering
- Medical records must be maintained in a confidential manner, periodic training must be provided to office staff regarding confidentiality and usage
- All entries must be legible, dated, and identify the author and their credentials when applicable. It should be apparent from the documentation which individual provided a given service
- Clearly label or document subsequent charges to a medical record entry by including the author or the change and date of change. The provider must also maintain a copy of the original entry
- Documentation should be created at the time of service or shortly thereafter
- Cite medical conditions and significant illnesses on a Problem List, and document clinical findings and evaluation for each visit that:
    - Emphasize in notes and charts all known medication allergies and adverse reactions, as well as if the member has no known allergies or adverse reactions
    - Medication records must reflect the name of the medication, dosages, and the rationale for their application. Over the counter medications utilized by the member must also be listed
    - Document all pertinent medical history, chief complaints, significant issues, chronic illnesses, accidents, and surgical procedures
    - Records reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the provider
    -

The following must be recorded:

- Blood pressure, height, weight, and body mass index
- Immunization record

- Tobacco habits, including advice to quit, alcohol use and substance abuse for members age eleven (11) and older
- Family and social history
- Preventive screenings/services and risk screenings
- Acknowledgement on all critical laboratory values with the providers signature or initials and date
- Screening for depression and evidence of coordination with behavioral health providers
- Advanced directives (where appropriate), including documentation of refusal
- HIPAA education and acknowledgement

Demographic information should include:

- Member name and date of birth, or member name and health care ID number, on every page
- Gender, both assigned at birth and gender identity
- Age or date of birth
- Address
- Marital status
- Sexual Orientation
- Race & Ethnicity
- Occupational history
- Home and/or work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Insurance information

For each visit, documentation should include:

- Member's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with findings
- Growth charts for pediatric members
- Member education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Review by the primary physician (initialed or signed) on consultation, lab, imaging, special studies, and ancillary, outpatient and inpatient records
- Consultation and abnormal studies are initiated and include follow-up plans

- Chronic illness and interventions are addressed

Behavioral Health providers follow the Record Keeping recommendations of the American Psychological Association (APA) Record Keeping Guidelines (2007). Included in these guidelines are required elements:

- Patient identifying data (e.g., name, client ID number)
- Date, start and stop times of session
- Type(s) of services (e.g., consultation, assessment, treatment, training)
- Diagnosis and functional status
- Symptom and prognosis
- Treatment Plan and progress to date
- Modalities and frequencies of treatment furnished
- Results of clinical test
- Other elements as recommended by the aforementioned Guidelines (such as nature of professional intervention or contact; formal/informal assessment of client status, etc.)

Responding to Member Concerns

When Hometown Health receives a complaint from a member regarding the quality of their care, our Quality Improvement department is required to review and investigate the complaint. We ask the provider to respond to the complaint within 7 days for standard complaints and within 24 hours for urgent complaints, and to fully cooperate with the investigation. In working with our providers to address concerns, corrective action plans may be developed to ensure that a fair and satisfactory solution is reached.

By collaborating with our providers to continuously improve the quality of care and service provided to our members, Hometown Health is confident that our members' satisfaction with the health plan and our providers will continue to grow, along with providing the highest standard of care.

Non-Discrimination

You, as a provider, must not discriminate against any patient, with regard to quality of service, accessibility of services, on the basis that the patient is a member of Hometown Health or its affiliates, or on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You as a provider must maintain policies and procedures to demonstrate that you do not discriminate in

the delivery of service and accept for treatment any members in need of the services you provide except as detailed in the Provider Panel Status section of this document

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Credentialing and Re-credentialing

Practitioner Credentialing and Re-credentialing

Hometown Health is committed to providing our members with the highest quality of care available. As part of fulfilling this commitment, Hometown Health requires the practitioners requesting participation in its provider network to meet our stringent credentialing requirements that were created in accordance with CMS and NCQA guidelines, as well other applicable federal and state regulations.

The credentialing and re-credentialing processes establish the requirements for the qualifications and appropriate licensure of practitioners, as well as requirements for professional conduct, access and availability of care, clinical documentation, and the provision of quality care to our members.

Hometown Health utilizes the standardized credentialing/re-credentialing application as implemented by State of Nevada Division of Insurance. To facilitate a more streamlined credentialing process, Hometown Health follows the three-year re-credentialing cycle as accepted by most major healthcare organizations in northern Nevada.

Practitioners requesting participation in the Hometown Health provider network must fully complete the credentialing application, sign and date the application and attestation, and provide the requisite documentation in a timely manner. Failure to comply with all aspects of the credentialing/re-credentialing process, or offering false or misleading information, will result in denial of participation and termination of contract, and other actions as mandated by federal, state, accreditation, or other regulatory statutes.

Practitioners applying for participation in the Hometown Health provider network have the following rights regarding the credentialing/re-credentialing process:

- The right to review the information submitted to support the practitioner’s credentialing application;
- To correct erroneous information; and

- To be informed of the status of the practitioner's credentialing/re-credentialing application.

To review information, correct erroneous information, and to check the credentialing status, please email the Hometown Health Credentialing Department at HTHCredentialing@hometownhealth.com

For further questions regarding the credentialing, re-credentialing, or the credentialing/re-credentialing appeal process, please call the Hometown Health Credentialing Department at (775) 982-3017 or HTHCredentialing@hometownhealth.com.

Facility Credentialing and Re-credentialing

Hometown Health conducts a formal and ongoing assessment of its organizational facility providers.
An organizational facility provider is a facility or organization that provides services to Hometown Health and Senior Care Plus members. They include but are not limited to hospitals (including inpatient rehabilitation facilities); skilled nursing facilities and nursing homes; free standing surgical centers; home health agencies; inpatient, residential, and ambulatory behavioral health facilities; hospices; trauma facilities; clinical laboratories; diagnostic imaging services, durable medical equipment; and providers of end stage renal disease services.

Hometown Health confirms that the organizational facility providers are in good standing with state and federal regulatory bodies and have been reviewed and approved by an accrediting body, if appropriate. If the organizational facility providers have not been approved by an accrediting body, they must meet Hometown Health's standards as defined in Hometown Health′s Standards for Participation policy & procedure. Primary source verification of licensure is not required but the organization must provide a copy of the license and accreditation report, or the information must be verified through alternative sources (e.g. verification of accreditation status by searching list of accredited organization on the accrediting body's Web site, such as "The Joint Commission" site or by verification of license status with the state licensing body). A CMS or state review may be substituted for non-accredited organizational providers, unless an organization facility provider is in a rural area as defined by the U.S Census Bureau.

At a minimum of every three years, Hometown Health confirms that the organization facility providers continue to be in good standing with the state and federal regulatory bodies and, if applicable, are reviewed and approved by an accrediting body. Hometown Health "Organizational Provider" contracts provide for notice from the provider of any change in its Medicare approval, state licensure, or accreditation status.

Credentialing/Re-credentialing Denial Dispute Resolution

Hometown Health has an established process for the credentialing and re-credentialing of practitioners and organizational facility providers. This process includes the establishment of a process for appealing negative credentialing/re-credentialing decisions by the Medical Affairs Committee (MAC). A practitioner or organizational facility provider whose application has not been accepted due to the following reasons is NOT eligible to access the appeals process:

- Network adequacy pertaining to that practitioner's particular specialty, or
- Failure to comply with HTH's request for additional information

Practitioners/organizational facility providers for all Hometown Health products whose applications have been denied will be informed of the following appeal rights and processes:

1. The Notice of Denial will include the reason for denial as well as the practitioner/organizational facility provider's right to appeal to the Level I or Level II stage.
2. The practitioners/organizational facility provider has 30 days from receipt of the denial letter to request engaging the appeal process, for both the Level I and the Level II Appeals.

LEVEL I APPEAL

1. The Level I Appeal Process is only available to existing, contracting practitioners/organizational facility providers on the Hometown Health network. Initial, non-contracted, practitioners/organizational facility providers who have been reviewed and denied by the MAC may reapply in three years. The practitioners/organizational facility providers may only reapply twice for reconsideration before the application will no longer be considered further.

   The purpose of the Level I Appeal is to provide information the MAC may not have seen or to correct information the MAC used in making the recommendation for denial.

   Level I Appeal is initiated with a written request to the Hometown Health Credentialing Specialist or Supervisor of Network Services by the practitioner/organizational facility provider to appeal the MAC decision. The

request for the appeal must be made within thirty days of receipt of the denial letter. If the practitioner/organizational facility provider does not request a Level I Appeal within 30 days, the Committee's decision will be considered final on that date. The practitioner/organizational facility provider's denial will then be reported to the NPDB within 30 days.

2. The Level I Appeal will be scheduled no later than 60 days after receipt of request by the denied practitioner/organizational facility provider unless agreed upon by both the appellant and MAC. The Level I Appeal is hosted by MAC and conducted by a three-person panel comprised of selected participating and non-participating providers that were not involved in the initial denial decision. At least one practitioner must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. The clinical peer will have the same licensure as the appellant.

