THIS DOCUMENT REPRESENTS A SAMPLE PLAN DESIGN ONLY.
HARBOR PRODUCTS ARE PENDING REDULATORY APPROVAL. THE FINAL VERSION DEPENDS ON THE PLAN PURCHASED BY THE EMPLOYER

Evidence of Coverage
Harbor Health Plan

P.O. Box 211262
Eagan, MN 55121
1-855-481-0225
www.harborhealth.com

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Harbor Health
To get information or file a complaint with your insurance company or HMO:

Call: Member Services at 1-855-481-0225
Toll-free: 1-855-481-0225
Online: www.harborhealth.com

Mail: P.O. Box 211262, Eagan, MN 55121

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Harbor Health
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Member Services al: 1-855-481-0225
Teléfono gratuito: 1-855-481-0225
En línea: www.harborhealth.com
Dirección postal: P.O. Box 211262, Eagan, MN 55121

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar

una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Table of Contents

Section 1: Welcome

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits

normally required in Evidence of Coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated benefits are excluded in this Evidence of Coverage.

Evidence of Coverage

This *Evidence of Coverage (EOC)* is part of the Contract that is a legal document between Harbor Health Insurance Company and the Employer. The *EOC* is a guide to your health plan benefits provided by Harbor Health. You are responsible for carefully reading this *EOC* so you will be aware of all the benefits and requirements in the Harbor Health plan.

This plan is a Health Maintenance Organization health care plan and 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.

In addition to this *EOC*, the Contract also includes:

- The Group Contract;
- The Schedule of Benefits;
- The Group's Application for Coverage;
- Riders; and
- Amendments

Certain capitalized words have special meanings. We have defined these words in *Section 8: Glossary of Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to Harbor Health Plan. When we use the words "you" and "your," we are referring to people who are Members, as defined in *Section 8: Glossary of Terms*.

We may, from time to time, change this *EOC* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *EOC*. When this happens, we will send you a new *EOC*, Rider, or Amendment.

We have the right to change, interpret, withdraw or add Covered Health Services, or to end the Contract, as permitted by law, without your approval.

If there is a conflict between this *EOC* and any summaries provided to you by the Employer, this *EOC* will govern. The EOC is part of the Group Contract as if fully incorporated, and any direct conflict between the group agreement and the *EOC* will be resolved according to the terms most favorable to the Subscriber. On its effective date, this *EOC* replaces and overrules any *EOC*

that we may have previously issued to you. This *EOC* will in turn be overruled by any *EOC* we issue to you in the future.

We are delivering the Contract in Texas. The Contract is subject to the laws of the state of Texas and ERISA, unless the Group is not a plan sponsor subject to ERISA. To the extent that state law applies, Texas law governs the Contract.

THE CONTRACT UNDER WHICH THIS EVIDENCE OF COVERAGE IS ISSUED IS NOT A CONTRACT OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

If you have questions about how your plan works, you can find information on our website at www.harborhealth.com or by calling Harbor Health Member Service at the telephone number on the back of your ID Card.

ID Cards

The ID Card issued to you by us identifies you as a Member in the Harbor Health Plan offered by your Employer. This ID Card contains essential information about you, your Employer, and the benefits to which you are entitled. Always remember to carry your ID Card with you, present it when receiving Covered Health Services, and make sure your Provider always has an updated copy.

You can also request another ID Card at any time by contacting Harbor Health Member Services at the telephone number on your ID Card or by calling toll-free 1-855-481-0225.

Network Providers

You can select a Network Primary Care Physician, or PCP, but it is not required to obtain Benefits. You may designate a Network Physician who specializes in pediatrics as the Network Primary Care Physician for an enrolled Dependent child. For obstetrical or gynecological care, you may seek care directly from any Network Physician who specializes in obstetrics or gynecology.

If you have a chronic, disabling, or life-threatening illness, you may apply to our medical director to use a non-Primary Care Physician Specialist as a Primary Care Physician.

Continuity of Care

If you are undergoing a course of treatment from a Network Physician, Provider or facility at the time that Network Physician's, Provider's or facility's contract terminates with us for any reason, except for medical competence or professional behavior, you may be entitled to continue that care at the Network Benefit level. Continuity of care is available in special circumstances in which the treating Physician or health care Provider reasonably believes discontinuing care by the treating Provider could cause harm to the Member. Special circumstances include Members with a disability, acute condition, life-threatening illness, pregnant and undergoing a course of treatment for the pregnancy, undergoing inpatient care, or scheduled to undergo nonelective surgery, including receipt of postoperative care.

The treating Provider must submit the continuity of care request. If continuity of care is approved, it may not be continued beyond 90 days after the Physician's, Provider's or facility's contract is terminated, or nine months after the Physician's, Provider's or facility's contract is terminated, if the Member has been diagnosed as having a terminal illness at the time of termination. If the Member is pregnant and the time of termination, coverage at the Network level will continue through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after delivery.

If you have questions regarding this continuity of care policy or would like help determining whether you are eligible for continuity of care Benefits, please contact us at the telephone number on your ID Card.

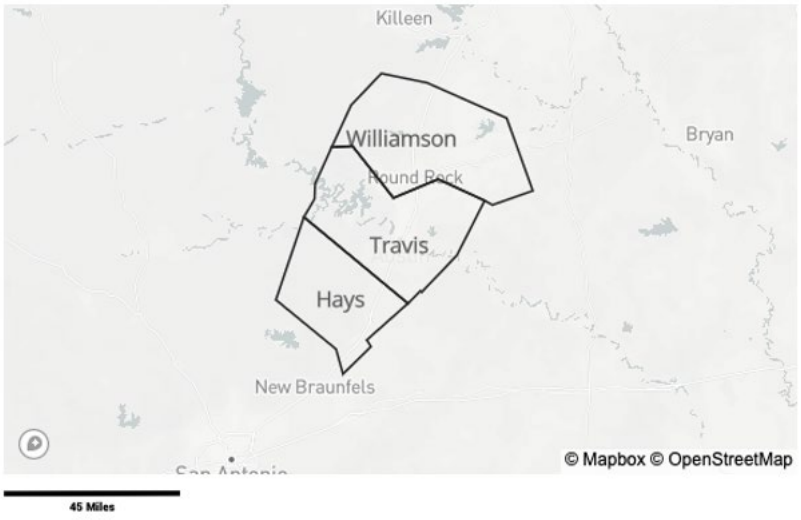
Geographic Service Area

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

- Hays
- Travis
- Williamson

For a list of up-to-date Harbor Health Plan Physicians and health care Providers, you can access information by visiting our online Provider Directory at www.harborhealth.com. If you would like additional information pertaining to our contracted Providers, you can call us at the telephone number on your ID Card.

Geographic Overview



Section 2: What Your Plan Covers

Covered Health Services

The following Covered Health Services are covered by the Harbor Health Plan only when all of the following are true:

- You receive the Covered Health Service while the Contract is in effect.
- You receive the Covered Health Service prior to the date that any of the individual termination conditions occur. Refer to *Section 7: Plan Provisions*.
- The person who receives the Covered Health Service is a Member and meets all eligibility requirements specified in the Contract.

Please refer to the attached Schedule of Benefits for information on:

- How much you are required to pay for Covered Health Services; and
- Visit, day or dollar limitations for Covered Health Services.

Acquired Brain Injury

Benefits are provided for Covered Health Services that are determined by the Member's treating physician, in consultation with the treatment or care provider, the Member, and, if appropriate, the Member's family, to be Medically Necessary as a result of and related to an Acquired Brain Injury. Covered Health Services will be covered on the same basis as treatment for any other medical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post-acute transition services and community integration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

To ensure that appropriate post-acute care treatment is provided, we include coverage for reasonable expenses related to periodic reevaluation of the Member's care who:

- Has incurred an acquired brain injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or prevention of, or slowing of, further deterioration.

Note: Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury. Treatment for an Acquired Brain Injury may be provided at a

hospital, an acute or post-acute rehabilitation hospital, an Assisted Living Facility or any other facility at which appropriate services or therapies may be provided.

Acupuncture

Acupuncture services are covered when provided in an office setting for the following conditions:

- Pain therapy
- Nausea that is related to surgery, pregnancy or chemotherapy

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

You are not required to use a Network Provider to receive acupuncture services. You can see any Acupuncturist in the Geographic Service Area and submit a claim for reimbursement if the Acupuncturist will not submit a claim on your behalf. Refer to *Section 6: Claims* for instructions on filing a claim. Refer to your *Schedule of Benefits* for cost share information.

Ambulance Services

Ambulance Services (either ground, Air Ambulance or water vehicle) are covered when Medically Necessary as noted below:

- The Member's condition must be such that ambulance services are the only form of transportation that would be medically acceptable; or
- The Member is transported to the nearest site when another facility is required for the appropriate treatment of the injury or illness or in the case or organ transplant, to the approved transplant facility.

Air Ambulance Services are Medically Necessary as noted below:

- The time needed to transport the Member when land ambulance poses a threat to the Member's survival;
- The point of pick-up is inaccessible by land vehicle; or
- Great distances, limited time frames, or other obstacles are involved in getting the Member to the nearest Hospital with appropriate facilities for treatment (i.e., transport of a critically ill person to an approved transplant facility with a waiting organ).

The following services are not Medically Necessary, as they do not require ambulance transportation:

- Ambulance Services when the Member has been legally pronounced dead prior to the ambulance being summoned.
- Services provided by an ambulance crew who do not transport a Member but only render aid.

Non-emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Service can be delivered.

Cellular and Gene Therapy

Benefits will be provided for Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Organ and Tissue Transplants.

Clinical Trials

Benefits will be provided for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV Clinical Trial if the Clinical Trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition. The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (IRBs) before you are enrolled in the trial. We may, at any time, request documentation about the trial.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial. Benefits are available only when the Member is clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the following:
    - The clinically appropriate monitoring of the effects of the service or item, or

  - The prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for Members with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services that clearly do not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any Member taking part in the trial.
- Any item or service that is not a Covered Health Service, regardless of whether the item or service is required in connection with the participation in a clinical trial.
- Any item or service that is specifically excluded from coverage under this Contract.

Diabetic Management Services

Benefits associated with the treatment of diabetes for Members diagnosed with Type I or Type II diabetes, whether insulin dependent or not, elevated blood glucose levels induced by pregnancy, or another medical condition associated with elevated blood glucose levels. Emergency refills of diabetes equipment or diabetes supplies, dispensed to the Member in accordance with the applicable state law, will be covered in the same manner as for a non-emergency refill of diabetes equipment or diabetes supplies. Covered Health Services will be consistent with standards for coverage adopted by the Commissioner of Insurance pursuant to applicable state law and include:

Diabetic Equipment:

- Blood glucose monitors (including non-invasive glucose monitors and monitors for the blind);
- Insulin pumps and necessary accessories (infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies); and
- Podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

Note: If an *Outpatient Prescription Drug Rider* is included under the Contract, Benefits for

diabetes supplies will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this Benefit category.

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care
Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits are also available for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regimen and periodic continuing education training as warranted by the development of new techniques and treatment of diabetes.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diagnostic Services

Advanced Imaging
Advanced imaging services are covered when Medically Necessary including, but not limited to, MRIs, MRAs, nuclear medicine, PET Scans, CT Scans, and major diagnostic services received on an outpatient basis at a Hospital, Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Computed tomography (CT) scan measuring coronary artery calcification.
- Diagnostic Imaging in relation to breast imaging. Coverage for Diagnostic Imaging will be no less favorable than coverage for screening mammograms.

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares apply when services are provided in a Physician's office.

Lab, X-ray and All Other Diagnostic Services
Lab, X-ray and diagnostic services are covered for sickness and injury-related diagnostic purposes received on an outpatient basis at a Hospital, Alternate Facility or in a Physician's office such as:

- Diagnostic lab testing.
- Radiology/X-ray.
- Genetic testing.
- Allergy testing.
- Mammography, including diagnostic imaging. Coverage for diagnostic imaging will be no less favorable than coverage for screening mammograms.
- Annual breast cancer screenings by all forms of Low-dose Mammography in females 35 years of age and older for the presence of occult breast cancer, including 3-D imaging. We will also provide mammogram coverage for diagnostic imaging that is:
    - no less favorable than the coverage for a screening mammogram;

  - designed to evaluate an abnormality detected by a patient and an individual with dense breast tissue; and
  - not limited to females age 35 years or older.
- Noninvasive screening tests for atherosclerosis and abnormal artery structure such as ultrasonography measuring carotid intima-media thickening and plaque.
- Prostate-specific antigen test for the detection of prostate cancer.
- A newborn screening test kit in the amount provided by the Health and Safety Code under §33.019. Benefits will be provided for administration of the screening test kit under the corresponding Benefit category in this *EOC*.
- Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the test is supported by medical and scientific evidence. Coverage is provided in a manner that limits disruption in care, including the number of biopsies and biospecimen samples.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Mammography screenings that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force are described under Preventive Care Services.

Lab, X-ray and diagnostic services for preventive care are described under Preventive Care.

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares apply when services are provided in a Physician's office.

Durable Medical Equipment (DME) and Supplies

Durable medical equipment and supplies are covered when Medically Necessary. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs, as determined by your treating Provider. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Continuous Positive Airway Pressure (CPAP) machine.

- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described above under Diabetic Management Services.
- External cochlear devices and systems, including external speech processor and controller with necessary components replacement every three years. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *EOC*. Benefits for cochlear implants are limited to one in each ear with internal replacement as medically or audiologically necessary.

