Harbor Health

Member Handbook

Health Maintenance Organization Plan

Coverage is provided by Harbor Health Plan, a Health Maintenance Organization health care plan licensed to provide Individual health plans in Texas. This coverage provides benefits only when a Network Provider is used. You will not receive coverage when you receive care from a non-contracted, or out-of-Network Provider, except in certain circumstances such as there is no choice of a Network Provider, Emergency Health Care Services, facility-based Providers and Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.

This document is a brief summary of the benefits, rights and responsibilities under this plan. This document may be delivered to you electronically. Any notices included in this document may be sent to you electronically by us. Paper copies are available upon request. You can find more complete information about this plan in the *Evidence of Coverage* documents (*EOC*) which you will receive after you enroll.

We want you to be satisfied with your new health care program. If you would like more information about the plan, a Member Service representative will be happy to help you. Call Member Service Monday – Friday, 7:00am – 8:00pm, Saturday, 8:00am – 5pm, and Sunday and legal holidays, 8:00am – 12:00pm CST at 1-855-481-0225. You may also write to us at:

Harbor Health Plan
PO Box 211262
Eagan, MN 55121
www.harborhealth.com

NOTE: If there is a conflict between this member handbook and the *Evidence of Coverage*, the *Evidence of Coverage* supersedes.

Thank you for considering us for your health care coverage.

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Medically Necessary Covered Health Services and Benefits

The *EOC* contains specific information regarding health care benefits, cost share, limitations and exclusions. You will receive this document after you enroll. To obtain the most from your health care coverage, please take time to review your *EOC* and all attachments carefully and keep them for reference. You are not required to select a Network Primary Care Physician (PCP) in order to receive Benefits under this plan. However, your Primary Care Physician can help you determine the best next step for the symptoms you are currently experiencing or the condition you have been diagnosed with. A PCP may be a family or general practitioner, Advanced Practice Nurse, Physician Assistant, internist, or pediatrician. Female members may also elect to receive care from an Obstetrician/Gynecologist (OB/GYN). Please see the "Receiving Care" section below for more information about PCPs.

Hospitalization

If you need to be hospitalized, your Network PCP, OB/GYN or Specialist can arrange for your care at a local participating hospital. Your Network PCP, OB/GYN, or Specialist will make the necessary arrangements (including Pre-Authorization) and keep you informed. We will review the Pre-Authorization request and issue a determination indicating whether proposed services are approved within the timeframe required by state or federal law. Refer to your *Schedule of Benefits* to determine your cost share for hospitalizations.

When you think you need hospital care in non-emergency situations, first call your PCP. Special rules apply in emergency situations or in cases where you are out of the service area. See the *Emergency Care* section below for more information.

Other Medical Services

In addition to PCPs, specialists, and hospitals, the network includes other health care professionals to meet your needs. If you need diagnostic testing, laboratory services or other health care services, your Network PCP or OB/GYN will coordinate your care or refer you to an appropriate setting. You may have to pay a cost share for some of these services, depending on your plan.

Preventive Care

Preventive care is a key part of your plan, which emphasizes staying healthy by covering:

- Well-child care, including immunizations
- Prenatal and postnatal care
- Hearing loss screenings through 24 months
- Periodic health assessments
- Eye and ear screenings
- Annual well-woman exams, including, but not limited to, a conventional Pap smear
- Annual screening mammograms
- Bone mass measurement for osteoporosis
- Prostate cancer screening
- Colorectal cancer screening
- Any other evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Task Force ("USPSTF") or as required by state law

Mental Health Care and Substance-Related and Addictive Disorders Services

Your mental health and substance-related and addictive disorders disorder benefits include outpatient and inpatient visits for crisis intervention and evaluation. Please refer to your *EOC* for additional information.

Prescription Drugs

To find out which prescription drugs are covered under a plan, you can review the applicable drug list at www.harborhealth.com. You may also request a drug list exception. For information on how to request a drug list exception, please refer to your *EOC*.

REMEMBER:

- Your Network PCP or OB/GYN can help arrange for specialty care or hospitalization.
- Preventive care is an important part of your program to help you stay healthy. These services can be provided or arranged by your PCP.
- You won't have to file claims for services received from Network Providers.