3. The Level I Appeal will be considered informal, with the MAC minutes documenting the attendees, the highlights of the discussion, and the decision of the Committee. Attorneys are not invited to participate on behalf of the appellant at a Level I Appeal.

4. The appellant will be notified of the date and time of the meeting so he/she can call in and/or provide additional information. Any additional information supplied by the appellant must be received no later than two weeks before the scheduled appeal meeting in order to be considered at the meeting.

5. Any data the appellant supplies must be:
   - Detailed;
   - Documented in writing by the appellant and/or include copies of documents such as a license, DEA certificate, letters of support, etc. and
   - Verifiable, either orally, written or through Internet website data, through acceptable sources identified in Hometown Health's Standards for Participation policy & procedure.

6. The Committee will notify the practitioner in writing of its decision within ten (10) business days of the meeting. If the practitioner was denied, the written notification will contain an explanation of the reason(s) for the MAC's decision and the practitioner's right to submit a Level II Appeal.

7. The practitioner has thirty (30) days from receipt of the notification to request a Level II Appeal.

8. If the practitioner does not request a Level II Appeal within 30 days, the Committee's decision will be considered final. The practitioner's denial will then be reported to the NPDB within 30 days. Additionally, the contents of the denial letter will be reported to the Commissioner of Insurance and the denial letter will be made available to the Commissioner upon request pursuant to Nevada Revised Statute (NRS) 679B.124.

LEVEL II APPEAL

1. The Level II Appeal is initiated at the request of the practitioner/organizational facility provider writing the Senior Clinical Staff Person or his/her designee.

2. The Level II Appeal will be scheduled no later than 60 days after receipt of request by the denied practitioner/organizational facility provider unless agreed upon by both the appellant and MAC.

3. The Level II Appeal is conducted by a five-person panel composed of three selected participating and non-participating practitioners. The panel will also include Hometown Health's CEO or designee and another Hometown Health staff member not involved in the Level I Appeal. At least one practitioner must be a participating provider who is not otherwise involved in network management and who is a clinical peer of the participating provider that filed the dispute. The clinical peer will have the same licensure as the appellant.

4. The Level II Appeal will be considered a formal appeal, and the appealing provider may be represented by counsel at his/her own expense. Minutes of the meeting will be taken.

5. The Senior Clinical Staff Person or his/her designee will present the reason(s) for the denial of credentialing of the practitioner/organizational facility provider.

6. The practitioner/organizational facility provider may provide any material he/she feels is relevant, but it must be:
   - Detailed

- Documented in writing by the appellant and/or accompanied by supporting documentation, and
- Verifiable; either orally, written, or through Internet website date, through acceptable sources identified in Hometown Health's Standards for Participation policy and procedure.
- Any material supplied by the appellant must be received no later than two weeks before the scheduled Level II Appeal meeting to be considered at the meeting.

7. The practitioner/organizational facility provider will be notified in writing of the panel's decision within 10 business days of the meeting. The written notification will include the panel's findings based upon the information considered. If the practitioner/organizational facility provider was denied, the written notification will contain NPDB reporting language and notify the practitioner/organizational facility provider that they can reapply in 3 years. The practitioner/organizational facility provider's denial will then be reported to NPDB within 30 days of the decision. Additionally, the contents of the denial letter will be reported to the Commissioner of Insurance and the denial letter will be made available to the Commissioner upon request pursuant to Nevada Revised Statute (NRS) 679B.124.

8. All decisions from the Level II Appeals are considered final.

Hometown Health Committees

Hometown Health Quality Improvement Committee

Hometown Health Quality Improvement Committee meets monthly and is composed of network primary care and specialist physicians, as well as the Hometown Health Medical Director, Healthcare Utilization Management Director and Quality Improvement Director.

This committee evaluates and recommends medical functions and activities that promote improved quality and the delivery of appropriate, efficient patient care by providers contracted with Hometown Health.

The committee reviews the Quality Improvement, Population Health, and Utilization Management Program Descriptions to ensure that it includes indicators, studies, and focused interventions that improve clinical and service quality, as well as new and existing industry payment policies related to patient care. The committee provides suggestions for the design of Quality Improvement studies, disease management programs and clinical action plans.

To guide utilization management, the committee reviews over-and under-utilization of services and the consistency of utilization review criteria. The committee reviews MCG (formerly Milliman Care Guidelines) criteria on a yearly basis. This committee reviews and recommends preventative care and disease specific treatment guidelines that are disseminated to the network providers.

The committee reviews and approves new medical technology or new applications of established technologies.

Medical Affairs Committee

The Medical Affairs Committee meets as often as necessary (at least quarterly) and is composed of participating and non-participating providers who perform peer review activities on the files presented for credentialing and re-credentialing review. Facility credentialing is also the responsibility of this committee.

This committee reviews the credentialing and re-credentialing of Hometown Health practitioners/organizational facility providers. In addition, they review and approve the policies and procedures for credentialing and re-credentialing practitioners, facilities, and healthcare delivery organizations. The committee conducts peer reviews and institutes corrective action as needed according to policy.

Physician's Role as a Contracted Provider

The physician plays a vital role with our organization by providing and overseeing a patient's care. A physician contracted with Hometown Health may participate as:

- A PCP designated to manage the care of a given patient;
- A specialty care physician, or specialist, called upon when the patient requires specialized care.
    - Please see the Prior Authorization and Utilization Management Program Requirements section of this manual for information regarding obtaining authorizations.

Physicians and physician extenders, like physician assistants, nurse practitioners, and licensed behavioral health interns with specialties of MFT, CSW, CPC, and ADC, are expected to comply with credentialing and re-credentialing requirements as established by Hometown Health in relation to URAC standards. Physicians and physician extenders are attached to a specific contracted TIN for billing and payment. Providers and/or subcontractors such as physicians and physician extenders are required to comply with all terms and conditions of the current contracted agreement. All members of a physician practice that is billing under a TIN must be credentialed and services rendered by that physician or physician extender must be billed under the NPI of the servicing provider, not the TIN owner to meet Hometown Health and CMS guidelines. Paraprofessionals that do not require credentialing such as an RBT, BCaBA, or Physical Therapy assistants should be billed under his/her supervising physician. Failure of a provider to bill correctly could lead to a fraud, waste, and abuse investigation and termination from the Hometown Health network.

Because providers are paid according to a contracted TIN, providers and extenders who leave a contracted provider arrangement are considered to have been termed from the provider network. Any request for a new contract for that provider will be subject to review according to Hometown Health policies and procedures.

Limits on Billing Participants

Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payer for services not listed in the contract unless the participant has acknowledged the services will not be covered by Hometown Health and has signed a waiver of liability.

Providers Responsibility to Refer to Participating Providers

It is the provider's responsibility to refer members to participating providers in the Hometown Health network as outlined in the provider agreement. If Hometown Health identifies a member has been referred to an out of network provider, Hometown will require the referring provider to coordinate the resolution of the member's out of pocket cost with the out of network provider within ten (10) business days of notice from Hometown Health or the member.

Providers Responsibility to Adhere to Pharmaceutical Formularies

Adhering to Closed Formularies for Medical and Pharmacy Benefit Drugs:

- **Prescription Guidelines:** Healthcare providers are expected to adhere to the closed formulary established by Hometown Health and Senior Care Plus, or the Pharmacy Benefit Manager of Hometown Health and Senior Care Plus. These formularies specify the medications that are preferred for coverage based on efficacy, safety, and cost-effectiveness considerations.

- **Prior Authorization:** Prior authorization MUST be obtained for medications not included in the closed formularies. Providers must submit appropriate documentation justifying the medical necessity of non-formulary medications before prescribing them to patients. Submission of documentation by the provider does not guarantee prior authorization approval.

- **Therapeutic Interchange:** Providers are required to consider therapeutic interchange opportunities within the closed formulary, where clinically

appropriate. This involves substituting a prescribed medication with a therapeutically equivalent alternative listed on the formulary.

- **Formulary Review:** The closed formularies are subject to periodic review and updates based on emerging evidence, treatment guidelines, and pharmaceutical market dynamics. Providers are encouraged to stay informed about changes to the formulary and adjust prescribing practices accordingly.

- **Patient Education:** Providers should communicate with patients about the closed formularies and the rationale behind formulary-based prescribing. This includes discussing alternative medication options, potential cost-saving opportunities, and the importance of medication adherence.

- **Appeals Process:** In cases where a non-formulary medication is deemed medically necessary for a patient's treatment, providers may initiate an appeals process to request coverage approval. Providers should familiarize themselves with the appeals process and assist patients in navigating it when necessary.

Adherence to the closed formularies is essential for promoting cost-effective medication utilization, ensuring consistent quality of care, and maximizing patient access to clinically appropriate treatment options.

Site of Care

Providers are responsible for ensuring compliance with site of care requirements outlined in these guidelines and obtaining necessary authorizations or referrals as per the patient's insurance coverage and healthcare plan.