Benefits include lymphedema stockings for the arm as required by the Women's Health and Cancer Rights Act of 1998.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 3: Limitations and Exclusions*.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implicated into the body are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Service category in this *EOC*.

Emergency Care

Medical emergencies are services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility, independent freestanding emergency department, or comparable emergency facility.

You may receive Emergency Health Care Services from a Network or out-of-Network facility or Provider. We will reimburse services by an out-of-Network Provider as described in the Schedule of Benefits for the following Emergency Health Care Services until the Member can reasonably be expected to transfer to a Network Physician or Provider.

- A medical screening exam or other evaluation required by state or federal law to be provided in the emergency facility or a Hospital that is necessary to determine whether a medical Emergency condition exists.
- Necessary Emergency Health Care Services, including the treatment and stabilization of an Emergency medical condition.
- Services originating in a Hospital Emergency facility or independent freestanding emergency department following treatment and stabilization of an Emergency medical condition.
- Supplies related to the Emergency Health Care Services.

You will only be responsible for the cost share amount reflected in the Schedule of Benefits.

For post-stabilization care as requested by a treating Physician or Provider, we will approve or deny coverage within the time appropriate to the circumstances relating to the delivery of the services and your condition, but not to exceed one hour from the time of the request.

Enteral Nutrition

Enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, are covered for certain conditions which require specialized nutrients or formulas. Benefits will be provided to the same extent that coverage is provided for drugs that are available only on the orders of a Physician. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) or a heritable disease, including maple syrup urine disease.
- Severe food allergies
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract, which includes the absorptive surface, functional length and motility of the gastrointestinal tract.
- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
- Severe food protein-induced enterocolitis syndrome.
- Eosinophilic disorders, as evidenced by the results of a biopsy.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietician.

For the purpose of this Benefit, “enteral formulas” include:

- Amino acid-based elemental formulas
- Extensively hydrolyzed protein formulas
- Modified nutrient content formulas

For the purpose of this Benefit, “severe food allergies” mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to

cancer. Services include the following procedures when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provide as described under your *Outpatient Prescription Drug Rider* or under *Pharmaceutical Products – Outpatient* in this section.

Benefits are not available for elective fertility preservation.
Benefits are not available for embryo transfer.
Benefits are not available for long-term storage costs (greater than one year).

Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed plan of treatment to help a person with a disabling condition to learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Chiropractic Services.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.

- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite Care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow us to prove that medical treatment is needed.

When the treating Provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as part of habilitative services, are described under the Durable Medical Equipment and Prosthetic Devices sections.

Harbor Health will provide habilitative services that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the Interagency Council on Early Childhood Intervention. Covered Health Services include:

- Occupational therapy evaluations and services.
- Physical therapy evaluations and services.
- Speech therapy evaluations and services.
- Dietary or nutritional evaluations.

Hearing Aids

Hearing aids are covered when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear.

These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider. Benefits are provided for the hearing aid, associated fitting charges, testing, dispensing services and the provision of ear molds as necessary to maintain optimal fit of the hearing aid.

Benefits for habilitation and rehabilitation services as necessary for educational gain related to hearing aids and cochlear implants are a Covered Health Service for which Benefits are available under Habilitative Services and Rehabilitative Services.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *EOC*.

Home Health Care

We cover Medically Necessary services and supplies provided in the Member's home during a visit from a home health agency as part of a Physician's written home health care plan. Coverage includes:

- Coordinated Home Care provided by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Provided when Skilled Care is required;
- Physical, occupational, speech and respiratory therapy services provided by licensed therapists;
- Supplies and equipment routinely provided by the home health agency; and
- If care is taught to a caretaker, this service will not be covered after training has been provided.

Home health care benefits are not provided for food or home-delivered meals, social casework or homemaker services, transportation, or services provided primarily for custodial care.

Rehabilitation services provided in your home by a Home Health Agency are provided as described under this section. Rehabilitation services provided in your home other than by a Home Health Agency are provided as described under Rehabilitation Services - Outpatient Therapy and Chiropractic.

Hospice Care

We cover Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill to Members confined at home or in a hospice facility.

The following services are covered for hospice care in the home:

- Part-time or intermittent nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Part-time or intermittent home health aide services for patient care;
- Durable Medical Equipment (DME) and supplies;
- Physical, respiratory, and speech therapy by licensed therapists; and
- Counseling services routinely provided by the hospice agency, including bereavement counseling.

The following services are covered in a Hospice facility:

- All usual nursing care by a Registered Nurse (RN), Advanced Practice Nurse (APN) or Licensed Vocational Nurse (LVN);
- Room and board and all routine services, supplies and equipment provided by the hospice facility;
- Physical, speech and respiratory therapy services by licensed therapists; and
- Counseling services routinely provided by the hospice facility, including bereavement counseling.

Hospital Admissions

Harbor Health covers services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a semi-private room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Inpatient care for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer. The Member and the treating Physician may determine that a shorter period of inpatient care is appropriate.
- General nursing care.
- Private duty nursing when Medically Necessary.
- Use of operating room and related facilities.
- Use of intensive care unit and services.
- X-ray services.
- Laboratory and other diagnostic tests.
- Drugs, medications, biologicals, anesthesia, and oxygen services.
- Radiation therapy.
- Inhalation therapy.
- Whole blood including cost of blood, blood plasma, and blood plasma expanders that are not replaced by or for the Member.

- Administration of whole blood and blood plasma.
- Short term rehabilitation services in the acute Hospital setting.

Upon admission to a Network Hospital for an Inpatient Stay, a Physician other than your Primary Care Physician may direct and oversee your care.

Infertility Diagnostic Services

Testing for the diagnosis of infertility is covered.

Maternity Care

We cover maternity related expenses for Members. Maternity care includes diagnosis of pregnancy, pre- and post-natal care, delivery and any related Complications of Pregnancy.

Harbor Health covers inpatient care for the mother and newborn child in a healthcare facility for a minimum of:

- 48 hours for the mother and newborn child following an uncomplicated vaginal delivery.
- 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery.
- 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

Concurrent reviews will be required for prolonged stays exceeding the standard coverage period.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If the discharge occurs earlier or if the delivery does not occur in a hospital or other facility, Benefits are included for post-delivery care when provided by a Physician, a registered nurse or other appropriately licensed provider, either in the mother's home or at another location determined to be appropriate.

Post-delivery care includes services provided in accordance with accepted maternal and neonatal physical assessment, parent education, breast or bottle feeding, educational/training and performance of necessary and appropriate clinical tests.

We will cover administration of newborn screening tests required by Section 33.011, Texas Health and Safety Code, including for the cost of a newborn screening test kit in the amount provided by the Department of State Health Services on the date the test was administered.

We will only allow services provided by a midwife if affiliated with a contracted Network OB/GYN provider.

Mental Health Care and Substance Use Disorder Services

Mental Health Care and Substance Use Disorder Services include those received on an inpatient or outpatient basis in a Hospital, and Alternative Facility or in a Provider's office. All

services must be provided by or under the direction of a behavioral health Provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits and services under this section are provided under the same terms and conditions without quantitative or non-quantitative treatment limitations that are more restrictive as are applicable to medical and surgical treatment.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Programs.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a semi-private room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures.
- Medication management.
- Individual, family and group therapy.
- Crisis intervention.
- Substance Use Disorder Medication Management.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)*).

  This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder including the screening of a child for Autism Spectrum Disorder, speech therapy, occupational therapy, physical therapy, and medications or nutritional supplements is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Care Service in this *EOC*.

  Benefits are provided for generally recognized services, including evaluation and assessment services, applied behavior analysis, and behavior training and management, when prescribed by the enrolled Dependent child's Primary Care Physician in the treatment plan recommended by that Physician. The individual providing generally recognized services must be a health care practitioner who is licensed, certified, or registered by an appropriate agency of the State of Texas; whose professional credentials are recognized and accepted by an appropriate agency of the United States; who is certified as a provider under the TRICARE military health system; or other qualified provider acting under the supervision of a health care practitioner listed above.

- Mental Health Care Services for the following psychiatric illnesses (defined as Serious

Mental Illness in *Section 8: Glossary of Terms*):

- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Depression in childhood and adolescence.
- Major depressive disorders (single episode or recurrent).
- Obsessive-compulsive disorders.
- Paranoid and other psychotic disorders.
- Schizo-affective disorders (bipolar or depressive).
- Schizophrenia.

Benefits are provided for alternative Mental Health Care Services for treatment of a Serious Mental Illness in a Residential Treatment Center for Children and Adolescents or from a Crisis Stabilization Unit, as required by State of Texas insurance law.

- Chemical Dependency services including detoxification from abusive chemicals or substances, limited to physical detoxification when necessary to protect your physical health and well-being. Detoxification is the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

Obesity Surgery

Surgical treatment of morbid obesity is covered when Medically Necessary.

Covered medical expenses for bariatric surgery include charges made by a hospital or a Physician for the surgical treatment of morbid obesity of a Member.

All underlying medical conditions that will likely impact or complicate the Member's surgical and postoperative course must be adequately controlled before surgery.

Covered procedures include:

- Open or laparoscopic Roux-en-Y gastric bypass;
- Laparoscopic sleeve gastrectomy; or
- Open or laparoscopic biliopancreatic diversion with or without duodenal switch.

Coverage is limited to one procedure per lifetime under this plan regardless of when or where the surgery was performed.

Oral Surgery

Coverage of Medically Necessary oral surgical is limited to:

- Services provided to a newborn for treatment or correction of a congenital defect;
- Correction of damage caused solely by external violent accidental injury to healthy, un-restored natural teeth and supporting tissues, if the accident occurs while the Member is covered by the Harbor Health Plan. Initial visit must occur within 72 hours of the accident and treatment must be completed within 24 months; or
- Orthognathic surgery for Members when Medically Necessary.

What oral surgery is covered?
Covered oral surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms; including benign tumors and cysts, and all malignant and premalignant lesions and growths;
- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; or
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint with radiographic evidence of derangement.

General dental services are NOT covered by the Harbor Health Plan.

Organ and Tissue Transplants

Organ and tissue transplants (bone marrow, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung) when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service and is not Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Services and are payable through the organ recipient's coverage under the Contract, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

Covered Health Services and supplies related to an organ or tissue transplant include, but are not limited to, X-rays, laboratory testing, chemotherapy, radiation therapy, and complications arising from such transplant.

We will help you select a Network transplant Provider, which may be inside or outside your

geographic area. If you are required to travel to obtain such Covered Health Services from a Network transplant Provider, we will provide Benefits for travel and lodging expenses for the Member and a companion up to a maximum of $10,000 per lifetime per Member as follows:

- *Lodging* – We'll reimburse up to $50 per day, for the Member (when not in the hospital) or the caregiver. We'll reimburse up to $100 per day for the Member and one caregiver.
- *Travel* – Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the Member's home and the Network Provider. We will reimburse taxi fares, economy or coach airfare, parking, trains, boat, bus, and tolls. We will not reimburse limousines or car services.

Orthotics

Harbor Health covers appropriate Orthotic Devices that adequately meet the medical needs of the Member to participate in Activities of Daily Living (ADL)/standard activities as determined by your treating Physician or prosthetist. Orthotic Devices include, but are not limited to:

- Non-dental braces (i.e. an orthopedic appliance used to support, align, or hold body parts in a correct position) and crutches, including rigid back, leg or neck braces.
- Casts for treatment of any part of the legs, arms, shoulders, hips or back.
- Special surgical and back corsets; and
- Physician- prescribed, directed or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

Non-covered items include, but are not limited to:

- Splints and bandages available for purchase over the counter for support of strains and sprains.
- Orthopedic shoes which are a separable part of a covered brace.
- Specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or effect changes in the foot; or
- Foot alignment, arch supports, elastic stockings, and garter belts.

Maintenance and repairs to orthotics resulting from accident, misuse or abuse are the Member's responsibility and not covered by Harbor Health.

Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Palliative Care

Harbor Health provides Palliative Care coverage for Members with a chronic, complex, or terminal illness.

Pharmaceutical Products – Outpatient

Pharmaceutical Products for Covered Health Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licenses/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *EOC*.

Benefits for medication normally available by a Prescription Order or Refill are provided as described under the *Outpatient Prescription Drugs Rider*.

If you require certain Pharmaceutical Products, including Specialty Pharmaceutical Products, we will assist you in choosing a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If your Provider chooses not to get your Pharmaceutical Product from a Designated Dispensing Entity, your provider may contact us, and we will assist your Provider in selecting another pharmacy to obtain your Pharmaceutical Product.

If you have a chronic, complex, rare, or life-threatening medical condition, and your Provider notifies us in advance that:

- A delay of care would make disease progression probable; or
- The use of a Designated Dispensing Entity would:
    - Make death or harm probable; or
    - Potentially cause a barrier to your adherence or compliance with your plan of care; or
    - Because of the timeliness of the delivery or dosage requirements for the Pharmaceutical Product, necessitate delivery by a pharmacy other than a Designated Dispensing Entity.

Then:

- Your Provider may obtain the Pharmaceutical Product from any pharmacy, including an out-of-Network pharmacy;
- If the Pharmaceutical Product is a Covered Health Service, we will apply the Network Benefits even if the Pharmaceutical Product is dispensed by an out-of-Network pharmacy;
- If your Provider is a Network Provider, we will not require your Provider to bill for or be reimbursed for the delivery and administration of the Pharmaceutical Product under the Benefits available under the *Outpatient Prescription Drug Rider* rather than the Benefits available under this *EOC* unless we have:

- Your informed written consent; and
- A written attestation by your Provider that a delay in the administration of the Pharmaceutical Product will not place you at an increased health risk; and
- You will not pay an additional fee, higher or second Copayment, or any other price increase based on your choice of pharmacy or because the Pharmaceutical Product was not dispensed by a Network Pharmacy.]