Emergency Care, After-Hours Care and Urgent Care

Medical Emergencies

Emergency care is defined as health care services provided in a Network or out-of-Network hospital emergency facility, freestanding emergency medical care facility, or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily function, cause serious dysfunction of any organ or part of the body, cause serious disfigurement or, in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

In a medical emergency, seek care immediately. Present your Member ID card to the hospital emergency room or comparable facility. You or a family member should call your PCP within 48 hours or as soon as possible after receiving emergency care. This call is important so that your PCP can coordinate or provide any follow-up care required because of a medical emergency.

REMEMBER:

- In an emergency, seek care immediately.
- You or a family member should call your PCP within 48 hours or as soon as possible after receiving emergency care.

If post stabilization inpatient care is required after an emergency care condition has been treated and stabilized, the treating physician or provider will contact us, or our designee, who must approve or deny such treatment within the timeframe appropriate to the circumstances relating to the delivery of the services and the condition of the patient.

After Hours Care

Our Network Providers have systems in place to respond to your needs when their business offices are closed. These systems may include the use of an answering service or a recorded telephone message informing patients how to access further care.

Urgent Care Services

Urgent care services are covered when rendered by a Network urgent care center provider for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health and does not require emergency care services.

Facility Based Physicians

When you receive care at a Network health care facility, other professional services within that facility may be performed by providers who are not in the Harbor Health network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by Harbor Health. If you receive such a bill, please contact us.

Your Financial Responsibilities

Annual Deductible

Your plan may have an Annual Deductible, which is the total amount you pay out-of-pocket for Covered Health Services per year before we start to pay for Benefits. It does not include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the total dollar amount you must pay each Calendar Year before We pay benefits at 100%. The Out-of-Pocket Maximum includes the Annual Deductible and Copayments. It does not include Premiums, non-covered services, and balance billing amounts.

Cost Share Amounts

Covered Health Services under the Plan require payment of a Copayment at the time of service for most services. Your *Schedule of Benefits* outline cost share responsibility based on the type of service you receive. Your Copayment could be per visit, per day, per service, or a mix of these.

Network physicians and providers have agreed to submit claims to us for payment of Covered Health Services. For Covered Health Services provided by a Network provider, except for your cost share obligations, you are not responsible for any difference between eligible expenses and the amount the provider bills.

Premium

You are responsible for payment of the required Premium. The first Premium payment is due on or before your Effective Date. After your first Premium is made, Premium payments are due on or before the 1st of each month based to keep your benefits active, subject to the grace period provisions in your Plan.

Limitations and Exclusions

Your *EOC* contains specific information about limitations and exclusions. The *Written Plan Description* also includes a summary of limitations and exclusions.

Pre-Authorization Requirements, Referral Procedures and Other Review Requirements

If care from another Network Provider is needed, you are not required to obtain a referral from your Primary Care Physician. However, your Primary Care Physician can help you determine the most clinically appropriate next step for the symptoms you are currently experiencing or the condition you have been diagnosed with. Your Primary Care Physician can also help you select a Provider if you need to be treated by a Network Specialist or other Network Provider. Because navigating the health care system can be confusing and complicated, we strongly encourage you to establish a relationship with a Primary Care Physician. Additional information about referrals and cost share responsibility are detailed in your *Schedule of Benefits*.

Pre-Authorization

Harbor Health requires advance approval (Pre-Authorizations) for certain types of Covered Health Services, even if you have a referral from a Network provider. Network providers are responsible for obtaining pre-authorization of Covered Health Services before they provide these services to you unless they qualify for an exemption from pre-authorization requirements as described in TIC §4201.651-§4201.659.

Emergency care services for screening and stabilization do not require Pre-Authorization.

Routine requests for inpatient admissions and certain outpatient services are Pre-Authorized by registered nurses who utilize a system of clinical protocols and criteria to determine the following:

- Medical necessity of the requested care;
- Appropriateness of the location and level of care;
- Appropriateness of the length of stay; and/or
- Assignment of the next anticipated review point.

Concurrent Review

We support the review of requests for continued services including inpatient hospital admissions. Reviews are conducted by registered nurses and include the following:

- Evaluation for appropriateness (medical necessity/level of care/length of stay);
- Evaluation and coordination of discharge planning requirements;
- Identification of potential quality of care issues.

Retrospective Review

We may conduct reviews after services have been provided. Retrospective review includes a medical necessity evaluation of the care/service provided to the member.