Primary Care Physician

Each PCP contracted with Hometown Health has the primary responsibility for coordinating comprehensive healthcare for members who select or are assigned to the physician as their PCP. These responsibilities include:

- Managing the delivery of covered health services to these members in accordance with the physician’s agreement with Hometown Health;

- Obtaining the appropriate authorizations/referrals to specialists and other providers under contract with Hometown Health when required;
- Providing care for all routine office visits and related services of the physician and other providers received in the physician's office, including evaluation, diagnosis and treatment of illness and injury;
- Providing visits and examination, including consultation time; time for personal attendance with the members during a stay in a hospital, skilled nursing facility or other facility, including the member's home if necessary;
- Administering injections;
- Providing well-childcare from birth in accordance with Hometown Health policies and protocols for pediatric members;
- Providing periodic health-appraisal examinations and applicable preventative health screenings and management;
- Providing patient health education services and referrals as appropriate, including information and personal health patterns, appropriate use of health care services, family planning, adoption, and other educational and referral services;
- Having telephone consultations with other physicians and members;
- Submitting medical records upon request to another provider or to Hometown Health in accordance with the terms of the provider contract;
- Complying with Hometown Health's Utilization Review and Quality Improvements programs;
- Complying with all requirements for credentialing and re-credentialing and participation in the Hometown Health provider network;
- Complying with the referral authorization process as outlined in the Medical Management section of this manual.

Specialist Physicians

Specialists contracted with Hometown Health provide specialty care to our members as follows:

- Upon receipt of an authorized referral (if required) for a member from a participating PCP, evaluate, diagnose, or treat the member as indicated on the authorized referral;
- Maintain communication with the PCP's office regarding the continuing care of the member;

- Some plans require prior-authorization referrals from Hometown Health for specialty care. Please refer to the Authorization Matrices located on EpicCare Link. If a Prior Authorization is required, failure to obtain the authorization prior to rendering services may result in a "Hold Harmless" claims denial where the physician may not collect payments from the member for services denied by Hometown Health including the applicable copayments.
- Submitting medical records upon request to another provider or to Hometown Health in accordance with the terms of the provider contract.
- Comply with Hometown Health's Utilization Review and Quality Management programs.
- Comply with all requirements for credentialing and re-credentialing and participation in the Hometown Health provider network.
- Obtain authorizations from Hometown Health for procedures and request additional office visits from the PCP prior to services being rendered, when required.

Provider Dispute Resolution Processes

Written Formal Complaints (Any written complaint from providers will be categorized as a Formal Complaint):

1. Claim disputes see "Claims Reconsiderations"

2. Credentialing / Recredentialing disputes see "Credentialing/Recredentialing Denial Dispute Resolution"

3. For any non-claim related complaints please email HTHProviderRelations@hometownhealth.com. A response will be sent to the provider or third-party entity no later than 30 calendar days from receipt of the complaint, or as dictated by the state regulation.

No Surprises Act

Hometown Health has partnered with BetterDoctor to fulfill the regulatory requirements of the No Surprises Act, to ensure directory updates are completed timely. Your office will receive quarterly requests directly from BetterDoctor to complete attestations. Effective 6/1/2025, Hometown Health will now require providers or facilities to have attested within the last 365 days for inclusion in the directory. Attest today and don't get caught by surprise!

Appointment Accessibility Survey
Appointment accessibility forms will be sent out annually to monitor member access.

Provider Cultural Competency Training
Upon contracting, providers are required to complete cultural competency training. The training will be provided during the onboarding process and must be completed within 30 days of the effective date of the contract.

Referrals to Preferred Providers and Facilities
Providers will refer members to preferred facilities and providers if Preferred Providers and Facilities list is made available by Hometown Health.

Provider Panel Status

Purpose of Identifying Panel Status

PCP panel status is important for new members who must select a PCP and for existing members who wish to make a change.

Status Definitions:

- **Open** – Provider is accepting new patients. Members may select any PCP with an open panel.

- **Established Only** – Providers who are at capacity may select the "Established Only" status. Existing patients who become newly enrolled with Hometown Health may then be assigned to the practice. In order to be compliant with the contract's and Hometown Health's nondiscrimination clause, it is important to note that if a provider chooses to have a status of "Established Only" for Hometown Health members, the provider must also be "Established Only" for all insurance carriers.

Changing Panel Status

To change the status of the panel, you must notify Network Services in writing, on your practice letterhead within thirty (30) days prior to the effective date of the change. This will give Hometown Health adequate time to ensure members are not adversely impacted. Please include your tax identification number on all correspondence. Notices to change panel status should be emailed to ProviderUpdates@hometownhealth.com

Provider Demographics & Information Changes

This section applies to all contracted providers and vendors.

Submitting Demographic Changes or Corrections

Changes should be submitted 60 days in advance or as soon as possible, on your office letterhead and emailed to Network Services at ProviderUpdates@hometownhealth.com or faxed to (775) 982-8003.

Please include your tax identification number on all correspondence to ensure timely processing of all changes.

Demographic Changes/Corrections consists of such items as:

- Ownership changes
- Practice Name
- Billing Address
- Practice Address
- Telephone Number
- Fax number

Tax Identification Number changes include:

- Terminating an existing tax identification number
- Adding a new tax identification number
- Correcting an existing tax identification number

Note: Any name or tax identification number changes must include a revised W-9.

Additions include:

- Adding a new provider to the practice.
    - Providers will be added to the contract with the date the notification is received, or the future date listed on the Group Add Form or Letter of Intent. Hometown will not retrospectively add providers to a contract. Providers must be current with Hometown Health credentialing standards if applicable.
- Opening an additional location

Terminations include:

- Terminating a provider from the practice (Please refer to the Term and Termination Notice Section in your contract for the notice requirement.)
- Closing an office location

To notify Hometown Health of the above changes please use the forms located at: https://www.hometownhealth.com/provider-partners/provider-forms/

Appointments for Members

Appointment Access

Because members rely on their physicians to make initial diagnoses and manage their treatment (from preventive to chronic care), plan members must have access to the healthcare providers they need and receive appropriate services promptly.

Hometown Health has established the following availability standards for appointments shown in the tables on the following pages.

Waiting Time

Waiting time at the PCP or specialist office is not more than 15 minutes from the scheduled appointment time except when the provider is unavailable due to an emergency.

We understand, however, that providers can be delayed when they "work in" urgent cases or find a serious problem or when the patient has an unknown need that requires more services or education than were described at the time the appointment was made.

24-Hour Availability

PCPs and specialists have appropriate arrangements to ensure the availability of physician's services to members 24 hours a day, seven days a week, including coverage after hours or when the physician is absent.

Hometown Health monitors these standards through appointment accessibility surveys, Provider Directory audits, proactive office visits, online directory report discrepancy notification, and member notifications.

Primary Care Appointments

	Definition	Standard
New patient to practice	A visit to establish care	90% of appointments can be scheduled within 14 days from date of call
Routine/Preventative Appointment for Established Patients	A visit not related to an acute problem. -Regular follow up for chronic problem -Preventive care	90% of appointments can be scheduled within 14 days from date of call
Urgent Care	Acute but not life or limb threatening, symptoms present sufficiently bothersome or of recent onset	90% appointment availability within 48 hours or direct member to urgent care
After Hours Care	Care, direction of care, or provision of care by the primary care provider during non-office hours	24 hours per day; 7 days per week
Emergent Care	Problem requiring immediate specialty physician consultation for treatment and diagnosis as determined by the PCP	Providers will direct member to call 911 or go to the nearest emergency room. If request is received during non-business hours, the provider's voicemail will direct the member to call 911 or go to the nearest emergency room.
Prenatal Care	Maternity care	1. First Trimester: Within two weeks of first request 2. Second Trimester: Within seven calendar days of first request

		3. Third Trimester: Within three calendar days of first request or immediately in an emergency

Behavioral Health Appointments

	Definition	Standard
New patient to practice	A visit to establish care	90% of appointments can be scheduled within 10 business days from date of call
Routine/Follow-up Appointment for Established Patients	A visit not related to an acute problem. -Regular follow up for chronic problem -Preventive care	90% of appointments can be scheduled within 30 days from date of call for prescribers and 20 days from date of call for non-prescribers
Urgent Care	Acute but not life threatening, symptoms present sufficiently bothersome or of recent onset	90% appointment availability within 48 hours or direct member to Behavioral Health Crisis Unit
Emergency	Non-life-threatening emergency	Within 6 hours, or refer to ER or Behavioral Health crisis unit

Specialty Care Appointments

	Definition	Standard
Routine/Preventative Appointment for Established Patients	A problem requiring care or evaluation by a specialist but not considered urgent or emergent by the PCP	90% of appointments can be scheduled within 14 days from date of referral
Urgent Specialty Care	Problems requiring evaluation by a specialist	90% of appointments can be scheduled within 48 hours or based on the PCP's assessment or direct member to Urgent Care
Emergent Care	Problem requiring immediate specialty physician consultation for treatment and diagnosis	Providers will direct member to call 911 or go to the nearest emergency room. If request is received during non-business hours, the provider's voicemail will direct the member to call 911 or go to the nearest emergency room.