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product(s) for which Benefits are provided as described under the *Outpatient Prescription Drug Rider* first.

In the case of FDA-approved drugs for the treatment of stage four advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment of stage four advanced, metastatic cancer and is supported by peer-reviewed medical literature.

If you are 18 years of age or older, you will not be required to fail to successfully respond to, or prove a history of failure of, more than one different drug for each drug prescribed to treat a serious mental illness, excluding the generic or pharmaceutical equivalent of the prescribed drug. We may require a trial of a generic or pharmaceutical equivalent of the prescribed drug as a condition of continued coverage once per plan year if the generic or pharmaceutical equivalent drug is added to the Prescription Drug List. Refer to the *Outpatient Prescription Drug Rider* for more information about your outpatient prescription drug coverage.

You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at the telephone number on your ID Card.]

Benefits for certain Pharmaceutical Products are subject to the supwply limits that are stated in the Schedule of Benefits. For a single cost share, you may receive Pharmaceutical Products up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per order or refill and/or the amount dispensed per month's supply.

You may find out whether a Pharmaceutical Product has a supply limit for dispensing by contacting us at the telephone number on your ID Card.

Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services are a Covered Health Benefit when received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician’s Office Services – Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the health of a trained health professional.

Covered Services include Genetic Counseling.

Benefits include allergy injections.

Benefits also include necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.

Covered Health Services for preventive care provided in a Physician's office are described under Preventive Care.

Preventive Care

Harbor Health encourages preventive care and maintenance of good health.

Covered Health Services under this benefit must be billed by the provider as "preventive care". Preventive care benefits will be provided for the following covered services. When using Network Providers, the services will not be subject to a cost share unless stated as covered on the same basis as for any other illness.

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved; and
- Evidence based preventive care recommended by American Academy of Pediatrics and Bright Futures.
- Immunizations are available from your provider or at a Pharmacy location.
- Eye and ear exams for children to determine the need for vision and hearing correction in accordance with established medical guidelines.

The preventive care services described above may change as USPSTF, or other national guidelines are modified. For the most recent list of recommended services, check with your Physician or visit www.healthcare.gov.

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include one breast pump per pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Provider. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration or any rental).
- Timing of purchase or rental.

More about Preventive Care Benefits:

Benefits for the Prevention and Detection of Osteoporosis
Benefits are available on the same basis as for any other illness to qualified Members for medically accepted bone mass measurement for the detection of low bone mass and/or to determine the Member's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Members are those who are:

Postmenopausal and not receiving estrogen replacement therapy;

- An individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures;
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or effectiveness of approved osteoporosis drug therapy.

Benefits for the Prevention and Detection of Breast Cancer
Benefits are available for annual screening Low-dose Mammography and Breast Tomosynthesis for a Member who is 35 years of age and older.

Benefits for Certain Tests for Detection of Prostate Cancer
Benefits are available to male Members for a medically recognized diagnostic examination for the detection of prostate cancer. Benefits will include:

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test used for the detection of prostate cancer for each covered male who is at least 50 years of age and asymptomatic, or 40 years of age with a family history of prostate cancer or another prostate risk factor.

Benefits for Colorectal Cancer Screening
Benefits are available for colorectal cancer screening for Members who are 45 years of age and older and who are at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include:

- A stool DNA test performed every 3 years;
- A colorectal cancer examination, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk

individuals; and

- An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Benefits for Certain Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer
Benefits are available to each woman 18 years of age or older enrolled in the Plan for expenses for an annual medically recognized diagnostic examination for the early detection of ovarian cancer and cervical cancer. This includes:

- a CA 125 blood test;
- a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus; and
- any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

Benefits for Early Detection Tests for Cardiovascular Disease
Benefits are available for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structures and function every 5 years. Eligible tests are available to each Member who is diabetic or has a risk of developing coronary heart disease and who is:

- A male older than 45 years of age and younger than 76 years of age; or
- A female older than 55 years of age and younger than 76 years of age.

Eligible Tests include:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Benefits for Speech and Hearing Services
Benefits are available on the same basis as for any other illness for the services of a Provider to restore the loss of or correction of impaired speech or hearing function. For more information regarding this benefit refer to the Hearing Aids benefit in this section.

Immunizations
Benefits are available for immunizations for those recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) based on the Member's age requirements.

Immunizations that are covered at no cost share covered Dependent children until they reach their 6th birthday are:

- Diphtheria;

- Haemophilus influenzae type b;
- Hepatitis B;
- Measles;
- Mumps;
- Pertussis;
- Polio;
- Rubella;
- Tetanus;
- Varicella;
- Rotovirus; and
- Any other immunizations that may be required by law

Prosthetic Devices

Harbor Health covers appropriate prosthetic devices that adequately meet the medical needs of the Member to participate in Activities of Living (ADL)/standard activities. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Professional services related to the fitting and use of prosthetic devices are Covered Health Services. These prosthetic devices include replacements necessitated by growth to maturity of the Member. Coverage is provided for Medically Necessary artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices (excluding dental appliances and the replacement of cataract lenses).

Harbor Health covers breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under Durable Medical Equipment and Supplies.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most appropriate model of prosthetic device that meets the minimum specifications for your needs, as determined by your treating Physician or prosthetist. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Maintenance and repairs to prosthetic devices resulting from accident, misuse or abuse are the Member's responsibility.

For purposes of this definition, a wig or hairpiece is not considered a prosthetic appliance.

Reconstructive Surgery

Reconstructive procedures are covered when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an injury,

sickness or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly or traumatic injury without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Benefits are provided for the reconstructive procedures for craniofacial abnormalities to improve the function of, or attempt to create the normal appearance of, and abnormal structure caused by congenital defects, developmental deformities, trauma, tumor, infections, or disease.

Please note that Benefits for reconstructive procedures include all stages of breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy, are provided in the same manner and at the same level as those for any other Covered Health Care Service. Coverage will be provided in a manner determined to be appropriate in consultation with the Member and attending Physician. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Refractive Vision Exams

Refractive vision exams received from a health care provider in the provider's office or outpatient facility. Routine vision exams include refraction to find vision impairment.

You are not required to see a Network Provider for refractive eye exams. You can see Optometrist in the Geographic Service area and submit a claim for reimbursement if the Optometrist or Ophthalmologist will not submit a claim on your behalf. Refer to *Section 6: Claims* for instructions on filing a claim.

Benefits for eye exams required for the diagnosis and treatment of a sickness or injury are provided under Physician's Office Services – Sickness and Injury.

Rehabilitation Services – Outpatient Therapy and Chiropractic

Short-term outpatient rehabilitation services are limited to:

- Physical therapy.
- Occupational therapy.
- Chiropractic Treatment
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy Provider. Benefits include rehabilitation services provided in a Provider's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitation services provided in your home by a Home Health Agency are provided as described under Home Health Care. Rehabilitation services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits may be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer, congenital anomaly, or determined to be Medically Necessary by your Physician. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Benefits are available only for rehabilitation services that are expected to restore a Member to the previous level of functioning. Benefits for rehabilitation services are not available for services that are expected to provide a higher level of functioning than the Member previously possessed. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Harbor Health will provide rehabilitative services that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the Interagency Council on Early Childhood Intervention. Covered Health Services include:

- Occupational therapy evaluations and services.
- Physical therapy evaluations and services.
- Speech therapy evaluations and services.
- Dietary or nutritional evaluations.

Scopic Procedures – Outpatient Diagnostic and Therapeutic

Harbor Health covers diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery - Outpatient.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)

Benefits that apply to certain preventive screenings are described under Preventive Care.

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares apply when services are provided in a Physician's office.

Skilled Nursing Facility and Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

Upon admission for an Inpatient Stay at a Skilled Nursing Facility or Inpatient Rehabilitation Facility, a Physician other than your Primary Care Physician may direct and oversee your care.

Surgery – Outpatient

Surgery and related services are covered when received on an outpatient basis at a Hospital

or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares apply when services are provided in a Physician's office.

Temporomandibular Joint (TMJ) Services

Harbor Health covers services for the evaluation and treatment of TMJ and associated muscles, including the jaw and the craniomandibular joint, which are required as a result of an accident, trauma, congenital defect, developmental defect, or pathology.

Diagnosis: Exam, radiographs and applicable imagine studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.

- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Telehealth, Telemedicine and Teledentistry Services

Benefits include Telehealth Services, Telemedicine Medical Services and Teledentistry Dental Services. Benefits are also provided for Remote Physiologic Monitoring. An in-person consultation is not required between the health care provider and the patient for services to be provided. Services provided by telemedicine, telehealth and teledentistry are subject to the same terms and conditions of the Contract as any service provided in-person.

Therapeutic Treatments - Outpatient

Therapeutic treatments are covered when received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for all other Physician services are described under Physician Fees for Surgical and Medical Services.)

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares apply when services are provided in a Physician's office.

Urgent Care

Services received at an Urgent Care Center are covered. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under Physician's Office Services – Sickness and Injury.

Wigs

Wigs and other scalp hair prostheses are covered subject to any limits noted in your *Schedule of Benefits*. You are not required to use a Network Provider for purchasing a wig. You can obtain wigs from any vendor in the Geographic Service area and submit a Claim for reimbursement if the vendor will not submit a claim on your behalf. Refer to *Section 6: Claims* for instructions on filing a claim.

Section 3: Limitations and Exclusions

In addition to limitations and exclusions noted in *Section 2: What the Plan Covers*, the following list of services, treatments, items or supplies are not covered.

1. Any services, supplies or drugs that are not Medically Necessary and essential to the diagnosis and direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Health care services and supplies that do not meet the definition of a Covered Health Service. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

    - Provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
    - Medically Necessary.
    - Described as a Covered Health Service in this *EOC* under *Section 2: What Your Plan Covers* and in the *Schedule of Benefits*.
    - Not otherwise excluded in this *EOC* under *Section 3: Limitations and Exclusions*.
3. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an *Outpatient Prescription Drug Rider* is included under the Contract, Benefits for the prescription and non-prescription oral agents will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under the *EOC*.
4. Any Experimental or Investigational Services, supplies, or drugs. The fact that an Experimental or Investigational Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational Services in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in *Section 2: What Your Plan Covers*.

    Experimental and Investigational Services denials are considered Adverse Determinations and subject to the utilization review process including reviews by an Independent Review Organization (IRO). Refer to *Section 5: Questions, Complaints and Appeals* for a complete explanation of your appeal rights.
5. Room and board charges incurred during a hospital admission for diagnostic or evaluation procedures if the tests could have been covered on an outpatient basis without adversely affecting the Member's physical condition or the quality of medical care provided.
6. The following items are excluded, even if prescribed by a Physician:
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Trusses.

- Ultrasonic nebulizers.

7. Devices and computers to help with communication and speech.
8. Oral appliances for snoring.
9. Repair or replacement of prosthetic devices or DME items due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
10. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.
11. Non-covered Durable Medical Equipment includes, but not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.
12. Powered and non-powered exoskeleton devices.
13. Cosmetic Procedures. See the definition in *Section 8: Glossary of Terms*. Examples include:
    - Abdominoplasty.
    - Blepharoplasty.
    - Breast enlargement, including augmentation mammoplasty and breast implants.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.
    - Facial bone remodeling for facial feminizations.
    - Hair removal or replacement by any means.
    - Hair transplantation.
    - Lip augmentation.
    - Lip reduction.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under Reconstructive Procedures in *Section 2: What Your Plan Covers*.
    - Mastopexy.
    - Pectoral implants for chest masculinization.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Rhinoplasty.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins, unless Medically Necessary.
    - Skin abrasion procedures performed as a treatment for acne.
    - Skin resurfacing.
    - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
    - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins.
    - Voice modification surgery.
    - Voice lessons and voice therapy.

14. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed a mastectomy. See Reconstructive Procedures in *Section 2: What Your Plan Covers*.
15. Treatment of benign gynecomastia (abnormal breast enlargement in males).
16. Home Infusion Therapy unless Medically Necessary.
17. Any services, supplies or drugs provided for custodial care, long term care, respite care. This exclusion does not apply to services for which Benefits are provided as described under Hospice Care in *Section 2: What Your Plan Covers*.
18. Any services, supplies and drugs provided for any medical social services, bereavement counseling (except as provided under Hospice Care in *Section 2: What Your Plan Covers*), and vocational counseling.
19. Private Duty Nursing services, except as described under *Hospital Admissions* in *Section 2: What Your Plan Covers*.
20. Nursing and Home Health Aide services, unless Medically Necessary.
21. Weight loss drugs, food products, and exercise programs or equipment.
22. Over-the-counter home tests.
23. Bariatric surgery is limited to one procedure during the entire period of time a Member is enrolled under the Plan. For more on bariatric treatment refer to Obesity Surgery in *Section 2: What Your Plan Covers*.
24. Food and nutritional items. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in *Section 2: What Your Plan Covers*.
25. Any services, supplies or drugs supplied to increase or decrease height or alter the rate of growth, including surgical procedures or devices to stimulate growth (except for certain endocrine conditions).
26. Any services, supplies or drugs in connection with:
    - Routine foot care, including but not limited to the removal of warts, corns or calluses, or the trimming, cutting or deriding of toenails in the absence of severe systemic disease. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetic Management Services in *Section 2: What Your Plan Covers*;
    - Hygienic and preventive maintenance foot care. Examples include:
        - Cleaning and soaking the feet.
        - Applying skin creams in order to maintain skin tone.