Continuity of Care in the Event of Termination of a Network Provider

If you receive notice that your provider is no longer participating with the Harbor Health plan, it is important to understand that there are special circumstances that allow the provider to continue treatment for a limited time. Except for reasons of medical competence or professional behavior, termination does not release the plan from the obligation to reimburse a provider who is treating you if you have a disability, acute condition, life-threatening illness, or a pregnancy which has passed the 13th week.

If your provider reasonably believes that discontinuing the care that he or she is providing may cause you harm, he or she must identify the special circumstances to us and request that you be allowed to continue treatment. Continuity of treatment may last:

1. For up to 12 months in the case of a member who at the time of provider termination has been diagnosed with a terminal illness; or
2. Through delivery of the child and immediate postpartum care within the six-week period after delivery; or
3. For up to 90 days from the provider's termination date.

Complaint Procedure for Members: Appeal of Adverse Determination, Independent Review Organization Process and Non-Retaliation

Claim or Benefit Reconsideration

If a claim or request for benefits is partially or completely denied, you will receive a written explanation of the reason for the denial and be entitled to a full review. If you wish to request a review or have a question regarding the explanation of benefits, call or write Member Service at the telephone number or address on your ID card (also found on page 1 of this Member Handbook). If you are still not satisfied, you may request an appeal of the decision or file a complaint. You may obtain a review of the denial by following the procedures set forth below and more fully in the Complaint and Appeal Procedures in the *EOC*.

Complaints

There may be times when you find that you don't agree with a particular policy or procedure or benefit decision, or you are not satisfied with some aspect of the treatment by a Network Provider. We encourage you to communicate your dissatisfaction promptly and directly to us.

The goal of Member Service is to prevent small problems from becoming large issues. To express a complaint regarding any aspect of the plan, call or write Member Service at the telephone number or address on your ID card (also found on page 1 of this Member Handbook).

If an inquiry is not resolved promptly to your satisfaction, it will be handled according to the complaint procedure described below.

Member Complaint Procedure

A complaint is any dissatisfaction expressed orally or in writing, made by an enrollee or by someone designated to act on behalf of a member, to us regarding any aspect of our operation, such as plan administration, procedures related to review or appeal of an adverse determination, the denial, reduction, or termination of a service for reasons not related to medical necessity, the way a service is provided or disenrollment decisions. A complaint is not a

misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to your satisfaction.

Also, a complaint does not include your oral or written dissatisfaction or disagreement with an adverse determination (a denial of care or service based on a lack of medical necessity or appropriateness of care).

Within five business days of receiving your oral or written complaint, we will send you a letter acknowledging the complaint, together with a description of our complaint process and timeframes. If the complaint is received orally, we will send a complaint form that you must fill out and return for prompt resolution.

After receiving your written complaint or the written complaint form, we will investigate your concerns and send you a letter outlining and explaining the resolution. The letter includes a statement of the specific medical and contractual reasons for the resolution including any benefit exclusion, limitation or medical circumstance, additional information required to adjudicate a claim, if applicable, and the specialization of any provider consulted. The total time for acknowledging, investigating and resolving your written complaint will not exceed thirty calendar days from the date we receive your written complaint or complaint form.

If the complaint is not resolved to your satisfaction, you have the right to dispute the resolution by following the complaint appeals process. A full description of the complaint appeals process will accompany the complaint resolution.

Investigation and resolution of complaints concerning emergencies or denials of the continued hospitalization are concluded in accordance with the medical or dental immediacy of the case, not to exceed one business day from receipt of the complaint.

We are prohibited from retaliating against an individual because the individual has filed a complaint against or appealed a decision of the plan. Also, we are prohibited from retaliating against a physician or provider because the physician or provider has on your behalf reasonably filed a complaint against or appealed a decision of the plan.

Filing Complaints with the Texas Department of Insurance

Any person, including those who have attempted to resolve complaints through the Member complaint process, who is dissatisfied with the resolution, may report their dissatisfaction to: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. TDI's telephone number is 1-800-252-3439.

There are three methods of filing a TDI complaint:

- Via mail
- Via fax
- Via online at www.TDI.texas.gov

The Texas Department of Insurance will investigate complaints against us within sixty (60) days of receiving the complaint. The time necessary to complete an investigation may be extended if:

- Additional information is needed;
- An on-site review is necessary;
- Complainant, HMO, or the physician or provider does not provide all documentation necessary to complete the investigation; or

- Other circumstances beyond the control of the Texas Department of Insurance occur.