Member Missed Appointments

Failed Appointments

A “failed appointment” is an appointment that a member does not keep, cancel or reschedule.

Providers should document failed appointments clearly in the chart of each member who did not keep an appointment.

Notifying Members Who Fail to Keep Appointments

Members who fail to keep two appointments in three months or three appointments in six months may be considered a problem for the individual provider’s practice.

When the provider has identified such a member, the provider should send a letter to the member.

If the member fails to keep another appointment within six months of receiving the first letter, the provider should send a second letter to the member.

If any member continues to fail to keep appointments, the practice may choose to dismiss the member. The provider is required to notify the member in writing of the dismissal using the standards set by the Nevada State Medical Board. Those standards state that the provider must offer emergency care for no fewer than 30 days upon notification to the member.

The provider must also notify Hometown Health of any dismissal in order to allow us to assist the member in accessing care with a new provider.

Mail or fax a copy of your dismissal letter to:

Hometown Health
Customer Service Department
10315 Professional Circle
Reno, NV 89521
FAX: (775) 982-3741

EpicCare Link

The EpicCare Link portal facilitates secure communication between Hometown Health and our providers and their support staff. EpicCare Link is a secure web portal used to grant providers and their staff access to referrals, claims, and enrollment information for their patients. With the appropriate access, providers can use the EpicCare Link portal to review both clinical and insurance information for their patients.

EpicCare Link's web-based features include:

- Hometown Health pre-authorization
  - Online submitting, viewing, and printing

- Hometown Health claims viewing
  - Claim Reconsiderations
  - Print an Explanation of Payment (EOP)
  - Print an Explanation of Benefit (EOB)

- Hometown Health eligibility search
  - Up-to-date status of Hometown Health members eligibility
  - Summary of Benefits
  - Member deductible and out-of-pocket information
  - Member accumulator amounts

- Hometown Health and Senior Care Plus Formularies
  - Most current copy of the Hometown Health and Senior Care Plus Formularies

- EpicCare Link (Electronic Medical Records)
  - Internet version of the Renown Health Electronic Medical Records system
  - Access to predefined views of patient data (face sheets, rounds, reports, etc.)

To sign up for access EpicCare Link, please visit
https://ecl.renown.org/EpicCareLink/common/epic_login.asp

Federal and State Regulations

The False Claims Act, 31 U.S.C. §§ 3729 - 3733

The False Claims Act (FCA) is one of the laws the federal government uses to prevent and detect fraud, waste, and abuse in federal health care programs. The FCA provides that anyone who "knowingly" submits a false claim to the Government is liable for damages up to three times the amount of the erroneous payment, mandatory penalties between $5,500 and $11,000 for each false claim submitted, and potential administrative remedies, such as exclusion from future participation in government health care programs.

The FCA defines "knowingly" to mean that a person (1) has actual knowledge of the false claim; (2) acts in deliberate ignorance of the truth of the falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information.

Specifically, there are seven (7) actions that may form the basis for liability under the federal False Claims Act including:

- Knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval by the federal Government;
- Knowingly making or using, or causing to be made or used, a false record or statement to get a false claim paid or approved;
- Conspiring to defraud the Government by getting a false or fraudulent claim allowed or paid;
- Knowingly making, using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.
- The FCA applies to claims submitted for payment by a federal health care program, physician or other care provider who participate in federally funded programs such as Medicare and Medicaid.

Nevada False Claims Act, N.R.S. §§ 357.010 - 357.250

The Nevada False Claim Act (NFCA) provides that a person who, with or without specific intent to defraud, knowingly presents or causes to be presented a false claim for payment; knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment or approval of a false claim; conspires to defraud by obtaining allowance or payment of a false claim; or after discovering the falsity of the claim fails to disclose the falsity to the state within a reasonable time is liable to the state for a civil penalty of not less than $5,000 or more than $10,000 for each act. The Attorney General is required to investigate any alleged liability pursuant to the NFCA and bring a civil action pursuant to the NFCA against the person liable.

The Anti-Kickback Statute, 42 U.S.C. §§ 1320a - 7b (b)

The federal Anti-Kickback Law provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursement under Medicare or other federal health care programs. In addition to applicable criminal sanctions, such as individual or entity may be excluded from participating in Medicare and other federal health care programs and is subject to civil monetary penalties.

The Beneficiary Inducement Law, 42 U.S.C. §§ 1320a - 7a (a) (5)

The Beneficiary Inducement Law prohibits the provision of remuneration to a beneficiary to influence his or her selection of health care providers. Specifically, the Law prohibits a person from offering or transferring remuneration to a Medicare or Medicaid beneficiary, where such person knew or should have known that the remuneration was likely to influence the beneficiary to order or receive items or services from a particular provider, practitioner, or supplier for which payment may be made under the Medicare or Medicaid programs.

Consolidated Appropriations Act - Prohibition on Gag Clauses on Price and Quality Information in Provider Agreements

Internal Revenue Code (Code) section 9824, Employee Retirement Income Security Act (ERISA) section 724, and Public Health Service (PHS) Act section 2799A-9(a)(1), prohibit group health plans and health insurance issuers offering group

health insurance coverage from entering into an agreement with a health care provider, network or association of providers, third-party administrator (TPA), or other service provider offering access to a network of providers that would directly or indirectly restrict a plan or issuer from—

(1) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;

(2) electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan or coverage upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Americans with Disabilities Act of 1990 (ADA), including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(3) sharing information or data described in (1) and (2), or directing such information be shared, with a business associate, as defined in 45 CFR 160.103, consistent with applicable privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA. PHS Act section 2799A-9(a)(2) prohibits health insurance issuers offering individual health insurance coverage from entering into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the issuer from—

(1) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or

(2) sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in (1) with a business associate, consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA.

Plans and issuers must annually submit an attestation of compliance with these requirements to the Departments. These provisions became effective December 27, 2020

Recovery Audit Contractors

The fee-for-service (FFS) Medicare Recovery Audit Program is authorized under Section 1893(h) of the Social Security Act. The mission of the Recovery Audit Program is to identify and correct Medicare and Medicaid improper payments through the efficient detection and collection of overpayments made on claims for health care services provided to Medicare and Medicaid beneficiaries, to identify underpayments to providers, and to provide information that allows CMS to implement actions that will prevent future improper payments.

CMS has identified five key factors for measuring the success of the Recovery Audit Program: increasing accuracy, implementing effective and efficient program operations, maximizing transparency, minimizing provider burden, and developing robust provider education. In addition, communication with key stakeholders is essential to the program's success, as it seeks to identify problems and develop solutions early and to discuss those issues with all parties. CMS has named four national Recovery Audit Contractors (RAC) to audit Medicare fee-for-service providers. Providers should know who the RAC is in their region and take the RAC mission seriously.

For more information on the Recovery Audit Program, visit the "Recovery Audit Program" Web page at go.cms.gov/RAC.

Some of the issues affecting providers are as follows:

- Short-stay inpatient visits
- “Incident to” services provided by non-physician practitioners
- Unbundling of procedures
- Medical necessity
- Units of service
- Therapy services (e.g. Occupational Therapy, Physical Therapy, Speech Language Pathology)
- Skilled nursing facilities
- Home health agencies
- Part B hospital inpatient services when a Part A inpatient admission is denied as not reasonable and necessary
- Prior authorization of power mobility devices

The Mental Health Parity and Addiction Equity Act (MHPAEA)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Summary of MHPAEA Protections

Under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits.

MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits.

Under MHPAEA, a plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits unless the factors used in applying the limitation to mental health or substance use disorder benefits are comparable to and applied no more stringently than with respect to medical/surgical benefits in the same classification, except to the extent that recognized clinically appropriate standards of care may permit a difference. Examples if nonquantitative treatment limitations include:

- medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- formulary design for prescription drugs;
- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods for determining usual, customary, and reasonable charges;

- refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- exclusions based on failure to complete a course of treatment.

If you are not sure if the requirements or limitations that apply to your mental health or substance use disorder benefits are permissible you may contact the plan. Members (or their authorized representatives) in ERISA-covered plans are entitled to comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply limitations to medical/surgical benefits and MH/SUD benefits under the plan. If a provider or other individual is acting as a patient's authorized representative, the provider or other authorized representative may request these documents.

Provider Regulatory Requirements Senior Care Plus

This section is to provide our preferred providers and their office staff with details on the structure and policies and procedures of SCP products as they relate to CMS regulatory requirements. Hometown Health requires that SCP providers and their office staff read, abide by, and reference this manual as necessary.

Hometown Health contracted providers agree to comply with all state or federal laws and regulations and CMS regulatory requirements applicable to SCP products in providing or arranging for services to any Member.

In addition, the obligations of each participating provider that are specifically applicable to SCP enrollees are detailed in the provider agreement with Hometown Health.