      This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
    - Foot care for flat feet and fallen arches. Treatment of subluxation of the foot.
    - Shoes. This exclusion does not apply to podiatric appliances or therapeutic footwear for which Benefits are provided as described under Diabetic Management Service in *Section 2: What Your Plan Covers*.
    - Shoe orthotics. This exclusion does not apply to orthotics for which Benefits are provided as described under Orthotics in *Section 2: What Your Plan Covers*.
    - Shoe inserts and arch supports.
27. Replacement prosthetic appliances except those necessitated by growth due to maturity of the Member.
28. The use of the procedures or supplies for treatment of male sexual or erectile

dysfunction/impotence.

29. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
30. Devices used as safety items or to help performance in sports-related activities.
31. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
32. All expenses related to dental care or oral surgery, including but not limited to:
    - Cleaning of the teeth;
    - Any services related to crowns, bridges , filings or periodontics;
    - Rapid palatal expanders;
    - X-rays or exams;
    - Dentures or dental implants;
    - Dental prostheses, or shortening or lengthening of the mandible or maxilla for Members over the age of 18, correction of malocclusion;
    - Treatment of dental abscess or granuloma;
    - Treatment of gingival tissues (other than tumors);
    - Surgery or treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies;
    - Orthodontics, such as splints, positioners, extractions of teeth, or repairing damaged teeth; and
    - Odontogenic cysts.

    This exclusion does not apply to Benefits described under Oral Surgery and Temporomandibular Joint (TMJ) Services in *Section 2: What Your Plan Covers*.
33. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to eyeglasses or contacts required following surgery to treat cataracts, aphakia, acute corneal pathology or keratoconus for which Benefits are provided.
34. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
35. Eye exercise or vision therapy, unless Medically Necessary.
36. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
37. Educational testing and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training (i.e. including, but not limited to, dyslexia, typing, language, or learning courses.)
38. Alternative / Optional Therapies (including, but not limited to, recreational therapy, exercise programs, hypnotherapy, art therapy, music therapy, reading therapy, sensory integration therapy, vision therapy, vision training, orthoptic therapy, behavioral vision therapy, integration vision therapy, orthotripsy, chelation therapy, Cryotherapy, aromatherapy, massage therapy, hair replacement or removal regardless of indication.
39. Any services or supplies provided for the following treatment modalities including, but not limited to:
    - Intersegmental traction;
    - Surface EMGs;
    - Spinal manipulation under anesthesia; and
    - Muscle testing through computerized kinesiology machines such as Issostation, Digital Myograph and Dynatron.
40. Biofeedback is not covered for any reasons except for urinary incontinence or for the diagnosis of acquired brain injury.

41. Extracorporeal Shock Wave Therapy (ESWT) except for treating kidney stones.
42. Physical exams, treatment and evaluations required or requested by employers, insurers (other than this Harbor Health Plan), schools, camps, courts, licensing authorities, flight clearance and other third parties.
43. Athletic performance enhancing drugs.
44. Strength equipment or drugs.
45. Sports cords and TENS units or other Athletic Assist devices.
46. Services and supplies used primarily for patient convenience.
47. Convenience services provided by a hospital (included, but not limited to, private rooms, guest beds, tv).
48. Personal comfort and convenience items, including, but not limited to, heating pads, air purifier, blood pressure cuffs.
49. Support garments including, but not limited to, compression support hose, compression socks, over the counter orthotic, unless Medically Necessary.
50. Home and mobility improvements including, but not limited to, widening doorways, ramps or home modification.
51. Health care services for organ and tissue transplants, except those described under Organ and Tissue Transplants in *Section 2: What Your Plan Covers*.
52. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Contract.)
53. Health care services for transplants involving animal organs.
54. Health care services for human organ transplant or post-transplant care when:
    - The transplant operation is performed in China, or another country known to have participated in forced organ harvesting.
    - The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting.
55. Transportation cost for personal transport and other than ambulance, except when Medically Necessary.
56. Infertility treatment includes medical services, artificial insemination and all drugs associated with the treatment of infertility or any assisted reproductive technology or related treatment.
57. Costs of donor eggs and donor sperm.
58. Storage of body fluids, including, but not limited to semen, ovum and body parts.
59. Reversal of voluntary sterilization; any cost related to surrogate parenting; infertility services required because of a gender change by the Member.
60. Elective Abortion, as defined by Section 245.002, Texas Health and Safety Code, other than an abortion performed due to a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a Physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.
61. Gene Therapy, except as covered in *Section 2: What Your Plan Covers*.
62. Services related to Mental Illness and/or Substance Use Disorder that are provided by half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Harbor Health requires that any facility providing healthcare for Mental Illness and/or a Substance Use Disorder treatment program

be accredited as a Residential Treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.

63. Any portion of a charge for a service, supply or drug that is in excess of the Allowed Amount as determined by Harbor Health.
64. Any benefits in excess of specified benefit maximums in the *Schedule of Benefits*.
65. Claims submitted after 180 days from the date of service.
66. Any services, supplies or drugs provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employer whether or not benefits are, or could upon proper claim be, provided under a Worker's Compensation plan.
67. Any services, supply, or drugs for which a Member is not required to make payment or for which a Member would have no legal obligation to pay in the absence of this or any similar coverage, except services and supplies for treatment of Mental Illness or mental retardation provided by a tax supported institution of the State of Texas.
68. Immunizations that are not routine and are for the purpose of travel.
69. Any services, supplies or drugs provided for injuries sustained as a result of war (declared or undeclared), insurrection, participation in a riot, or from a criminal felonious activity.
70. Services related to a disaster. In the event of a major disaster, services shall be provided insofar as practical, according to the best judgment of health professionals and within the limitations of facilities and personnel available, but neither the Plan, nor any health professionals shall have any liability for delay or failure to provide or to arrange for services due to lack of available facilities or personnel.
71. Court ordered services. Healthcare services provided solely because of the order of a court or administrative body are excluded. Charges for a Provider to appear in court are also excluded.
72. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
73. Health care services during active military duty or for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
74. Reimbursement for services, supplies or drugs provided by an out-of-Network Provider, except in cases of Emergency Health Care Services, out-of-network providers at a Network facility as required by the No Surprises Act, or when services are arranged by us.
75. Any services, supplies or drugs provided to a Member incurred outside of the United States, even if the Member traveled to the location for the purpose of receiving medical services, supplies, or drugs. This exclusion does not apply to Benefits described under Emergency Care in *Section 2: What Your Plan Covers*.
76. Any services, supplies or drugs provided or prescribed by a provider that is related to the Member by blood or marriage.
77. Services provided by a Christian Science or other faith or culturally based facility or practitioner.
78. Any charges resulting from failure to keep a scheduled visit with a physician or other professional provider; or for completion of any insurance forms; or for acquisition of medical records.
79. Reimbursement for same day duplicate services by different Providers.
80. Any services, supplies or drugs provided before the patient is covered as a Member in

this Plan or any services or supplies after the termination of the Member's coverage.

81. Home births.

Section 4: Pre-Authorization and Utilization Management

Pre-Authorization

Harbor Health requires advance approval, called Pre-Authorization, for certain services. Pre-Authorization establishes in advance the Medical Necessity of certain care and services covered under the Harbor Health Plan. Benefit coverage is subject to other applicable requirements including the Network status of Providers, limitations and exclusions, payment of Premium and eligibility at the time care and services are provided. Your Primary Care Physician and other Network Providers are responsible for submitting a request for Pre-Authorization of services to us 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. Information about Pre-Authorization requirements can be found on www.harborhealth.com or by calling the telephone number on your ID Card.

Please note that requests for Pre-Authorization are required even if you have a referral submitted from your Primary Care Physician to seek care from another Network Provider.

When a request for Pre-Authorization is submitted, there are three possible responses that will be provided by us:

- An approved Pre-Authorization.
- An Adverse Determination.
- Confirmation of receipt of your request, when there are no clinical issues for us to determine.

Upon receiving the request for Pre-Authorization and any additional information necessary to complete our review, we will communicate notice of our decision within three calendar days. If you are hospitalized at the time of the request for Pre-Authorization, a determination will be provided within 24 hours. For services related to post-stabilization treatment or a life-threatening condition, a determination will not exceed one hour from receipt of the request.

If we issue an Adverse Determination, a written notice regarding the Adverse Determination will be forwarded to you and the Provider of record within three business days.

If you are hospitalized at the time of the Adverse Determination, we will provide notice within one business day by either telephone or electronic transmission to the Provider of record. Within three business days, a written notice will be forwarded to you and the Provider of record.

A response will be provided no later than one hour after the time of request for post-stabilization care subsequent to Emergency treatment.

We recommend that you confirm with us that all Covered Health Care Services have been Pre-Authorized as required. Before receiving these services from a Network Provider, you may want to call us to verify that the hospital, Physician and other Providers are Network Providers and that they have obtained the required Pre-Authorization. Network facilities and Network Providers cannot bill you for services they do not Pre-Authorize as required. You can call us at the telephone number on your ID Card if you have any questions about Pre-Authorization.

Concurrent Review

Harbor Health will review care and services during a hospital stay and if your Provider

recommends a longer stay than was first Pre-Authorized, your Provider may seek an extension for the additional days. Harbor Health will respond to your provider request no later than 24 hours after receiving the request. Benefits will not be available for room and board charges for days that are not Medically Necessary.

Renewal of Pre-Authorizations

Your Provider may request a renewal of a Pre-Authorization at least 60 days before the date the Pre-Authorization expires. If Harbor Health receives a renewal request before the existing Pre-Authorization expires, Harbor Health will, if practicable, review the request and issue a determination indicating whether the Pre-Authorization is renewed before the existing Pre-Authorization expires.

Request for Step Therapy Exception

If your Provider would like an exception to the step therapy requirement, as explained in the *Outpatient Prescription Drugs Rider*, they may submit a request to Harbor Health. We will review and provide a decision within 72 hours of the request. If your prescribing Physician reasonably believes that an Adverse Determination of the step therapy exception request could cause you serious harm or death, the request is considered approved if we do not make an Adverse Determination within 24 hours of receiving the request. If we do make an Adverse Determination, you have the right to request an expedited internal appeal and also have the right to request a review by an Independent Review Organization (IRO) as explained in *Section 5: Questions, Complaints and Appeals*.

Adverse Determinations

An Adverse Determination is a decision that is made by us or our Utilization Review Agent that the health care services or prescription drugs furnished, proposed to be furnished or prescribed are not Medically Necessary or appropriate, or are Experimental or Investigational Services.

Harbor Health, or its contracted utilization review agent, will provide notice of Adverse Determinations as follows:

- If you are hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying you and the provider of record of the Adverse Determination
- If you are not hospitalized at the time of the Adverse Determination, within three working days in writing to you and the provider of record.
- Within the time appropriate to the circumstances relating to the delivery of the services to you and your condition - when denying post-stabilization care subsequent to Emergency treatment as requested by a treating Provider, notice will be provided to the Provider no later than one hour after the time of the request.

Harbor Health, or its contracted Utilization Review Agent, will provide notice of an Adverse Determination for a concurrent review regarding a prescription drug or intravenous infusions for which you are receiving benefits under the plan no later than the 30th day before the date on which the prescription drugs or intravenous infusion will be discontinued.

Adverse Determination Due to Formulary Limitation

If we deny a prescription drug that has been prescribed to you because the drug is not included on the drug Formulary, and the prescribing Physician has determined that the drug is Medically Necessary, we will treat the denial as an Adverse Determination and provide appeal rights as described in *Section 5: Questions, Complaints and Appeals*.

Section 5: Questions, Complaints and Appeals

Questions

If you have a question about your Plan, call the telephone number shown on your ID Card. Representatives are available to take your call and answer any question you may have Monday – Friday from 7:00 a.m. – 8:00 p.m. and Saturday from 8:00 a.m. – 5 p.m., CST.

Complaints

If you have a complaint about your Plan, such as a representative who did not answer your question, you have not received an Explanation of Benefits or a Network Provider was rude, call the telephone number shown on your ID Card. Representatives are available to take your call and address your complaint.

If you would rather send your complaint in writing to us, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will send you a complaint form that you must return to us for prompt resolution of the complaint.

We will promptly investigate each complaint. Within five business days, we will send a letter acknowledging the date we received your complaint. The total time for acknowledgement, investigation and resolution of the complaint, including the response letter, will not exceed 30 calendar days after we receive the written complaint or complaint form.

Complaints concerning an Emergency or denials of continued hospitalization will be investigated and resolved in accordance with the medical immediacy of the case and will not exceed one business day from receipt of the complaint.

We will not engage in any retaliatory action against any Member, Physician or Provider. We will not retaliate for any reason including, cancellation of coverage or a Provider contract, or refusal to renew coverage or a Provider contract because the Member, Physician, Provider or person acting on behalf of the Member has filed a complaint against the Contract or has appealed a decision.

Complaint Appeal Procedures

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision.

We will send an acknowledgement letter to the complainant within five business days after the date we receive the written request for an appeal.

We will appoint members to the complaint appeal panel, which advises us on the resolution of the appeal. The members of the complaint appeal panel cannot have been involved with your complaint in the past. The complaint appeal panel will include an equal number of our staff, Physicians, or other Providers with experience in the area of care to which your appeal is related, and Members.