Appeal of Adverse Determinations

An adverse determination is a determination made by us or a utilization review agent physician that health care services provided or proposed to be provided are experimental, investigational or not medically necessary. An adverse determination is not a denial of health care services due to the failure to request prospective or concurrent utilization review. In life-threatening or urgent care circumstances, if we discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the *Evidence of Coverage*, or if you do not receive a timely decision, you are entitled to an immediate appeal to an Independent Review Organization ("IRO") and are not required to comply with the appeal of an adverse determination process. An IRO is an organization independent of us which may perform a final review of an adverse determination.

We maintain an internal appeal system that provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination. The appeal of an adverse determination process is not part of the complaint process. You, your designated representative or your physician or provider, may initiate an appeal of an adverse determination.

When services provided or proposed to be provided are deemed experimental, investigational or not medically necessary, we or a utilization review agent will regard the expression of dissatisfaction or disagreement as an appeal of an adverse determination.

Within five business days of your appeal request, we will send you a letter acknowledging the date of receipt of the appeal and a list of documents you must submit. For oral appeals, we will also send you a one-page appeal form for completion that must be returned to us. We will provide a review by a board-certified physician or provider who has not already reviewed your case and who is of the same or similar specialty as typically manages the medical condition, procedure or treatment under review. We have thirty days from your appeal request to provide you written notice of the appeal determination.

You will receive a written decision of the appeal that will include medical and contractual reasons for the decision, clinical basis for the decision, specialization of provider consulted, notice of your right to have an independent review organization review the denial and TDI's toll free telephone number and address.

Expedited Appeal or Adverse Determination Procedures

Investigation and resolution of appeals relating to ongoing emergencies, denials of continued hospital stays, or the discontinuance of prescription drugs or intravenous infusions for which you were receiving health benefits under the *Evidence of Coverage*, are eligible for an expedited appeal process and will be concluded in accordance with the medical immediacy of the case. In no event will the request for an expedited appeal exceed one working day from the date all information necessary to complete the appeal request is received. We will provide a review by a board certified physician or provider who has not already reviewed your case and who is of the same or similar specialty as typically manages the medical condition, procedure or treatment under review. That physician or provider may interview you and will render a decision on the appeal. The initial notice of the decision may be made orally. Written notice of the determination will follow within three days.

Independent Review Organization

An independent review organization is an organization we have contracted with, and that is independent of us, to perform a final administrative review of an adverse determination.

In a circumstance involving a life-threatening or urgent care circumstances, if we have discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the *Evidence of Coverage*, or if you do not receive a timely decision, you are entitled to an immediate appeal to an independent review organization rather than going through the internal appeal process first.

The independent review organization process is not part of the complaint process but is available only for appeals of adverse determination. You may request a review of an appeal of an adverse determination by the independent review organization. We will adhere to the following guidelines/criteria:

- Provide you, your designated representative, or your provider of record, information on how to appeal the denial of an adverse determination to an independent review organization;
- Provide this information at the initial adverse determination and the denial of the appeal;
- Provide the appropriate form to complete;
- You, a designated representative, or your provider of record must complete the form and return it to us to begin the independent review process;
- In life-threatening or urgent care situations, or if we have discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the *Evidence of Coverage*, you, your designated representative, or provider of record, may contact us by telephone to request the review;
- Submit medical records, names of providers and any documentation pertinent to the adverse determination to the independent review organization;
- Comply with the determination by the independent review organization; and
- Pay for the independent review.

Upon request and free of charge, you are provided reasonable access to, and copies of all documents, records and other information relevant to the claim or appeal, including:

- Information relied upon in making the benefit determination;
- Information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- Descriptions of the administrative process and safeguards used in making the benefit determination;
- Records of any independent reviews conducted by us;
- Medical judgments, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate; and
- Expert advice and consultation obtained by us in connection with the denied claim, whether or not the advice was relied upon in making the benefit determination.

The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if exhausting the process for appeal and review places your health in serious jeopardy.

Network Providers

To find out more about our Network Providers, refer to the website at www.harborhealth.com to search our provider directory. It has important information about the locations and availability of providers, restrictions on accessibility and referrals to specialists. You may also request a hard copy or electronic copy of the provider directory, which is updated quarterly, by calling or writing to Member Service. Upon admission to an inpatient facility (e.g., hospital or skilled nursing facility), a Network physician other than your PCP may direct and oversee your care.