Hometown Health offers SCP, a Medicare Advantage Plan with prescription drug coverage (MAPD), available to anyone with both Medicare Parts A and B. A member must be a resident of Washoe, Carson City, Clark, or Nye Counties in Nevada and continue to pay his or her Medicare Part B premiums.

Through a contract with CMS, the U.S. government agency that administers Medicare, SCP coordinates Medicare benefits and offers additional coverage.

SCP members effectively assign their Medicare benefits to Hometown Health and SCP assumes total responsibility for meeting the covered health needs of the enrolled Medicare beneficiaries.

To implement the various statutes on which the CMS contracts are based, CMS issues regulations under authority granted by the Secretary of the Department of Health and Human Services and related provisions of the Social Security Act. CMS also issues various manuals, memoranda and statements necessary to administer the programs. Each MAO must comply with these requirements. CMS conducts routine regulatory audits to review the MAO's procedures and to ensure compliance with federal regulations.

Audits/Reviews of Medicare Advantage Programs and Providers

CMS has a risk-adjusted payment methodology for Medicare Advantage programs. The methodology is based on diagnostic information as well as demographic information. MA organizations must obtain the risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service. In providing covered services to SCP enrollees, providers agree to comply with access and reporting requirements.

MA organizations may include in their contracts with providers provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data.

CMS conducts data validation every year after risk adjustment data is collected and submitted, and payments are made to Hometown Health. The purpose of the risk adjustment data validation is to ensure risk-adjusted payment integrity and accuracy. Risk Adjustment Data Validation (RADV) is the process of verifying that diagnosis codes submitted for payment by SCP are supported by medical record documentation for a member.

Overview of CMS Risk Adjustment Data Validation Audit

CMS conducts data validation every year after risk adjustment data is collected and submitted, and payments are made to Hometown Health. The purpose of the risk adjustment data validation is to ensure risk-adjusted payment integrity and accuracy. Risk Adjustment Data Validation (RADV) is the process of verifying that diagnosis codes submitted for payment by SCP are supported by medical record documentation for a member.

CMS data validation is accomplished through medical record review. SCP requests the medical records from the provider and submits them to the designated CMS contractor for review. The goals of the data validation audit are to:

- Validate member diagnosis through documentation in the medical record
- Validate appropriate coding according to ICD-9/10 Guidelines
- Identify provider discrepancies in coding and documentation
- Measure accuracy of risk adjustment discrepancies
- Measure impact of SCP member payments

Compliance Program

Hometown Health's Compliance Program reflects a good faith commitment to compliance and to the identification, correction of non-compliance, and prevention of fraud, waste and abuse. Hometown Health is committed to compliance and follows the below principles:

1. Appointment of compliance leader and compliance committees with appropriate authority
2. Develop and maintain policies and procedures that address regulatory requirements
3. Effective education and training
4. Internal auditing and monitoring for compliance
5. Effective communication
6. Enforcement of policies and procedures
7. Prompt response to compliance issues
8. Risk management
9. Vendor oversight

Compliance Committees

Hometown Health has established appropriate committee to accomplish the work of the Compliance Program. Each committee meets at least quarterly and is chaired by Hometown Health's Compliance Officer. The Committee is responsible for advising and providing support to the Compliance Officer in the creation, implementation and operation of the Compliance Program.

Hometown Health Compliance Committee is accountable to Hometown Health's Board. Reports on the status of the Program will be reported through Hometown Health's Compliance Officer. In addition, the Compliance Committee is authorized to invite other operational subject matter experts to meetings where their relevant expertise is relied on

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act

Physician and Provider Compliance for Privacy Regulations

Providers and covered entities will comply with federal/state laws, statutes, and regulations pertaining to our member's protected health information ("PHI"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

Both covered entities and providers are "covered entities" as defined under HIPAA are required to understand and comply with the HIPAA and HITECH Rules.

Activities Allowed Under the HIPAA Privacy Regulations

As allowed by the HIPAA Privacy and Security Rules, covered entities and providers may use or disclose its member's PHI for the purpose of treatment, payment and/or health plan operations ("TPO") without a member's consent or authorization. Below are examples:

1. Treatment: includes the provisions, coordination, management, consultation, and referral of a member between and among health care providers.

2. Payment:

   - Determination of member eligibility
   - Review of health care services and utilization
   - Review of various activities of health care providers for payment and/or reimbursement to fulfill Hometown Health's coverage responsibilities and provide appropriate benefits
   - To obtain or provide reimbursement for health care services delivered to members

3. **"**Operations:

- Certain quality improvement activities (***e.g.***, care management and care coordination)
- Quality of care reviews in response to member and/or state/federal queries
- Response to member complaints/grievances
- Health Plan Employer Data and Information Set Reviews (HEDIS)
- Legal activities (***e.g.***, audit programs, FWA)

Providers are responsible for obtaining Hometown Health's authorization for any necessary treatment beyond what the member acquired through their enrollment process.

Members have the right to approve or deny release of their PHI for uses other than TPO.

In accordance with the HIPAA Enforcement and Breach Notification Rules, providers will promptly notify Hometown Health of any unlawful or unauthorized uses or disclosure of confidential or PHI regarding our members and will be subject to the provisions relating to compliance, investigations, and the imposition of civil money penalties for violations of the HIPAA Administrative Simplification Rules.

Compliance for Electronic Data Transmissions

Hometown Health is required to document HIPAA regulations to ensure physicians and providers are aware of and follow Hometown Health's policies and procedures for electronic transmissions.

Physicians and providers are subject to provisions of the rules promulgated under the Health Insurance and Portability Act of 1996 (HIPAA). These rules include Standards of Privacy for Individual Identifiable Health Information, Standards for Electronic Transactions, Security and Electronic Signature Transactions, and the National Standard Provider Identifier.

Physicians and providers conform to each electronic transaction submitted to Hometown Health to the X12 Implementation Guide Specifications applicable to the transaction. As of May 2008, all healthcare providers who submit electronic health claims are required to obtain an NPI. Claims submitted by physicians and providers without their NPI are considered non-compliant claims and may be rejected by Hometown Health.

Physicians and providers are solely responsible for the preservation, privacy and security of data in its possession, including data transmissions received from Hometown Health and other persons.

Providers will promptly notify Hometown Health of any unlawful or unauthorized uses, disclosure, or security incidents of PHI regarding our members.

Provider Medical Records

Hometown Health requires medical records to be maintained in a manner that is current, detailed, and organized and permits effective and confidential patient care and quality review. As a contracted provider with Hometown Health, you are required to do the following:

- Maintain records for at least 10 years from the end of the final contract period or completion of audit, whichever is later, unless there is a special need to retain longer.
- Provide medical records to Hometown Health for the annual HEDIS audit and Risk Adjustment reviews/audits in a timely manner at no cost to the plan or to the member.
- Provide medical record access to deferral entities, such as the Department of Health and Human Services (HHS) and the Comptroller General, which is head of the Government Accountability Office (GAO).
- The medical record, whether electronic or paper, communicated the Member's past medical treatment, past and current health status, and treatment plans for further health care.

Confidentiality of Member Medical Records

Hometown Health also considers all records to be confidential and requires that providers do the following:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office when staff is not present
- Permit review or removal of medical records only with member's authorization
- Release medical and mental health records only in accordance with state and federal laws, regarding confidentiality and disclosure

Provider Employment of Sanctioned, Precluded, or Opted-Out Individuals

Sanctioned Individuals

Federal Fraud and Abuse regulations adopted by the Health and Human Services Office of the Inspector General in compliance with both HIPAA (Public Law 104-191) and The Balanced Budget Act of 1997 (Public Law 105-33), identify significant civil and criminal actions that may be taken against Medicare/Medicaid providers who employ federally sanctioned individuals. This is true even if the sanctioned individual does not work directly in providing services to individuals under any federally funded healthcare program.

Contracted providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicare, Medicaid, or other Federal Health Care Programs are employed or subcontracted to provide services.

If a contracting provider does employ an individual who is on the federal sanction list, and that person provided services which are directly or indirectly reimbursed by a federally funded program, the employer may be subject to legal action which could include civil penalties, criminal prosecution and/or exclusion from program participation. The contracted provider must notify Hometown Health of any violation and must remove the employee form performing any services for Hometown Health's members.

It is essential that providers regularly check the federal sanction list which can be found at: https://exclusions.oig.hhs.gov/. All providers should check current and potential employees against the list on the federal database to ensure that no sanctioned individuals are working for their organization. Providers are to maintain documents related to their screening process and, when requested, attest to Hometown Health that no sanctioned individuals are providing healthcare services to Hometown Health's members.

Providers included in the Preclusion List
Effective April 1, 2019, the Preclusion List is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. The list includes individuals or entities who meet the following criteria:

- Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.
- Have been convicted of a felony under federal or state law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program.

MA plans are required to deny payment for a health care item or service furnished by an individual or entity on the Preclusion List. Reference 42 CFR 422.222 for specific rules and timing of preclusion list effective dates and when claims will being to deny. You can obtain additional information by contacting providerenrollment@cms.hhs.gov.