No later than the fifth business day before the complaint appeal panel meets, we will provide to you or your designated representative with the following:

- Any documentation that will be presented by our staff to the complaint appeal panel.
- The specialization of any Physician or Provider consulted during the investigation of your appeal.
- The name and affiliation of each of the members of our complaint appeal panel.

You, or your designated representative if you are a minor or disabled, have the right to:

- Appear in person before the complaint appeal panel at the site at which the complainant normally receives health care services, or at another site agreed to by the complainant.
- Address an appeal over the phone or in writing to the complaint appeal panel.
- Present alternative expert testimony.
- Request the presence of, and to question, any person that was involved in making the prior determination that resulted in your appeal.

We will complete the appeals process not later than the 30th calendar day after we receive your written appeal. Our final decision on the appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Investigation and resolution of appeals involving ongoing Emergencies or denials of continued hospitalization will be resolved in accordance with the medical immediacy of the case but no later than one business day after your request for appeal. At your request, we will provide, instead of a complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and who is of the same or similar specialty as ordinarily manages the medical condition, procedure, or treatment under appeal. The Physician or Provider reviewing the appeal may interview you or your designated representative and will make a decision of the appeal. Initial notice of the decision on the appeal including a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision may be delivered orally to you but will be followed by a written notice of the determination within three days.

Filing Complaints with the Texas Department of Insurance

Any Member, including Members who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may file a complaint with the Texas Department of Insurance (“TDI”) at P.O. Box 149091, Austin, TX 78714-9091. TDI’s telephone number is 1-800-252-3439.

The Commissioner of Insurance will investigate a complaint against us to determine our compliance with insurance laws within 60 days after the Department receives your complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

- Additional information is needed.
- An on-site review is necessary.

- We, the Physician or Provider, or you do not provide all documentation necessary to complete the investigation.
- Other circumstances beyond the control of the Department occur.

Appeals

Harbor Health can make two types of decisions that result in a denial of coverage:

- Administrative denials are decisions that are not based on Medical Necessity or Experimental or Investigational Services. Examples of administrative decisions include a post-service claim determination, a rescission of coverage determination (coverage that was canceled or discontinued retroactively) or a denial because a health care service is excluded under the Plan. When you appeal this type of denial, it is called a Non-Clinical Appeal.
- Adverse Determination denials are decisions that the health care services furnished or proposed to a Member is not Medically Necessary or is an Experimental or Investigational Service. When you appeal this type of denial, it is called a Clinical Appeal.

When we have denied coverage, you have the right to appeal the decision. Refer to the appropriate appeal section based on the type of denial you received.

Non-Clinical Appeal Procedures for an Administrative Denial

If you disagree with a pre-service request for Benefits determination, post-service claim determination, or a rescission of coverage determination, you can contact us orally or in writing to request an appeal. Within five business days, we will send a letter acknowledging the date we received your appeal. Your request for an appeal should include:

- The Member's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The Provider's name.
- The reason you believe the claim should be paid or that your coverage should not have been canceled/discontinued.
- Any documentation or other written information to support your request for claim payment or that your coverage should be active.

Your appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. The appeals process will be completed no later than 30 calendar days after the written request is received.

Please note that our decision is based on whether Benefits are available under the Contract for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Clinical Appeal Procedures for an Adverse Determination

An Adverse Determination is a decision that is made by us or our utilization review agent that the health care services furnished or proposed to be furnished to a Member are:

Not Medically Necessary or appropriate.

Experimental or Investigational Services.

An Adverse Determination does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is Medically Necessary. A complete definition of Adverse Determination is contained in *Section 8: Glossary of Terms*.

Procedures for Appealing an Adverse Determination

If you, your designated representative or your Provider of record receive an Adverse Determination in response to a claim or a request for Pre-Authorization of services, you, your designated representative or your Provider of record may appeal the Adverse Determination orally or in writing within 180 days from the date of your denial letter.

If you, your designated representative or your Provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your Provider of record a one-page appeal form.

If you submit a written request an appeal of the Adverse Determination, your request must include:

- The Member's name and the identification number from the ID card.
- The Member's address.
- The date(s) of medical service(s).
- The Provider's name.
- The reason you believe the claim should be paid or that your coverage should not have been canceled/discontinued.
- Any documentation or other written information to support your request for claim payment or that your coverage should be active.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a healthcare professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Determination.

We will complete the appeals process no later than the 30th calendar day after we receive your appeal and will send you or your designated representative and your Provider of record a response letter with our decision. If you are appealing a denial of your prescription drug, we will complete the appeals process no later than the 7th calendar day after we receive your appeal.

If an appeal is upheld, within 10 working days of the appeal denial your treating Physician may request an additional review. A Physician who is of the same or similar specialty as the health care provider who would typically manage the medical condition, procedure, or treatment will conduct

the review. The specialty review will be completed within 15 working days from receipt of the request.

Retrospective Reviews

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your Provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Urgent Appeals that Require Immediate Action

You or your Physician can request an urgent appeal if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. We will automatically give you an urgent appeal if your Physician requests one for you or if your Physician supports your request. If you request an urgent appeal without your Physician's support, we will decide if your request requires an urgent appeal.

In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you of the decision within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Expedited Appeals for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, prescription drugs or intravenous infusions will include a review by a health care provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure or treatment under review, provided that the resolution of the appeal may not

exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but will be followed with a letter within three working days of the initial telephonic or electronic notification.

You are not required to submit an expedited internal appeal when you received an Adverse Determination for Emergency Care, continued hospitalization, prescription drugs or intravenous infusion. In this instance, you are entitled to an immediate external review through an Independent Review Organization (IRO). Refer to the section below titled Federal External Review Program for additional information.

Federal External Review Program

You may be entitled to request an external review of our determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by us.
- We fail to respond to your appeal within the timeframe required by the applicable regulations.

You are also entitled to an external review without first exhausting your internal appeals when you received an Adverse Determination for the following:

- Emergency Care;
- Continued hospitalization;
- Prescription drugs; or
- Intravenous infusion

If one of the above conditions is met, you may request an external review of Adverse Determination based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was canceled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting us at the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received our final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.

- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO) that we have entered into agreements with to perform such reviews. There are two types of external reviews available:

- A standard external review.
- An expedited external review.

Standard External Review
A standard external review includes all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the IRO.
- A decision by the IRO.

After receipt of the request, we will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

After we complete this review, we will issue a notification in writing to you. If the request is eligible for external review, we will assign an IRO to conduct such review.

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days after the date you receive the IRO's request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

Within three business days of receiving the request for external review, we will provide to the assigned IRO the documents and information considered in making our determination. The documents include:

- All relevant medical records.
- All other documents relied upon us.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. We will include it with the documents forwarded by the IRO.
- A list of each Physician or other Provider who:
    - Has provided care to the Member; and
    - May have medical records relevant to the appeal.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by us. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and us, and it will include the clinical basis for the determination.

If we receive a Final External Review Decision reversing our determination, we will provide coverage or payment for the Benefit claims at issue according to the terms and conditions of the Contract, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with our determination, we will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review
An expedited external review is similar to a standard external review. The main difference between the two is that the time periods for completing certain portions of the review process are much shorter for the expedited external review, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive any of the following:

- An Adverse Determination of a claim or appeal that involves a medical condition for which the time frame for completion of an expedited internal appeal would either jeopardize:
    - The life or health of the individual.
    - The individual's ability to regain maximum function.
- An Adverse Determination involving the denial of prescription drugs or intravenous infusions for which you are receiving Benefits.

In addition, you must have filed a request for an expedited internal appeal.

- A final appeal decision, that either:
    - Involves a medical condition where the timeframe for completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.
    - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

Immediately upon receipt of the request, we will determine whether the individual meets both of the following:

- Is or was covered under the Contract at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After we complete the review, we will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, we will assign an IRO in the same manner we utilize to assign standard external reviews to IROs. We will provide all required documents and information we used in making the Adverse Determination or final Adverse Determination to the assigned IRO electronically or by telephone or facsimile or any other available method in a timely manner. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by us. The IRO will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO's final external review decision is first communicated verbally, the IRO will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call us at the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Section 6: Claims

Filing a Claim

When you receive treatment or care from a Network Provider, you will not be required to file claims. The Network Provider will submit the claims directly to Harbor Health for you.

> **Exception:** You are not required to see a Network Provider for acupuncture services, refractive vision exams or purchasing a wig. You can see any provider in the Geographic Service Area and submit the claim for reimbursement if the provider will not file a claim on your behalf. Benefit coverage for these services can be found in *Section 2: What Your Plan Covers*. Reimbursement amounts can be found in the *Schedule of Benefits*. Refer to the section *How to File a Medical Claim* below for instructions on filing a claim.

You may be required to file your own claims when you receive treatment or care from an out-of-Network Provider. At the time services are provided, ask your out-of-Network provider whether they will file the claim for you.

Benefit payments will be made directly to Network Providers when they submit claims to Harbor Health. If the claim is for an out-of-Network provider, Harbor Health may choose to pay either you or your provider. If you receive the payment from Harbor Health, it will be your responsibility to pay your Provider for any billed services. If you have assigned your Benefits to a Provider via a valid assignment of benefits, Harbor Health will pay the provider.

Allowed Amounts due to an out-of-Network provider for Covered Health Services that are subject to the No Surprises Act of the Consolidated Appropriations Act (P.L 116-260) are paid directly to the provider.

If allowed by law, any Benefits available to you, if unpaid at your death, will be paid to your estate.

How to File a Medical and Pharmacy Claim

If you submit a claim directly to Harbor Health, you must submit the claim no later than 90 days after the date of service. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends. All benefits will be paid to you or your assignee.

When you request payment of Benefits from us, you can download a sample claim form from the Harbor Health website at www.harborhealth.com. If you do not use the sample claim form, you must provide us with all of the following information:

- The Eligible Employee's name and address.
- The patient's name and age.
- The number stated on your ID Card.
- The name and address of the Provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.

- An itemized bill from your Provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the injury or sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

The claim form or the above information should be filed with us at the address on your ID Card.

When filing a claim for Outpatient Prescription Drug Benefits, your claim should be submitted by mail to:

Capital Rx
Attn: Claims Dept.
9450 SW Gemini Dr., #87234
Beaverton, OR 97008

Claims will be processed in accordance with state and federal requirements.

Payment of Benefits

In circumstances where you receive Emergency Health Care Services in an out-of-Network facility, we will fully reimburse an out-of-Network Physician or Provider for Emergency Health Care Services as described in the *Schedule of Benefits* until you can reasonably be expected to transfer to a Network Physician or Provider. If an out-of-Network Provider for Emergency Health Care Services bills you for any difference between the Provider's billed charges and the Allowed Amount, you should contact us, and we will work with the Provider so that you are only responsible for your cost share amount.

Payment/Reimbursement for Certain Publicly Provided Services

As required by Texas law, we will pay Benefits on behalf of a child to the *Texas Department of Human Services*, if:

- The parent who purchased the plan or who is required to pay child support by a court order or court-approved agreement and is:
  - A possessory conservator of the child under a court order issued in the State of Texas, or
  - Not entitled to possession or access to the child.
- The *Texas Health and Human Services Commission* is paying Benefits on behalf of the child under Chapter 31 and 32, Human Resources Code.
- Harbor Health is notified, through an attachment to the claim for Benefits at the time the claim is first submitted, that the Benefits must be paid directly to the *Texas Department of Human Services.*

Payment of Benefits to Conservator of a Minor

As required by Texas law, we will pay Benefits to a court appointed possessory or managing conservator of a child if the court appointed person includes the following information when submitting a claim to Harbor Health:

- Written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made.
- A certified copy of a court order designating the person as a possessory or managing conservator of the child or other evidence designated by the rule of the Commissioner that the person is eligible for the Benefits as this section provides.

Right to Conduct Physical Examination or Autopsy

Pursuant to Texas law, Harbor Health has the right and opportunity to conduct a physical examination of an individual for whom a claim is made when and as often as is reasonably required during the pendency of the claim under the plan. In the case of a death, Harbor Health may require that an autopsy be conducted, unless the autopsy is prohibited by law.

Limitations on Legal or Equitable Actions

An action at law or in equity may not be brought to recover on Harbor Health before the 61st day after the date written proof of loss is filed as required under the Plan or after the third anniversary of the date on which written proof of loss is required under the plan to be filed.

Review of Claims Determination

When Harbor Health receives a properly submitted claim, it has the authority and discretion to interpret and determine benefits in accordance with the Plan terms and Texas laws. Harbor Health will review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing.

You have the right to seek and obtain a full and fair review by Harbor Health of any determination of a claim, any determination of a request for Pre-Authorization, or any determination made by Harbor Health in accordance with the benefits and procedures detailed in your medical plan. Refer to *Section 5: Questions, Complaints and Appeals*, *Appeal Procedures for an Administrative Denial* for information on appealing a claim denial.

Subrogation

If the Harbor Health Plan pays and provides benefits for you and your Dependents, the Plan is subrogated to all rights of recovery which you and your dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of Benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purpose of this provision, subrogation means the substitution of one person or entity (the Plan) in the place of another (you and your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the right of the other in relation to the debt or claim, and its rights and remedies.

Subrogation Example:
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the

Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident that that driver's insurance carrier to recover the cost of those Benefits.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Plan will have a right of reimbursement. If you and your Dependent recover money from any person, organization, or insurer for any injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of Benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement, or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of Benefits paid or provided by the Plan.