Your PCP will be the one you call when you need medical advice, when you are sick and when you need preventive care such as immunizations.

DIRECT ACCESS FOR OBSTETRICIAN/GYNECOLOGIST (OB/GYN) CARE

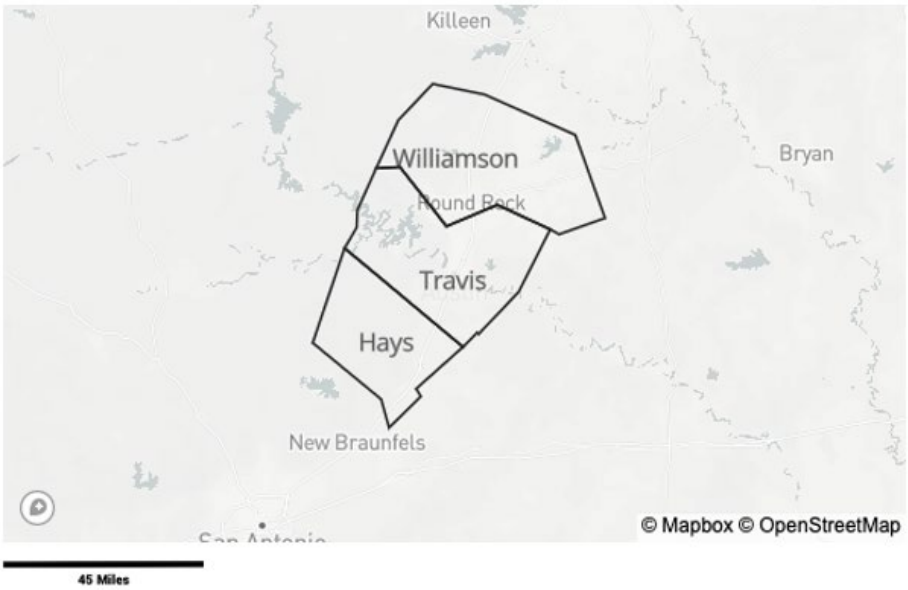
ATTENTION FEMALE MEMBERS: Your HMO plan provides direct access to participating OB/GYNs for gynecologic and obstetric conditions, including annual well-woman exams and maternity care, without first obtaining a referral from your PCP or calling us. Your PCP or Network OB/GYN will establish a referral for you for any required obstetric/gynecologic specialty care. It is not required that you select an OB/GYN; you may choose to receive your OB/GYN services from your PCP.

If you need help locating a participating OB/GYN in your area, refer to the online provider directory or call Member Service at the telephone number on the back of your ID card for assistance.

Geographic Service Area

The Geographic Service Area is the geographic area in which Harbor Health is licensed to arrange for medical and hospital services in the state. The Harbor Health Geographic Service area is comprised of the following counties:

- Hays
- Travis
- Williamson



General Information

Identification (ID) Card

Once enrolled, you and each of your covered dependents will receive an ID card. Please take a moment to check the following information on the card for accuracy, and call Member Service if changes are needed.

- Identification number
- Coverage effective date
- You and/or your covered dependents' names

Your ID card also shows certain cost share information that are part of the plan you selected. The ID card also includes the toll-free Member Service telephone number.

Be sure to take your ID card with you when you seek health care. It has important information on it that network providers will need to know. Always present your ID card to the medical office staff so they can verify eligibility and collect the appropriate cost share amounts due.

If your ID card is lost or stolen, call Member Service immediately and a new ID card will be sent to you.

REMEMBER:

- Your *EOC* contains important details about your health care benefits. Please review this document carefully. Contact Member Service if you have questions about your plan.
- The online provider directory at www.harborhealth.com gives you a complete listing of Network providers in your area. Contact Member Service if you need assistance in locating a PCP or other network providers in your area.
- Take your ID card with you when you seek care. It has important information your provider needs to know.

Receiving Care

Your Primary Care Physician/Practitioner (PCP)

While the Harbor Health plan does not require you select and use a PCP in order to receive Benefits, we encourage you to make an appointment with a PCP before you need health care so that you can establish yourself as a patient. One of the advantages of establishing a physician/patient relationship with a PCP is that your PCP becomes familiar with you and your medical history, which helps make sure you receive the care that is right for you.