Opt-Out Providers
An MA organization may not pay, directly or indirectly, on any basis, for basic benefits furnished to a Medicare enrollee by a physician or other practitioner who has filed with the Medicare contractor an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries.

If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of 2 years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. See 42 CFR 405.440. An MA organization must pay for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in their MA plan who has not signed a private contract with a beneficiary, but may not otherwise pay opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier.

Fraud, Waste & Abuse Program

As a Medicare Advantage Organization under contract with CMS, Hometown Health is required under federal law 42 C.F.R. 423.504(b), to have in place a comprehensive fraud, waste and abuse ("FWA") program to detect, correct, and prevent FWA. Hometown Health's FWA Program is designed to detect and prevent FWA committed by participating and non-participating providers, facilities, FDR, staff and our members.

Hometown Health's Compliance Department is supported by Hometown Health's CEO, Renown Health's Compliance Officer and senior management. Hometown Health has a fiduciary responsibility to the health care community to resist criminal behavior, instances of false claims and improper billing and coding practices, and other schemes that adversely impact patient safety, quality of health care services being delivered that impose a tremendous financial burden on the health care system.

Fraud, Waste & Abuse ("FWA") Program

Components of the FWA Program:

I. Detection and Prevention

II. Recovery of Duplicate or Erroneous Payments

III. Reporting

IV. Education and Training

V. Monitoring

A. Internal FWA

Hometown Health has adopted FWA detection, prevention and non-retaliation procedures. Below summarizes Hometown Health's controls.

Compliance Program

Hometown Health's compliance program ("Program") establishes a proactive, robust and ongoing detection and prevention program for FWA to comply with federal, state and other applicable regulations. All staff and entities are required to report any suspicion of FWA to their supervisor, the Compliance Manager, anonymous on the Compliance Hotline (at 1-800-611-5097) and/or online, without retaliation. The Compliance Department will provide oversight and assistance with FWA regulatory reports to state and/or federal agencies, as needed.

The Program prohibits retaliation against those who, in good faith, reports a concern or who participates in the investigation of compliance related issues. The Compliance Program provides that compliance concerns will be investigated rigorously and resolved promptly. Investigations regarding Compliance Program violations are conducted by Hometown Health's Compliance Department, Corporate Compliance/General Counsel, Internal Audit, or Human Resources depending upon the nature of the violation. Compliance and fraud and abuse training is provided to all new employees, and to existing employees no less than annually.

B. External Fraud

1. Prevention and Detection

Hometown Health strives to detect and prevent FWA by receiving referrals from variety of sources and through the use of its detection software. Hometown Health utilizes a variety of methods to seek out fraud and abuse as identified below:

a) Fraud Detection Software

Data will be routinely analyzed by Hometown Health's Special Investigation Unit and operational departments. This data analysis is key in the identification of repetitive questionable patterns.

The data analysis consists of claims data mining and rules-based analysis to identify possible instances of fraud and abuse.

The computer-based analysis includes provider, facility, pharmacy, and member claims data. Patterns of over-utilization, false claims, or other unusual billing practices are addressed.

b) Fraud/Suspicious Claim Sources

All providers, staff and entities have a critical role to play in the lawful and ethical conduct of Hometown Health's business. The goal is to have all providers, staff and entities take the time to understand the principles behind the laws and regulations that underlie the company's policies in order to be aware of conduct that is lawful and appropriate.

All providers, staff and entities are required to comply with all federal and state laws, statutes and regulations regarding FWA.

In addition to detection software, Hometown Health employs several other lead activities, such as:

- Complaint tracking
- Leads from other internal departments
- Fraud and Abuse Hotline
- Tips from members, the general public or employees
- Media reports
- Office of Inspector General Alerts

Investigation

The Compliance Manager will coordinate the need to conduct an investigation and to take corrective action. The disclosure of certain information may be required. Investigation procedures may include:

- Work with other departments to review questionable claims
- Assessing the quality and credibility of allegations or suspicious situations
- Prioritize cases based on business practices and objectives
- Timely investigation actions
- Relevant claim data gathered, reviewed, and analyzed as evidence
- Written summary of investigated finding with suggested corrective actions, monitoring, and follow-up.

c) NBI MEDIC Investigation

The Compliance Manager, if necessary, will coordinate or refer to NBI MEDIC the investigation of suspected fraudulent actives of misconduct relating to Part D or MA that could include:

- Suspected, detected or reported criminal, civil and/or administration violations;
- Allegations extend beyond Part C and/or Part D programs that involve multiple health plans, multiple states and/or widespread schemes
- Allegations involving know patters of fraud
- Scheme with large financial risk to the Medical Program and/or beneficiaries

The Compliance Manager will initiate an investigation of suspected fraudulent actives or misconduct within two (2) weeks from detection or will refer the matter to NBI MEDIC. The Compliance Manager will retain the NBI MEDIC acknowledgment letter and resolution letter.

I. Recovery of Duplicate or Erroneous Payments

Hometown Health contracts with numerous commercial client groups and Medicare. Hometown Health's acknowledges its responsibility to be a proper steward and ensure that only eligible employees or beneficiaries are afforded coverage, only medically necessary and medically appropriate services are covered, and that FWA Programs is in place. Additionally, Hometown Health acknowledges its responsibility to recoup overpayments made to providers, vendors, or others as a means of reducing unnecessary medical claims costs. To this end, Hometown Health will remedy and recoup overpayments, erroneous payment, duplicate payments or other payments of an amount in excess of which the provider or vendor is entitled. These recovery efforts are integral to the anti-fraud, waste, and abuse efforts. In addition, Hometown Health reserves the right to recoup monies paid to providers or vendors who have been identified on state or federal exclusion or preclusion lists based upon the effective date of the exclusion.

II. Reporting

All Hometown providers, staff and entities are required to report any suspicion of fraud, waste or abuse to their supervisor, the Compliance Manager or to the anonymous Compliance Hotline, so that reports can be investigated and corrected, as needed.

Hometown Health encourages providers, staff and its entities to report any issues or concerns related to compliance or ethical obligations under laws, regulations, and Hometown Health's policies, including laws governing Federal reimbursement programs, such as Medicare. Reports may be made confidentially and anonymously via Hometown Health's Compliance Hotline at 1-800-611-5097 or online. All reports will be followed up by the Compliance Manager and, where applicable, by additional appropriate individuals.

To the extent possible and appropriate under the circumstances, Hometown Health will maintain the confidentiality of the identity of anyone who reports a suspected violation of law or policy or who participates in the investigation. However, the need to conduct an adequate investigation and to take corrective action may require disclosure of certain information. In some circumstances, Hometown Health may be required by law to identify a person who makes a report or who is a witness. Providers, staff and entities should be aware that Hometown Health's Compliance Department and the Law Department are legally obligated to act in the best interest of the Company.

Hometown Health will cooperate and coordinate with NBI MEDIC, CMS, law enforcement and others for detecting and preventing FWA and may provide information in connection with their audit and/or investigation to the government agency.

III. Education and Training

An objective and goal of the FWA Program is to place emphasis on reducing the paid claims error rate by notifying providers and vendors of medical review findings and making appropriate suggestions or by offering education and training to address identified issues.

All Hometown staff will receive FWA education and training. The education and training include the following FWA topics:

- Examples of FWA by providers, vendors and staff
- A dedicated hotline to report suspected or actual FWA
- Information on how to contact the Compliance Manager to report FWA
- How to report suspected FWA to Hometown Health

IV. Monitoring

To effectively monitor adherence to applicable laws, statutes and regulations, Hometown Health conducts periodic review and analysis to determine if there are any changes that impact compliance.

All providers under corrective action plans will be re-reviewed after one year to determine whether or not their patterns of suspicious claims activity have changed. Additionally, routine randomized audits will be undertaken annually to ensure providers are conforming to acceptable health insurance billing.

V. Contact

Hometown Health

- Customer Service Department at 775-982-3232 or 800-336-0123
- Compliance Department Office at 775-982-3025
- Renown Confidential Reporting Line at 800-611-5097

Centers for Medicare and Medicaid Services (CMS)

- Office of Inspector General Hotline – *Maintains a confidential hotline*

Phone: 800-447-8477

Email: HHSTips@oig.hhs.gov

Mail: Office of the Inspector General
HHS TIPS Hotline
P.O. Box 23489 Washington, DC 20026

Hometown Health Plan (HMO) Member Rights and Responsibilities

Hometown Health Plan defines a member as an individual who meets all applicable eligibility requirements as defined in the Evidence of Coverage and whose enrollment form has been accepted by Hometown Health Plan in accordance with those requirements.

Members must choose a PCP at the time of enrollment or Hometown Health will choose one for the member based on geographic location. There is no coverage for PCP services outside of the network.

Requirements for members

Hometown Health Plan requires that the member fulfill these responsibilities when seeking services from preferred providers:

- Contact his or her PCP to make an appointment when services are needed
- We recommend that members establish themselves with the physician by scheduling an initial checkup, to meet the provider and fill out applicable paperwork
- Arrive for appointments with the provider on-time
- Notify the provider that he or she is insured through Hometown Health Plan

While some members may not know the name of their insurer, the provider staff should always ask for that information and review the identification card. When in doubt, please review eligibility on EpicCare Link or contact Customer Service at 775-982-3232 or 800-336-0123.