Reimbursement Example:
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

Right to Recovery by Subrogation or Reimbursement

You and your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent and attorney will notify the plan before settling any claim or suite so as to enable Harbor Health to enforce our rights by participating in the settlement of the claim or suite. You and your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits (COB)

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you. The language in this section is specific to Texas law regarding coordination of benefits.

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its plan terms without regard to the possibility that another plan may cover some expenses.
- **Secondary Plan.** The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

Definitions

For purposes of this section, terms are defined as follows:

(a) **Plan.** A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; vision benefit plan or vision discount plan that provides or arranges for benefits for vision or medical eye care services, procedures, or products; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non- medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

(b) **This Plan.** This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB

provisions to coordinate other benefits.

(c) **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense. A Contract may not reduce benefits on the basis that: another Plan exists and the Member did not enroll in that plan; a person is or could have been covered under another plan, except with respect to Part B of Medicare; or a person has elected an option under another plan providing a lower level of Benefits than another option could have been elected.

(d) **Allowable Expense.** Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a Provider by law or in according to contractual agreement is prohibited from charging a Member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care Provider or Physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care Provider's or Physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary

plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a Member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, Pre-Authorization of admissions, and preferred health care provider and physician arrangements.

(e) **Allowed Amount.** Allowed amount is the amount of a billed charge that a carrier determines to be covered for services provided by an out-of-Network health care Provider or Physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the Member is responsible.

(f) **Closed Panel Plan.** Closed panel plan is a plan that provides health care benefits to Members primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care Providers and Physicians, except in cases of Emergency or referral by a panel member.

(g) **Custodial Parent.** Custodial parent is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this Plan is always primary unless the provisions of both plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-Network benefits.

(c) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(d) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a Member uses an out-of-Network health care Provider or Physician, except for Emergency services or authorized

referrals that are paid or provided by the primary plan.

(e) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(f) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(g) Each plan determines its order of benefits using the first of the following rules that apply.

(1) **Nondependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
(i) If a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
(ii) If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage,

the provisions of subparagraph a) above must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;
(II) the plan covering the custodial parent's spouse;
(III) the plan covering the non-custodial parent; then
(IV) the plan covering the non-custodial parent's spouse.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

(D) (i) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

(3) **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled g.1. can determine the order of benefits.

(4) **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if the rule labeled g.1. can determine the order of benefits.

(5) **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, results in the total benefits paid or provided by all plans for the claim equaling 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by an non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Harbor Health will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give Harbor Health any facts it needs to apply those rules and determine benefits.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Harbor Health may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Harbor Health will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Harbor Health is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom

it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 7: Plan Provisions

Eligibility

The eligibility date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when they become an employee or a Dependent and is in a class eligible to be covered under the Plan.

Your eligibility date will be determined by the Plan in accordance with your Employer's established eligibility procedures.

Employee Eligibility

If you are eligible to participate in the Plan, you are eligible for the benefits described in this *Evidence of Coverage*.

For purposes of this Plan, the term Eligible Employee will also include those individuals who are no longer an employee of the Employer, but who are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA). You may enroll for coverage for yourself (or for yourself and your Dependents) on or before your benefit eligibility date, within 31 days of your eligibility date or during the annual enrollment period.

Dependent Eligibility

If you are eligible for coverage, you may include your Dependents. If you and your spouse or domestic partner are both eligible employees for your Employer's Plan, then your children may be covered as Dependents of either parent, but not both. In addition, a spouse or domestic partner that is an eligible employee for your Employer's Plan may not be covered as a Dependent.

The Plan defines dependents as:

- Your spouse or domestic partner;
- Your children under the age of 26 regardless of their marital status, including:
    - Biological children;
    - Stepchildren and adopted children;
    - Children for whom you are named a legal guardian or who are subject of a medical support order requiring such coverage; and
    - Certain children over age 26 who are determined to be medically incapacitated and are unable to provide their own support.
- A grandchild of the Subscriber, who is unmarried, under 26 years of age and is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made.

For a Dependent that is eligible due to a medical support order, and who resides outside Harbor Health's service area (but inside the United States), Harbor Health will make necessary arrangements in compliance with applicable state law to ensure access to Network benefits. Please call Harbor Health Member Services at the telephone number on your ID Card to notify us

of the need to make the arrangements.

New Dependent Child Coverage

Coverage for a new Dependent child by birth begins on the date of the event and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, the Eligible Employee must notify us of the event and pay any required Premium within 31 days of the event. Benefits for Covered Health Services for congenital defects and birth abnormalities (including Congenital Anomalies) are available at the same level as those for any other sickness or injury.

Coverage for a Dependent child when required by a medical support order begins on the date of receipt of either the medical support order, or the notice of the medical support order, and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, we must receive a completed enrollment form and payment of any required Premium within 31 days of receipt of the medical support order. The Subscriber, the custodial parent, a child support agency, or the Dependent child (if over age 18) may complete and sign the enrollment form on behalf of the Dependent child. If the eligible person is not already enrolled, he or she is also eligible to enroll if required by a medical support order to provide health care coverage to his or her Dependent child. The eligible person must provide proof, satisfactory to us, of the requirement to provide health care coverage.

If you fail to enroll within the first 31 days, your next opportunity will be at Open Enrollment. You may then enroll for coverage for your Dependent during the next open enrollment period or when a qualified change of status event occurs. Please contact your Employer's Benefits Office with questions or changes in status information.

Life Event Changes

You have 31 days from the date of a qualifying life event to notify your Employer and change your Plan elections. If you do not make the changes during the 31-day status change period, your changes cannot be made until the Annual Enrollment period for your Plan to be effective on the next Plan Year's effective date.

Qualified life events include:

- Birth.
- Legal adoption: on the date the adoption becomes final.
- Placement for adoption.
- The Eligible Employee is a party in a suite seeking adoption.
- Marriage, Divorce, Annulment, Legal Separation.
- Legal guardianship.
- Dependent's death;
- Court or administrative order, including a Qualified Medical Child Support Order for a dependent child;
- Significant change in residence if the change affects you or your Dependent's current plan eligibility;
- Starting or ending employment, starting or returning from unpaid leave of absence, or change of job status affecting eligibility for benefits;
- Change in Dependent eligibility;

- Significant change in coverage or cost of other benefit plans available to you and your family;
- An employee whose Dependent loses insurance coverage under Medicaid or CHIP program as a result of loss of eligibility or either the employee or Dependent; or
- An employee whose Dependent becomes eligible for a Premium assistance subsidy under Medicaid or CHIP program may enroll this Dependent in the Plan, as long as the Dependent meets all other Plan requirements and is enrolled within 60 days from the date of the applicable event. If enrollment of the Dependent is conditioned on enrollment of the employee, the employee will also be eligible to enroll.

Your benefit selection changes must be consistent with your change in status.

Termination of Coverage

Coverage under the Harbor Health Plan will terminate for you and your dependents if any of the following occur:

- Your portion of the Premium cost-share is not received timely;
- At midnight on the day in which you lose eligibility to participate in the plan;
- The plan is amended to terminate the coverage of the class of employees to which you belong; or
- A Dependent ceases to meet the plan's definition of a Dependent.

Harbor Health will provide a 30-day grace period for premium payment. If payment is not made within 31 days of the due date, Harbor Health may terminate coverage and you may be held liable for the cost of Covered Health Services received during the grace period.

Your coverage will end on the last day of the calendar month we receive the required notice from the Group to end your coverage. The Group is responsible for notifying you that your coverage has ended. The Group is liable for the premium through the last day of the calendar month.

The coverage of all Members will be terminated if the Plan is terminated in accordance with its terms.

Coverage for a Disabled Dependent

Coverage for an unmarried enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Contract.

We may require you to provide proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year. If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Termination of Coverage – Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 31 days' notice to you that your coverage will end on the date we identify in the notice because you engaged in an act or omission that constituted fraud, or an intentional misrepresentation of a material fact. Any statements made by the Subscriber on the enrollment application are considered representations and not warranties. A statement may not be used in a contest to void, cancel, non-renew or reduce coverage unless it is written in a signed copy which has been furnished to the Subscriber. You may appeal this decision prior to the termination date set forth in the notice. The notice will include information on how to appeal. If you have engaged in an act or omission that constitutes fraud or an intentional misrepresentation of material fact, we may demand that you pay back all amounts we paid to you, or paid in your name, while coverage was incorrectly effective.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Plan ends will not end your coverage automatically. We will extend the coverage only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- Ninety days.
- The Total Disability ends.

Coverage will not be extended by this provision if your coverage is being discontinued and replaced with coverage that is provided by a Succeeding Carrier and the coverage provides a level of benefits that is at least substantially equal to the level of benefits provided under this plan.

Continuation of Employer's Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by Congress provides that when Members (Employees and their Dependents) lose their eligibility for health coverage due to any of the events listed below, they may elect to continue their health plan coverage. The continued coverage can remain in for a maximum period of either 18, 29 or 36 months depending on the reason that eligibility for health plan coverage terminated.

You may qualify for an 18-month continuation of coverage if the loss of eligibility is as a result of:

- Reduction of employee work hours; or

- Employee retirement or termination of employment (voluntary or involuntary), except for termination for misconduct.

You may qualify for a 29-month continuation of coverage if the loss of eligibility is as a result of:

- The continuation period can be extended when any Member is determined by the Social Security Administration to be disabled at any time during the first 60 days following election of COBRA and able to supply documentation of prior proof to the end of the original 18-month eligibility period.

Note: The extension will not be granted if documentation of disability by the Social Security Administration is not provided during the initial 18-month eligibility period.

You may qualify for a 36-month continuation of coverage period if the loss of eligibility is as a result of:

- Death of the employee;
- Divorce or legal separation from the employee;
- Medicare eligible employee (employee becomes eligible for Medicare, leaving dependents without coverage); or
- Children who lose coverage due to eligibility requirements.

Eligibility for Continuation of Coverage
Members (employees and Dependents) covered by the Plan at the time of the qualifying event are qualified beneficiaries and are eligible for continuation of coverage. Each may make an independent COBRA election. A child born or adopted by the employee during COBRA coverage is also eligible to be a qualified COBRA Member upon timely application.

How You Can Elect COBRA Continuation Coverage
Your Employer (or their designated COBRA Administrator) will provide you with a COBRA eligibility package after your loss of coverage.

- If the qualifying event is for either a divorce of an employee or a child becoming ineligible for coverage, the Member's losing coverage should notify the employer. Then the notice will be sent to either the spouse, domestic partner or child who is losing coverage.
- If the event is due to an employee's death, Medicare eligibility, or termination of employment (or reduction of hours), the notice will be sent to eligible Members.

Eligible Members have 60 days to give written notice to the employer of their desire to continue coverage. The notice must include the names of covered individuals and the reason for and date of the qualifying event.

Initial Payment
When electing continuation coverage, you are not required to remit any payment with the election. You have 45 days from the date of election (post-mark date if mailed) to remit your initial

payment. Benefits will be reinstated back to the date of termination from the plan after the payment has been received and processed. You will need to make sure that the payment amount is correct. If you have any questions regarding the amount and how to make the payment, please contact the employer or the designated COBRA Administrator.

Note: If payment is not received within the 45 days from your election date, you will not be eligible to continue coverage under the Plan.

Continuing Monthly Payments
After you have made your first payment, you will be required to make payments for each month. Payments are due on the first day of the month with a 30-day grace period. If the payment is not received by the due date, the coverage will be suspended, and benefits may not be accessible during this time until payment is received. If the payment is received prior to the end of the grace period, coverage will be reinstated once payment has been processed.

If you fail to make the full payment before the end of the grace period, you will lose all rights to continuation of coverage under the Plan.

Termination of Continuation of Coverage:
A service fee of 2% of the Premium rate for Members is added to the Premium and is payable by the continued Member. An extra Premium of 50% may be added to the Premium for Members who extend coverage from 18 months to 29 months due to disability. You are responsible for the full Premium amount.

If you have any questions, please contact the Employer. The Member's continuation of coverage will terminate if any of the following occurs:

- The maximum qualifying time period expires;
- A continued Member obtains coverage after the date of election under any other health plan which does not contain an applicable exclusion for any pre-existing condition for the Member;
- A continued Member becomes covered by any Medicare benefits after the date of the election;
- The Employer no longer provides health coverage from Harbor Health for their employees; or
- The required payment to continue coverage is not made on a timely basis.

A Member on Continuation Coverage may also be terminated for fraud or intentional misrepresentation of material fact to the same extent the coverage for a similarly situated non-continued Member could be terminated.

Benefits for a Member on Continuation Coverage will be the same as those for active Members. Premium rates will be based upon the Employer's rates for an active employee and Dependents. If the employer receives changes to their benefits or rates during the continuation period, the continued Member will receive the new benefits and the new rates will apply.

If continuation of coverage is not elected, your Plan coverage will end the last day in which you were eligible and enrolled.

Continuation of Coverage Under State of Texas Law

You may elect State Continuation as described under the State of Texas Continuation Coverage provisions below.

Qualifying Events for State of Texas Continuation Coverage for Reasons other than Severance of the Family Relationship

A Member whose coverage terminates due to any reason except involuntary termination for cause, and who has been continuously covered under the plan (including any similar group coverage the plan replaced) for at least three consecutive months immediately prior to termination, is entitled to continue coverage under state law. A person whose coverage terminates due to severance of the family relationship may either continue coverage as described immediately below, or if the person meets the requirements described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship* may continue coverage as described there.