It is very important to visit or contact your PCP first when seeking medical care. Your PCP will either treat you or refer you for specialty care. Your PCP will also coordinate any required hospital admissions.

Making Appointments

You may make appointments for periodic health assessments at a time convenient for you.

If the nature of an illness warrants an urgent appointment, your PCP can generally fit you into his or her schedule within a reasonable period of time. If your PCP cannot fit you in, he or she may direct you to a designated back-up physician. If you need assistance, you may call Member Service at the telephone number on the back of your ID card.

If you need to change or cancel an appointment, be sure to call your PCP as soon as you can. When you visit your PCP's office for Covered Health Services, you will pay only the cost share reflected in your *Schedule of Benefits* for the office visit. There are no claims to file. If you need the care of a specialist, your PCP will refer you.

REMEMBER:

- We recommend that you have your health care provided or arranged by your PCP.
- For obstetric or gynecologic conditions, you may directly access a Network OB/GYN.
- It is important to schedule an appointment with your PCP as soon as you can. Contact Member Service if your PCP cannot fit you in.

Telehealth and Telemedicine Medical Services

Telehealth and Telemedicine Medical Services are covered as defined below.

Teledentistry Dental Service - a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth Service - a health care service, other than a Telemedicine Medical Service or a Teledentistry Dental Service, delivered by a health care professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health care professional's license, certification, or entitlement to a patient at a different physical location than the health care professional using telecommunications or information technology.

Telemedicine Medical Service - a health care service delivered by a Physician licensed in this state, or a health care professional acting under the delegation and supervision of a Physician licensed in this state and acting within the scope of the Physician's or health care professional's license to a patient at a different physical location than the Physician or health care professional using telecommunications or information technology.

Additional Information

Status Changes

Your records are very important to us. Incorrect records can delay membership verification or medical care, create problems in continuing coverage for a dependent, and possibly cost you money. To keep your coverage up to date, notify us within the timeframes outlined in your *EOC* of any change listed below:

- Birth of a child;
- Adoption or becoming a party in a suit for adoption or legal guardianship;
- Change of dependency status of a child;
- Court-ordered dependents;
- Loss of other health coverage;
- Marriage;
- Divorce;
- Death;
- Change of address; and
- Change of telephone number.

Coverage will be automatic for the subscriber or subscriber's spouse's newborn child for the first thirty-one (31) days following the date of birth. Coverage will continue beyond the thirty-one (31) days only if the child is an eligible dependent and you have submitted an enrollment application/change form to us and make or agree to make any additional premium payments.

Duplication of Coverage and Coordination of Benefits

Injuries and sometimes illnesses may be covered by other types of insurance such as auto, homeowners or workers' compensation. Please call Member Service in cases such as these for information on what steps to take.

REMEMBER:

- Notify us of changes within the timeframes outlined in your EOC of a change to your coverage.
- Be sure to indicate any other health coverage you have or contact Member Service with this information.

It is important that you provide this information to us to allow coordination of payment of your claims to ensure that claims are not paid twice. This helps keep your health care costs down.

New Medical Technology

We keep abreast of medical breakthroughs, experimental treatments and newly approved medication. Harbor Health evaluates new technologies, medical procedures, drugs and devices

for potential inclusion in the benefit packages we offer. Clinical literature and accepted medical practice standards are assessed thoroughly with ongoing reviews and determinations made by our medical policy group.

Your Rights and Responsibilities

You have certain rights and responsibilities when receiving health care services and should expect the best possible care available. We have provided the following information, so you can be an informed customer and active participant in your plan.

You have the right to:

- Know the qualifications, titles and responsibilities of the professionals responsible for your health care;
- Receive prompt and appropriate treatment for physical or emotional disorders and participate with your providers in decisions regarding your care;
- Be treated with dignity, compassion and respect for your privacy;
- Have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
- Have all medical and other information held confidential unless disclosure is required by law or authorized in writing by you;
- Be provided with information about:
    - Covered health care benefits
    - Cost share and limitations
    - Service access
    - Changes and/or termination in benefits and Network providers
    - Exclusions and limitations
- Express opinions, concerns, and complaints in a constructive manner or appeal regarding any aspect of the plan;
- Receive timely resolution of complaints or appeals;
- Have access to review by an Independent Review Organization;
- Refuse treatment and be informed of the medical consequences that may be a result of your decision; and
- Make recommendations regarding your rights and responsibilities policies.