- Pay all applicable co-payments, deductible or coinsurance for services rendered

- Upon referral, ensure that the PCP has referred the member to a network provider contracted with Hometown Health Plan
- Conduct him or herself respectfully toward the provider and the provider's office staff.

Dismissing a Member

Should the member fail to follow these, or any reasonable guidelines set forth by the provider office, the provider may dismiss that member from his or her care.

The provider is required to notify the member in writing of the dismissal using the standards set by the Nevada State Medical Board. Those standards state that the provider must offer emergency care for no fewer than 30 days upon notification to the member.

The provider must also notify Hometown Health Plan of any dismissal and to allow Hometown Health Plan to assist the member in accessing care with a new provider.

Mail a copy of your dismissal letter to:

Hometown Health
Customer Services Department
10315 Professional Circle
Reno, NV 89521

You may also fax the letter to Customer Service at 775-982-3741.

Statement of Member Rights and Responsibilities

Hometown Health Plan gives each member a document stating the rights and responsibilities of a member. The content of that document is as follows:

As a member, you have a right:

A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

A right to be treated with respect and recognition of their dignity and their right to privacy.

A right to participate with practitioners in making decisions about their health care.

A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

A right to voice complaints or appeals about the organization or the care it provides.

A right to make recommendations regarding the organization's member rights and responsibilities policy.

To be treated in a manner that respects your privacy and dignity as a person and to receive assistance in a prompt, courteous and responsible manner.

To appropriate medical care.

To a choice of physicians.

To be informed about how to obtain a referral for specialty care and how to obtain afterhours and emergency care inside and outside of your local area.

To be provided with information about the providers who deliver your health care and about your health-care benefits.

To be informed by your physician of your diagnosis, prognosis and plan of treatment in terms you understand.

To be informed by your physician about any proposed treatment you may receive. You have a right to participate in the plan of your care.

To confidential handling of all communications and medical information maintained by Hometown Health Plan.

To complete and easily understood information about the costs of coverage and changes in coverage.

To refuse treatment and be advised of the probable consequences. We encourage you to discuss your options with your PCP.

To select a PCP from a listing of participating providers, change your PCP for any reason and be informed about how provider incentives or restrictions might influence practice patterns.

To have your medical records transferred promptly to a new provider within or outside the network, to ensure continuity of your care.

To express a concern or grievance about Hometown Health Plan and/or the care you have received.

As a member you have a responsibility:

A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

To understand fully the materials provided by Hometown Health Plan regarding your health benefits, including Hometown Health Plan's policies and your rights.

To present your Hometown Health Plan membership care and pay any co-payment prior to receiving services.

To receive reauthorizations for services as outlined in your Evidence of Coverage and to comply with the limits of any preauthorization for medical services.

To make sure Hometown Health Plan is notified of any changes in family size, address, phone number, enrollment status, or other demographic information changes.

To keep scheduled appointments and notify the physician's office promptly if you will be unable to keep an appointment and to pay all charges, if any, for missed appointments and services not covered.

To participate actively in decisions about your health care.

To follow the advice of your PCP and consider the likely consequences when you refuse to comply. We encourage you to ask questions of your physician until you fully understand the care you are receiving.

To provide honest and complete information to those providing care.

To know what medication you are taking, the reason that they have been prescribed the medication and the proper way to take it.

To express your opinions, concerns or complaints in a constructive manner.

To make premium payments on time if they are not paid directly by your employer.

Hometown Health Plan (EPO) Member Rights and Responsibilities

Hometown Health Plan defines a member as an individual who meets all applicable eligibility requirements as defined in the Evidence of Coverage and whose enrollment form has been accepted by Hometown Health Plan in accordance with those requirements.

Members enrolled in the EPO plan may designate any PCP on the Nevada EPO Network who is available to accept them as a patient.

Requirements for members

Hometown Health Plan requires that the member fulfill these responsibilities when seeking services from preferred providers:

- Contact his or her PCP to make an appointment when services are needed
- We recommend that members establish themselves with the physician by scheduling an initial checkup, to meet the provider and fill our applicable paperwork
- Arrive for appointments with the provider on-time
- Notify the provider that he or she is insured through Hometown Health Plan

While some members may not know the name of their insurer, the provider staff should always ask for that information, review the identification card, and confirm the member is a Hometown Health Renown member. When in doubt, please review eligibility on EpicCare Link or contact Customer Service at 775-982-3232 or 800-336-0123.

- Pay all applicable co-payments, deductible or coinsurance for services rendered

- Upon referral, ensure that the PCP has referred the member to a Hometown Renown network provider.
- Conduct him or herself respectfully toward the provider and the provider's office staff.

Dismissing a Member

Should the member fail to follow these, or any reasonable guidelines set forth by the provider office, the provider may dismiss that member from his or her care.

The provider is required to notify the member in writing of the dismissal using the standards set by the Nevada State Medical Board. Those standards state that the provider must offer emergency care for no fewer than 30 days upon notification to the member.

The provider must also notify Hometown Health Plan of any dismissal and to allow Hometown Health Plan to assist the member in accessing care with a new provider.

Mail a copy of your dismissal letter to:

Hometown Health
Customer Service Department
10315 Professional Circle
Reno, NV 89521

You may also fax the letter to Customer Service at 775-982-3741.

Statement of Member Rights and Responsibilities

Hometown Health Plan gives each member a document stating the rights and responsibilities of a member. The content of that document is as follows:

As a member, you have a right:

A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

A right to be treated with respect and recognition of their dignity and their right to privacy.

A right to participate with practitioners in making decisions about their health care.

A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

A right to voice complaints or appeals about the organization or the care it provides.

A right to make recommendations regarding the organization's member rights and responsibilities policy.

To be treated in a manner that respects your privacy and dignity as a person and to receive assistance in a prompt, courteous and responsible manner.

To appropriate medical care.

To a choice of physicians.

To be informed about how to obtain a referral for specialty care and how to obtain afterhours and emergency care inside and outside of your local area.

To be provided with information about the providers who deliver your health care and about your health-care benefits.

To be informed by your physician of your diagnosis, prognosis and plan of treatment in terms you understand.

To be informed by your physician about any proposed treatment you may receive. You have a right to participate in the plan of your care.

To confidential handling of all communications and medical information maintained by Hometown Health Plan.

To complete and easily understood information about the costs of coverage and changes in coverage.

To refuse treatment and be advised of the probable consequences. We encourage you to discuss your options with your PCP.

To select a PCP from a listing of participating providers, change your PCP for any reason and be informed about how provider incentives or restrictions might influence practice patterns.

To have your medical records transferred promptly to a new provider within or outside the network, to ensure continuity of your care.

To express a concern or grievance about Hometown Health Plan and/or the care you have received.

As a member you have a responsibility:

A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

To understand fully the materials provided by Hometown Health Plan regarding your health benefits, including Hometown Health Plan's policies and your rights.

To present your Hometown Health Plan membership care and pay any co-payment prior to receiving services.

To receive reauthorizations for services as outlined in your Evidence of Coverage and to comply with the limits of any preauthorization for medical services.

To make sure Hometown Health Plan is notified of any changes in family size, address, phone number, enrollment status, or other demographic information changes.

To keep scheduled appointments and notify the physician's office promptly if you will be unable to keep an appointment and to pay all charges, if any, for missed appointments and services not covered.

To participate actively in decisions about your health care.

To follow the advice of your PCP and consider the likely consequences when you refuse to comply. We encourage you to ask questions of your physician until you fully understand the care you are receiving.

To provide honest and complete information to those providing care.

To know what medication you are taking, the reason that they have been prescribed the medication and the proper way to take it.

To express your opinions, concerns or complaints in a constructive manner.

To make premium payments on time if they are not paid directly by your employer.

Hometown Health Providers (PPO) Member Rights and Responsibilities

Hometown Health Providers defines a member as an individual who meets all applicable eligibility requirements as defined in the Evidence of Coverage and whose enrollment form has been accepted by Hometown Health Providers in accordance with those requirements.

Hometown Health Providers issues an identification card to each member. This card contains information about the member and the plan in which the member is enrolled. Members enrolled in the PPO plan may designate any PCP on the Hometown Health Network who is available to accept them as a patient.

Requirements for members

Hometown Health Providers requires that the member fulfill these responsibilities when seeking services from providers:

- Contact a physician to make an appointment when services are needed
- We recommend that members establish themselves with the physician by scheduling an initial checkup, to meet the provider and fill out applicable paperwork
- Arrive for appointments with the provider on time
- Notify the provider that he or she is insured through Hometown Health Providers

Note: While some members may not know the name of their insurer the provider staff should always ask for that information. When in doubt, confirm eligibility on EpicCare Link or contact our Customer Service Department at 775-982-3232 or 800-336-0123.