Notification Requirements, Election Period and Premium Payment for State of Texas Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

The Member must provide a written request for Continuation Coverage to the plan administrator within 60 days after the later of:

- The date Group coverage would otherwise terminate
- The date the Member is given notice of the right to elect continuation.

The Member must pay the Premium for the continuation coverage to the Employer within 45 days after the date of the initial election of coverage continuation and then on a monthly basis no later than the 30th day after the Premium payment due date.

Terminating Events for State of Texas Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

State of Texas Continuation Coverage due to reasons other than severance of the family relationship will end on the earliest of:

- Nine months from the date state continuation coverage was elected, if the Member is not eligible for Continuation of Coverage under Federal Law (COBRA)
- Six months from the date state continuation coverage was elected, if the state continuation coverage followed continuation coverage under Federal law (COBRA).
- The date coverage ends for failure to make timely payment of the Premium.
- The date the group coverage terminates in its entirety.
- The date the Member is or could be covered under Medicare.
- The date the Member is covered for similar benefits by another plan or program.
- The date the Member is eligible for similar benefits under another plan.

Qualifying Events for State of Texas Continuation Coverage Due to Severance of the Family

Relationship
A Member whose coverage terminates may elect state continuation coverage under the plan if:

- The Member has been covered under the plan for at least one year, or is an infant under one year of age.
- The Member's coverage under the plan was terminated for one of the reasons set forth below.
- Termination of the eligible Member from employment.
- Death, Divorce, or Retirement that severed the family relationship or terminated eligibility for a Dependent.

Notification Requirements, Election Period and Premium Payment for State of Texas Continuation Coverage Due to Severance of the Family Relationship
A Member must provide written notice to the Group within 15 days of any severance of the family relationship that might qualify for the continuation - see *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*. The Member will immediately give written notice of the right to state continuation. Within 60 days of severance of the family relationship or a retirement that impacts a Member's eligibility as a Dependent, the Dependent must give written notice to the Subscriber of the intent to continue the coverage through state continuation. Coverage under the plan will remain in place during the 60-day election period if the necessary Premium is paid. The Member must pay the monthly Premium for the coverage continuation to the employer each month. To avoid termination, the monthly continuation Premium must be paid on or before the 30th day after the due date.

Termination Events for State of Texas Continuation Coverage Due to Severance of the Family Relationship
State of Texas Continuation Coverage due to severance of the family relationship will end on the earliest of the following dates:

- Three years from the date that the family relationship was severed or the date of the eligible Member losing eligibility due to death or retirement.
- The date the continued Member fails to timely pay the required Premium.
- The date the continued Member becomes eligible for substantially similar coverage under another health insurance policy or health plan, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program.

Section 8: Glossary of Terms

Accidental Injury means accidental bodily injury resulting, directly or independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

ADL (Activities of Daily Living) means the tasks of everyday living. Basic ADLs include eating, dressing, getting into and out of bed or chair, taking a bath or shower, and using the toilet.

Adverse Determination means a determination by a utilization review agent that health care services provided or proposed to be provided to a Member are not Medically Necessary or appropriate or are Experimental or Investigational Services. This term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605.*

Allowed Amounts means the maximum amount determined by Harbor Health to be eligible for consideration of payment for a particular service, supply or procedure rendered by a Network Provider. The Allowed Amount is based on the provisions of the Network Provider's contract and the payment methodology in effect on the date of service, whether diagnostic related grouping (DRG), capitation, relative value, fee schedule, per diem or other.

Alternate Facility is a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance Use Disorder Services on an outpatient or inpatient basis, and includes a Crisis Stabilization Unit, a Psychiatric Day Treatment Facility, a Mental Health Care Center, and a Residential Treatment Center for Children and Adolescents.

Amendment is any attached written description or added or changed provisions to the Contract. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Contract, except for those that are specifically amended.

Ancillary Services are items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Emergency care.
- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
- Provided by assistant surgeons, hospitalists, and intensivists.
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by state or federal law.
- Provided by such other specialty practitioners as determined by state or federal law.
- Provided by an out-of-Network Physician when no other Network Physician is available.

Anniversary Date means the yearly return of the Employer's Annual Effective Date.

Annual Open Enrollment Period means an annual thirty-one (31) day period, beginning no less than thirty (30) days prior to the Anniversary Date of the Employer's health benefits program, during which:

- If the Employer has established and maintained more than one Plan for their Eligible Employees, an Eligible Employee who had elected another Plan, and maintained coverage under that Plan up to the beginning of the Annual Open Enrollment Period, can change to this Employer Contract.
- Eligible employees who decided not to enroll themselves and/or their Eligible Dependents for coverage under the Employer Contract during the Initial or Special Enrollment Periods can enroll.

Assisted Living Facility is a facility regulated by *Chapter 247 of the Health and Safety Code*.

Autism Spectrum Disorder is a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests, or activities and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association.* This includes conditions present in the ICD such as autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Basic Health Care Services means health care services that the Texas Commissioner determines an enrolled population might reasonably need to be maintained in good health.

Behavioral Health Practitioner - means a Physician or a Provider who renders services for Mental Health Care, Serious Mental Illness or Substance Use Disorder.

Benefits are your right to payment for Covered Health Services that are available under the Contract.

Breast Tomosynthesis is a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to product cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnosis may be determined.

Calendar Year means the period beginning on the original effective date of this Plan and ending on December 31 of that year. For each following year it is the period beginning on January 1 and

ending on December 31.

Cellular Therapy is the administration of living whole cells into a patient for the treatment of disease.

Chemical Dependency is the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance. For the purposes of this definition, "controlled substance" means an abusable volatile chemical, as defined by *Section 485.001, Health and Safety Code*, or a substance designated as a controlled substance under *Chapter 481, Health and Safety Code*.

Child means a natural child, a stepchild, an adopted child (including a child for whom you or your spouse or domestic partner is a party in a suit in which the adoption of the child is sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors. A child not listed above whose primary residence is your household and to whom you are legal guardian or related by blood or marriage and who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States, is also considered a Dependent Child under the Plan.

Clinical Appeal means a request to change an Adverse Determination for care or services that were denied on the basis of lack of medical necessity, or when services are determined to be Experimental or Investigational Services or cosmetic. The request may be pre-service or post-service. Review is conducted by a Physician. Members or their authorized representatives may file a Clinical Appeal. Providers may also file a clinical appeal on the Member's behalf.

Clinical Trials means an experimental or investigational research study performed to evaluate a new medical treatment prior to FDA approval.

Complications of Pregnancy means: (a) conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and (b) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Contract is the entire agreement issued to the Employer that includes all of the following:

- Group Contract
- Evidence of Coverage
- Schedule of Benefits
- Employer Application
- Enrollment Application
- Riders
- Amendments

These documents make up the entire agreement that is issued to the Employer.

Contract Charge is the sum of the Premiums for all Members enrolled under the Contract. We have the right to change rates with a 60 day written notice to the contract holder as outlined in the *Group Contract*.

Coordinated Home Care means organized skilled intermittent patient care initiated by a hospital or other inpatient facility to facilitate the discharge and planning of its patients into home care under the orders of a qualified Physician.

Copay (Copayment) means the charge, as stated as a set dollar amount or a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services. The Copayments are indicated in the *Schedule of Benefits*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The Copayment
- The Allowed Amount or the Recognized Amount when applicable.

Cosmetic Procedures are procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Services or Covered Services means those medical and health care services and items specified and defined in the *Evidence of Coverage* as being covered services but only when such services and items are Medically Necessary and when they are performed, prescribed, directed, or authorized in accordance with our policies and procedures and this *Evidence of Coverage*.

Crisis Intervention means a short-term process which provides intensive supervision and highly structured activities to the Member who is demonstrating an acute medical or psychiatric crisis of severe proportions, which substantially impairs the Member's thoughts, perception of reality, and judgment, or which grossly impairs behavior.

Crisis Stabilization Unit or Facility means a 24-hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Cryotherapy (or cold therapy) means the treatment of pain and/or inflammation by lowering the temperature of the skin over the affected area.

Custodial Care are services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the

patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test is a test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent means your spouse, Domestic Partner, or any child covered under the Plan. For purposes of this Plan, the term Dependent will also include those individuals who no longer meet the definition of a Dependent but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Texas Insurance Code and who has become enrolled as a Member of Harbor Health.

Designated Dispensing Entity is a pharmacy, Provider, or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, Providers, or facilities are Designated Dispensing Entities.

Diabetic Supplies and Equipment means equipment and supplies for the treatment of diabetes for which a Physician or Provider has written an order, including blood glucose monitors, including those designed to be used by or adapted for the legally blind; test strips specified for use with a corresponding glucose monitor; lancets and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated appurtenances, which include insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; and other required disposable supplies; repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump; prescription medications for controlling the blood sugar level; podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered after the previous device's life expectancy fails or fails due to no fault of the Member if determined to be Medically Necessary and appropriate by a treating Physician or other Provider through a written order. All supplies, including medications, and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitution is approved by the Physician or Provider who issues the written order for the supplies or equipment.

Diabetic Self-Management Training means training including (i) training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Supplies; (ii) additional training authorized on the diagnosis of a significant change in your symptoms or condition that requires changes to your self-management regime; and (iii) periodic or episodic continuing education training as warranted by the development of new techniques and

treatments for diabetes.

Digital Mammography means Mammography creating breast images that are stored as digital pictures.

Domestic Partner means a person who is not married to the enrolled employee but is in a committed relationship and plans to remain in the relationship. The Domestic Partner must be 18 years of age and reside with the member. The Domestic Partner may be the same or opposite gender of the Member.

Domestic Partnership is a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
    - They have a single dedicated relationship of at least 6 months.
    - They have joint ownership of a residence.
    - They have at least two of the following:
        - A joint ownership of an automobile.
        - A joint checking, bank or investment account.
        - A joint credit account.
        - A lease for a residence identifying both partners as tenants.
        - A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Effective Date means the date on which coverage begins for you and your Dependents if they are enrolled in the Plan.

Eligible Employee means an employee of the Group or other person connected to the Group who meets eligibility requirements shown in both the Group's application and the Contract. An Eligible Employee must reside, live and/or work within the Geographic Service Area.

Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member (or, with respect to a pregnant woman, the health of the woman or her fetus) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.

Emergency Health Care Services with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C.1395dd(e)(3)).
- Emergency Health Care Services include items and services otherwise covered under the Contract when provided by an out-of-Network Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay that is connected to the original Emergency, unless each of the following conditions are met:

  a. The attending Emergency Physician or treating Provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
  b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  c. The patient is in such a condition to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
  d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
  e. Any other conditions as specified by state or federal law.

  The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria have been satisfied.

Employer means the employer with 51 or more Employees who signed the Employer Application with Harbor Health, allowing this Employer's coverage to be provided.

Enrollment Application means the form prescribed by Harbor Health which the Member is required to complete and submit to the Employer for the purpose of enrolling them and any eligible Dependents for coverage hereunder.

Experimental or Investigational Services are medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA-approved under the Humanitarian Use Device exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in *Section 2: What Your Plan Covers*.
- We may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described under Clinical Trials in *Section 2: What Your Plan Covers*; and
    - You have a sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

Facility means a health care or Residential Treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization, or outpatient care.

Family means you and your Dependents who are covered under this Plan.

Freestanding Emergency Medical Care Facility means a facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care, as defined under Chapter 254, Health and Safety Code.

Gene Therapy is the therapeutic delivery of nucleic acid (DNA or RNA) into a Member's cells as a drug to treat a disease.

Genetic Counseling is counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and Physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing is an exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

We do not use genetic information, or the refusal of a Member to submit to a genetic test, to reject, deny, limit, cancel, refuse to renew, increase premiums for, or otherwise adversely affect eligibility for or coverage under the plan.

Gender Dysphoria means the feeling of discomfort or distress that occurs when gender identity differs from the gender assigned at birth.

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

- Hays
- Travis
- Williamson

For a list of up-to-date Harbor Health Physicians and health care Providers, you can access information by visiting our online Provider Directory at www.harborhealth.com. If you would like additional information pertaining to our contracted Providers, you can call us at the telephone number on your ID Card.

Home Health Care means the skilled health care services that are provided during a visit by a Home Health Agency to Members confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is: (1) Licensed in accordance with state law; or (2) Certified by Medicare as a supplier of Hospice Care.

Hospital means an acute care institution licensed by the State of Texas as a Hospital, and is accredited under the Joint Commission which is primarily engaged, on an inpatient basis, in providing medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, under supervision of a staff of Physicians and with 24-hour a day nursing

and Physician service; provided, however, it does not include a nursing home or any institution or part thereof which is used principally as a custodial facility.

Iatrogenic Infertility – an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Identification Card (ID Card) means the card issued to Harbor Health Members indicating pertinent information applicable to their coverage. This card should be presented to your healthcare Provider at time of service.

Imaging Center means a Provider that can furnish technical services with respect to diagnostic imaging services and is licensed by an agency of the State of Texas having legal authority to license, certify and approve.

Imaging Services including, but not limited to, CT Scan; MRI (Magnetic Resonance Imaging); PET Scan (Positron Emission Tomography).

Independent Freestanding Emergency Department is a healthcare facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Care Services.

Independent Review Organization (IRO) means an organization selected to review your medical care and benefit determination as provided under the Texas Insurance Code (also known as an IMR - Independent Medical Review).