You have the responsibility to:

- Meet all eligibility requirements;
- Identify yourself by presenting your ID card and pay the cost share and any other applicable amount due at the time of service for network benefits;
- If you choose to select a PCP, establish a physician/patient relationship with your PCP and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your Network OB/GYN;
- Understand the medications you are taking and receive proper instructions on how to take them;
- Communicate complete and accurate medical information to health care providers;
- Call in advance to schedule appointments with Network providers and notify them prior to canceling or rescheduling appointments;

- Ask questions and follow instructions and guidelines given by providers to achieve and maintain good health;
- Discuss disagreements and/or misunderstandings regarding treatment from providers;
- If you have a relationship with a PCP, notify your PCP within 48 hours or as soon as reasonably possible after receiving emergency care services;
- Provide, to the extent possible, information that we need in order to administer your benefit plan, including changes in your family status, address and phone numbers within the timeframes outlined in your *EOC* of the change;
- Read your *EOC* for information about the plan benefits, limitations, and exclusions; and
- Understand your health conditions and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

Confidentiality and Access to Records

We are required by federal and state law to maintain the privacy of your protected health information. “Protected health information” (PHI) is information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. With limited exceptions, your medical records may not be disclosed to others, including your employer, without your written consent. You, or an individual acting on your behalf, may request medical records for the purpose of providing care or resolving disputes related to coverage, reimbursement, or complaints.

Routine consent signed at the time of enrollment permits us to release information for purposes of quality assessment and measurement, treatment, coordination of care, accreditation, billing and other uses. Identifiable information is minimized and protected from inappropriate disclosure.

You have a right to specifically approve the release of information beyond the uses identified in the routine consent that you sign upon enrollment and, at other times, as needed for workers’ compensation claims, auto insurance claims, marketing or data used for research studies.

You may give us written authorization to use your PHI or to disclose it to another person only for the purpose you designate. PHI may not be disclosed to your spouse or family without written authorization from you or an authorized representative. Information regarding children under 18 years of age may be released to a parent or legal guardian. If an adult is incapacitated, a legally appointed guardian may act on their behalf. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in the HIPAA Notice.

Participating providers must comply with applicable HIPAA laws, professional standards and policies regarding the confidential treatment of medical information, including security measures to control access to confidential information maintained in computer systems. Access to electronic files containing information is to be protected and restricted to employees who have a business-related need to know. Oral, written and electronic personal health information across the organization will be kept confidential in accordance with applicable law.

Harbor Health understands the importance of confidentiality and respects your right to privacy. A summary of our privacy practices is available on the Harbor Health website at www.harborhealth.com or you may call Member Service at the telephone number on your ID card to obtain a paper copy.

Member Service

If you have questions about your benefits, Member Service representatives are available to help you at the telephone number on your ID card.

Member Service can assist you with finding a PCP or other network provider. They can also assist with special communications needs. If your first language is not English, you can ask to speak to a bilingual staff member. This Member Handbook is available in Spanish. Members may also ask for access to a telephone-based translation service to assist with other languages.

If you are not satisfied with the service you have received, we have a formal complaint process you can follow to advise us of issues related to quality of care or service. We monitor the care you receive and follow through on all complaints and inquiries, because your satisfaction is important to us.

NOTICE OUT-OF-NETWORK PHYSICIANS AND PROVIDERS

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan
Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called “contracted providers” (also known as “in-network” providers”). Contracted providers make up a plan’s network. Your plan will only pay for health care you get from doctors and facilities in its network.

However, there are some exceptions, including for emergencies, when you didn’t pick the doctor, and for ambulance services.

Your plan’s network
Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn’t have to travel too far or wait too long to get care. This is called “network adequacy.” If you can’t find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don’t think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of doctors
You can get a directory of health care providers that are in your plan’s network.

You can get the directory online at www.harborhealth.com or by calling 855-481-0225.

If you used your health plan’s directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care
If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn’t pick the doctor, you won’t have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care. However, protections do not apply for ground ambulance services.

If you get a bill for more than you’re expecting, contact your health plan. Learn more about how you’re protected from surprise medical bills at tdi.texas.gov.