- Pay any co-payment, coinsurance or other charges that are the patient's responsibility when they are requested

- Receive preauthorization for services as outlined in the Evidence of Coverage
- Conduct him or herself respectfully toward the provider and the provider's office staff

Dismissing a Member

Should the member fail to follow these, or any reasonable guidelines set forth by the provider office, the provider may dismiss that member from his or her care.

The provider is required to notify the member in writing of the dismissal using the standards set by the Nevada State Medical Board. Those standards state that the provider must offer emergency care for no fewer than 30 days upon notification to the member.

The provider must notify Hometown Health Providers of any dismissal and to allow Hometown Health Providers to assist the member in accessing care with a new provider.

Mail a copy of your dismissal letter to:

Hometown Health
Customer Service Department
10315 Professional Circle
Reno, NV 89521

You may also fax the letter to Customers Service at 775-982-3741.

Statement of Member Rights and Responsibilities

Hometown Health Providers gives each member a document stating the rights and responsibilities of a member. The content of that document is as follows:

As a member, you have a right:

A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

A right to be treated with respect and recognition of their dignity and their right to privacy.

A right to participate with practitioners in making decisions about their health care.

A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

A right to voice complaints or appeals about the organization or the care it provides.

A right to make recommendations regarding the organization's member rights and responsibilities policy.

To be treated in a manner that respects your privacy and dignity as a person and to receive assistance in a prompt, courteous and responsible manner.

To appropriate medical care.

To a choice of physicians.

To be informed about how to obtain after-hours and emergency care inside and outside of your local area.

To be provided with information about the providers who deliver your health care and about your health-care benefits. You need to know any exclusions and limitations associated with the plan and any charges for which you will be held responsible.

To be informed by your physician of your diagnosis, prognosis and plan of treatment in terms you understand.

To be informed by your physician about any proposed treatment you may receive. You have a right to participate in the plan for your care.

To confidential handling of all communications and medical information maintained at Hometown Health Providers.

To have your medical records transferred promptly to a new provider within or outside the network, to ensure continuity of your care.

To complete and easily understood information about the costs of your coverage and/or any changes that may affect your coverage.

To refuse treatment and be advised of the probable consequences of your decision by your treating physician. We encourage you to discuss your options with your physician.

To express a concern or grievance about Hometown Health Providers and the care you have received and to receive a response in a timely manner.

As a member you have a responsibility:

A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

To understand fully the materials provided by Hometown Health Providers Regarding your health benefits, including the policies of Hometown Health Providers and your rights.

To present your Hometown Health Providers membership card and pay any co-payment, deductible, coinsurance or other charges that are the patient's responsibility when they are requested and to know the proper use of those services.

To receive prior authorization for services as outlined in your Evidence of Coverage and to comply with the limits of any preauthorization for medical services.

To make sure Hometown Health Providers is notified of any changes in family size, address, phone number, enrollment status or demographic information changes.

To keep scheduled appointments and notify the physician's office promptly if you will be unable to keep an appointment and to pay all charges, if any, for missed appointments and services not covered.

To participate actively in decisions about your health care and cooperate fully on mutually accepted courses of treatment.

To follow the advice of your physician and consider the likely consequences when you refuse to comply. We encourage you to ask questions of your physician until you fully understand the care you are receiving.

To provide honest and complete information to those providing care.

To know what medication you are taking, the reason that they were prescribed medication and the proper way to take it.

To express your opinions, concerns or complaints in a constructive manner.

To make premium payments on time if they are not paid directly by your employer.

Senior Care Plus HMO Member Rights and Responsibilities

SCP defines a member as an individual who resides in Washoe, Carson City, Clark, or Nye Counties in Nevada, who is enrolled in Medicare Part A and B, and whose enrollment form has been accepted by SCP.

SCP assigns each member to a PCP of his or her choice and issues the member an identification card.

The card contains information about the member and plan in which the member is enrolled and has the name of the member's PCP. Please use the EpicCare Link Portal to access member eligibility and co-payment information.

Member Rights

Our plan must honor your rights as a member of the plan.

> We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.) To get information from us in a way that works for you, please call Customer Service.
>
> Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.
>
> If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

We must treat you with fairness and respect at all times.

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

We must ensure that you get timely access to your covered services and drugs.

As a member of our plan, you have the right to choose a Primary Care Provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Services to learn which doctors are accepting new patients. You also have the right to go to a specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers ***within a reasonable amount of time.*** This includes the right to get timely services from specialists with you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 of the Evidence of Coverage tells you what you can do.

We must protect the privacy of your personal health information. Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information? We make sure that unauthorized people don't see or change your records.

In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, ***we are required to get written permission from you first.*** Written permission can be given by you or by someone you have given legal power to make decisions for you.

There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law. For example, we are required to release health information to government agencies that are checking on quality of care.

Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others. You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with other for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

We must give you information about the plan, its network or providers, and your covered services. As a member of our plan, you have the right to get several kinds

of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

Please call Customer Service for more detailed information. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.

Information about our network providers including our network pharmacies.

- For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- For a list of the providers in the plan's network, see the *Provider Directory.*
- For a list of the pharmacies in the plan's network, see the *Pharmacy Directory.*
- For more detailed information about our providers and pharmacies, you can call Customer Service or visit our website at www.SeniorCarePlus.com.

Information about your coverage and rules you must follow in using your coverage.

- In Chapters 3 and 4 of the Evidence of Coverage, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
- To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of the Evidence of Coverage plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
- If you have questions about the rules or restrictions, please call Customer Service.

Information about why something is not covered and what you can do about it.

- If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to

change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of the Evidence of Coverage. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of the Evidence of Coverage.

We must support your right to make decisions about your care. You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information for your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand.*

You also have the right to participate fully in decisions about your healthcare. To help you make decisions with your doctors about what treatment is best for you; your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask

us for a coverage decision. Chapter 9 of the Evidence of Coverage tells how to ask the plan for a coverage decision.

- You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to,* you can:
    - Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself/
    - Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "advanced directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives. If you want to use an "advanced directive" to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, form a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms.
- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have a signed advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have a signed an advance directive.

As a member, you have a right:

A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.

A right to be treated with respect and recognition of their dignity and their right to privacy.

A right to participate with practitioners in making decisions about their health care.

A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

A right to voice complaints or appeals about the organization or the care it provides.

A right to make recommendations regarding the organization's member rights and responsibilities policy.

As a member, you have a responsibility to:

A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.

A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the Board of Medical Examiners or the Nevada State Board of Osteopathic Medicine for MD's and DO's respectively:

Board of Medical Examiners 9600 Gateway Drive Reno, NV 89521 775-688-2559 8:00am to 5:00pm Monday through Friday	Nevada State Board of Osteopathic Medicine 2275 Corporate Circle # 210 Henderson, NV 89074 702-732-2147 9:00am to 5:00pm Monday through Friday

You have the right to make complaints and to ask us to reconsider decisions we have made. If you have any problems or concerns about your covered services or care, Chapter 9 of the Evidence of Coverage tells what you can do. It gives the details about how to deal with types of problems and complaints.

As explained in Chapter 9 of the Evidence of Coverage, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make and appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service.

What can you do if you think you are being treated unfairly or your rights are not being respected? If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at 800-368-1019 or TTY 800-537-7697 or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and* it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Customer Service
- You can call the State Health Insurance Assistance Program.

How to get more information about your rights there are several places where you can get more information about your rights:

- You can call Customer Service
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2 Section 3 of the Evidence of Coverage.
- You can contact Medicare.
    - You can visit the Medicare website (http://www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
    - Or, you can call 800-MEDICARE (800-633-4227) 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

You have some responsibilities as a member of the plan

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service. We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services.
- If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us by calling Customer Service.
- We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.
- Tell your doctor and other health care providers that you are enrolled in our plan.

- Show your plan membership card whenever you get your medical care or Part D prescription drugs.

Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.

- To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

Be considerate

We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

Pay what you owe

As a plan member, you are responsible for these payments:

- You must pay your plan premiums to continue being a member of our plan.
- For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 of the Evidence of Coverage tells what you must pay for your medical services. Chapter 6 of the Evidence of Coverage tells what you must pay for your Part D prescription drugs.
- If you bet any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

Tell us if you move

If you are going to move, it is important to tell us right away. Call Customer Service

- If you move *outside* our plan service area, you cannot remain a member of our plan. (Chapter 1 in the Evidence of Coverage tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
- If you move *within* our service area, we still need to know so we can keep your membership record up to date and know how to contact you.

Dismissing a Member

The provider is required to notify the member in writing of the dismissal using the standards set by the Nevada State Medical Board. Those standards state that the provider must offer emergency care for no fewer than 30 days upon notification to the member.

The provider must notify SCP of any dismissal and allow SCP to assist the member in accessing care with a new provider.

Mail a copy of your dismissal letter to the address below or you may also fax the letter to Customer Service at 775-982-3741.

Senior Care Plus - Customer Service Department
10315 Professional Circle Reno, NV 89521