Inpatient Rehabilitation Facility is any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - is a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Program means a freestanding or hospital-based program that provides services in a facility for a few days per week, for few hours per day, to treat Mental Illness, drug addiction, substance abuse or alcoholism, or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder.

Life-Threatening means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Low-dose Mammography includes:

- The x-ray exam of the breast using equipment dedication specifically for mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than on rad mid-breast and with two views for each breast.
- Digital mammography.
- Breast Tomosynthesis.

Maternity Care means care, and services provided for treatment of the condition of pregnancy.

Medical Director means an accredited Physician designated by Harbor Health to monitor appropriate provision of Medically Necessary Covered Health Services to Members in accordance with the Plan.

Medical Injectables means any medication that is infused via intravenous infusion (IV), injected intramuscularly (IM), where medical supervision is required, or must be administered at the point of care (i.e.: Dialysis Centers).

Medical Expenses means the Allowed Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Member, provided such items are:

- Furnished by or at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the discretion of a Physician, Behavioral Health Practitioner or Provider if the listed service or supply is:

- Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Provider;
- Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Provider; and
- Billed by the directing Physician, Behavioral Health Practitioner or Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medical Order means one or more diagnostic or treatment directives (such as lab, diagnostic tests, physical therapy, home care) generated by a Provider that describes the specific activities to be performed or delivered as part of a diagnostic or therapeutic regimen of a Member.

Medically Necessary/Medical Necessity means the health care services or procedures that a prudent Physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating Physician, or other health care Provider; and (d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. No service is a Covered Health Service unless it is Medically Necessary.

Medicare means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or subsequently amended.

Member means a person who has enrolled in Harbor Health as an Employee or Dependent and is eligible to receive Covered Health Services. This person sometimes is also referred to as a Participant or Enrollee.

Mental Health Care Center – a tax supported institution of the State of Texas, including community centers for mental health and intellectual disability services.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Illness means those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases* section on the *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on the *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Intensive Care Unit (NICU) means a special care nursery or intensive care nursery. Admission into NICU generally occurs but is not limited to when the newborn is born prematurely, if difficulty occurs during delivery, or the newborn shows signs of a medical problem after the delivery.

Network means identified Physician, Behavioral Health Practitioner, professional other Providers, Hospitals, pharmacies, and other facilities that have entered into agreements with Harbor Health as a network contracted Provider or facility.

Network Provider means a Hospital, Physician, Behavioral Health Practitioner, pharmacy, or other Provider who has entered into an agreement with Harbor Health as a Network contracted Provider.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurophysiological Testing means an evaluation of the functions of the nervous system. (i.e. EMG- Electromyography, Intraoperative Neurological Monitoring)

Non-Clinical Appeal means a request to reconsider a previous inquiry, complaint or action by Harbor Health that has not been resolved to the Member's satisfaction. This relates to administrative health care services such as enrollment, access, claim payment, etc. and may be pre-service or post-service. Only Members or their designated representatives may file a non-clinical appeal.

Open Enrollment means the annual period each year in which you can make changes to your Plan benefits.

Organ Transplant means the harvesting of a solid and/or non-solid organ, gland, or tissue from one individual and reintroducing that organ, gland, or tissue into another individual.

Orthotic Device is a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Services provided by out-of-Network providers. Plans under this *Evidence of Coverage* do not provide coverage for services provided by out-of-Network providers with the exception of Covered Health Services provided:

- In an Emergency.
- By out-of-Network radiologists, anesthesiologists, pathologists, neonatologists, assistant surgeons, hospitalists, and intensivists, diagnostic imaging providers and laboratory service providers when confined in a Network facility.
- As pre-authorized by us to be subsequently provided by an out-of-Network Physician, facility or other Provider.

If you receive a bill from an out-of-Network provider after Covered Health Services were received in one of the above situations, you should contact us and we will work with the Provider so that you are only responsible for your cost share amount.

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

Palliative Care means specialized medical care focused to provide relief from the symptoms and

illness with the goal of improving the quality of life for a patient with chronic, complex, or terminal illnesses.

Partial Hospitalization / Day Treatment / High Intensity Outpatient is a structured ambulatory program. The program may be freestanding or hospital-based and provides services for at least 20 hours per week.

Pharmaceutical Product(s) are U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician means any person who is duly licensed and qualified to practice within the scope of a medical practice license issued under the laws of the State of Texas or in which state treatment is received. Physicians include a doctor of osteopathic medicine.

Plan, Your Plan, The Plan means the coverage of health care services available to you under the terms of this *Evidence of Coverage*.

Plan Year means the annual period that begins on the anniversary of the Plan's Effective Date. See the *Schedule of Benefits* to determine if Your Plan is administered on a Calendar Year or Contract Year basis.

Post-Acute Care means services provided after acute-care confinement and/or treatment that are based on an assessment of the patient's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Premium is the periodic fee required for each Eligible Employee and each enrolled Dependent, in accordance with the terms of the Contract.

Primary Care Physician is a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. This includes physician assistants and nurse practitioners who are employed by the Primary Care Physician practice.

Pre-Authorization means the review of the requested services for the medical appropriateness in advance of certain care and services under this Plan.

Presumptive Drug Test is a test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Prosthetics means prescribed devices meant to replace, wholly or partly, a lost limb or body part, such as an arm or a leg. Covered Health Benefits may be limited to the appropriate model of prosthetic device that adequately meets the medical needs of the Member as determined by the Member's Physician.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Provider, or any other

person, company or institution furnishing to a Member an item of service, supply or drug covered by the Harbor Health Plan.

Psychiatric Day Treatment Facility is a mental health care facility that provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program, utilizing individualized treatment plans with specific attainable goals and objectives that are appropriate both to the patient and to the treatment modality of the program. The facility must be clinically supervised by a *Doctor of Medicine* who is certified in psychiatry by the *American Board of Psychiatry and Neurology.*

Recognized Amount – the amount for which the Copayment is based on for the below Covered Health Services when provided by out-of-Network Providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by state or federal law.

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the Provider or facility.

The Recognized Amount for Air Ambulance services provided by an out-of-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based up an Allowed Amount.

Referrals are used by Providers to send you to a specialty Provider (such as a cardiologist or neurologist) to further evaluate and/or treat certain conditions.

Remediation means the process(es) of restoring or improving a specific function.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which

progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment is treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.
- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Residential Treatment Center for Children and Adolescents is a child-care institution that is both of the following:

- Provides residential care and treatment for emotionally disturbed children and adolescents.
- Accredited as a Residential Treatment center by:
    - *The Council of Accreditation.*
    - *The Joint Commission on Accreditation of Hospitals.*
    - *The American Association of Psychiatric Services for Children.*

Rider is any attached written description of additional Covered Health Services not described in this *EOC*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Contract except for those that are specifically amended in the Rider.

Service Area is the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Self-Injectables mean any medication that is injected subcutaneously or specifically designed and generally accepted to be self-injected and does not require direct medical professional oversight.

Serious Mental Illness - the following psychiatric illnesses as defined in the current *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*:

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomanic, manic, depressive, and mixed).

- Major depressive disorders (single episode or recurrent).
- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

Skilled Care is skilled nursing, skilled teaching, skilled habilitation, and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility means an institution which:

- Is accredited under one program of the Joint Commission as a Skilled Nursing Facility or is recognized by Medicare as an Extended Care Facility:
- Is not a Rehabilitation Facility;
- Furnishes room and board and 24 hour-a-day skilled nursing care by, or under the supervision of a registered nurse (RN); and
- Is not a clinic, rest Facility, home for the aged, place for drug addicts or alcoholics, or a place for Custodial Care.

Special Enrollment Period means an enrollment period that is provided for employees and/or their dependents due to special circumstances as described in the Special Enrollment provision.

Specialist - is a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Pharmaceutical Product - Pharmaceutical Products that are general high cost, biotechnology drugs used to treat patients with certain illnesses.

Substance Use Disorder Services are services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Succeeding Carrier means a carrier that replaces the health benefit plan coverage provided by another carrier with its own health benefit plan coverage.

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 means a synchronous, interactive office visit with your provider through the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone. Health care services will not be excluded based solely on the fact that they were provided through telemedicine and not provided through a face-to-face consultation.

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.

Total Disability (Totally Disabled) means the complete inability of that individual to perform all of the substantial and material duties and functions of the individual's occupation and any other gainful occupation in which the individual earns substantially the same compensation earned before the disability; and with respect to any other individual covered under a health plan, confinement as a bed patient in a hospital.

Ultrasound, Breast means a procedure that may be used to determine whether a lump is a cyst or a solid mass.

Unproven Service(s) are services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature.

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.

- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

Us, We or Our means Harbor Health.

Utilization Review means a system for prospective and/or concurrent review of the Medical Necessity and appropriateness of Covered Health Services your Provider is currently providing or proposes to provide to you. Utilization Review does not include elective requests by you for clarification of coverage. The Utilization Review provides:

- Pre-treatment Review;
- Concurrent Review;
- Discharge Planning; and
- Retrospective Review

Urgent Care Center is a facility that provides Covered Health Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen sickness, injury or the onset of sudden or severe symptoms.

Waiting Period means the period, if any, that must pass with respect to an individual before the individual is eligible to be covered for benefits under the Harbor Health Plan.

You or Your means a covered Member.

Section 9: Notices

TEXAS NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or Benefits provided by your Contract with Harbor Health Plan.

Please note that the Benefits specified below are subject to all terms, conditions, exclusions and limitations stated in your Contract, including, but not limited to, Pre-Authorization requirements, and cost share amounts.

Examinations for Detection of Prostate Cancer
Benefits are provided for each male Texas resident who is a Member for an annual medically recognized diagnostic examination for the detection of prostate cancer. Covered expenses include:

A. A physical examination for the detection of prostate cancer; and
B. A prostate-specific antigen test for each male Member who is:
   - At least 50 years of age; or
   - At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call Harbor Health at the telephone number on your ID Card or write us at P.O. Box 211262, Eagan, MN 55121. You may also visit our website at www.harborhealth.com.

Inpatient Stay Following Birth of a Child
For each person covered for maternity/childbirth Benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

A. 48 hours following an uncomplicated vaginal delivery, and
B. 96 hours following an uncomplicated delivery by cesarean section.

This Benefit does not require a covered female who is eligible for maternity/childbirth Benefits to give birth in a hospital or other health care facility or remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse or other appropriate licensed health care Provider, and the mother will have the option of receiving the care at her home, the health care Provider's office or a health care facility.

Prohibitions: We may not

A. Modify the terms of this coverage based on any Member requesting less than the minimum coverage required;
B. Offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
C. Refuse to accept a Physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
D. Reduce payments or reimbursements below the usual and customary rate; or
E. Penalize a Physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered under this plan has questions concerning the above, please call Harbor Health at the telephone number on your ID Card or write us at P.O. Box 211262, Eagan, MN 55121. You may also visit our website at www.harborhealth.com.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment
Coverage and/or Benefits are provided to each Covered Person for reconstructive surgery after mastectomy, including:

A. All stages of the reconstruction of the breast on which mastectomy has been performed;
B. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
C. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or Benefits must be provided in a manner determined to be appropriate in consultation with the Member and the attending Physician.

Refer to the *Schedule of Benefits* for specific cost shares applicable to the coverage and/or Benefits, which may not be greater than the cost shares applicable to other coverage and/or Benefits under the health benefit plan.

Prohibitions: We may not:

A. Offer the Member a financial incentive to forego breast reconstruction or waive the coverage and/or Benefits shown above;
B. Condition, limit, or deny any Member's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or Benefits shown above; or
C. Reduce or limit the amount paid to the Physician or Provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or Provider to provide care to a covered person in a manner inconsistent with the coverage and/or Benefits shown above.

If any person covered under this plan has questions concerning the above, please call Harbor Health at the telephone number on your ID Card or write us at P.O. Box 211262, Eagan, MN 55121. You may also visit our website at www.harborhealth.com.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual
Your Contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered under this plan has questions concerning the above, please call Harbor Health at the telephone number on your ID Card or write us at P.O. Box 211262, Eagan, MN 55121. You may also visit our website at www.harborhealth.com.

Mastecomy or Lymph Node Dissection
Benefits are covered under your health Contract for covered expenses related to mastectomy following diagnosis of breast cancer for:

A. Reconstruction of the breast on which the mastectomy has been performed;
B. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
C. Prostheses and treatment of physical complication, including lymphedemas.

If, due to treatment of breast cancer, any female Texas resident who is a Member under your Contract has either a mastectomy or a lymph node dissection, the Contract will provide coverage for inpatient care for a minimum of:

A. 48 hours following a mastectomy; and
B. 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not:

A. Deny any Member's eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
B. Provide money payments or rebates to encourage any Member to accept less than the minimum inpatient hours;
C. Reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a Member to receive the minimum inpatient hours; or
D. Provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

If any person covered under this plan has questions concerning the above, please call Harbor Health at the telephone number on your ID Card or write us at P.O. Box 211262, Eagan, MN 55121. You may also visit our website at www.harborhealth.com.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Covered expenses also include:

A. A CA 125 blood test, or any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer; and
B. A conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered under this plan has questions concerning the above, please call Harbor Health at the telephone number on your ID Card or write us at P.O. Box 211262, Eagan, MN 55121. You may also visit our website at www.harborhealth.com.

Testing for the Detection of Colorectal Cancer
Benefits are provided, for each Member who is 45 years of age or older and at normal risk for developing colon cancer, for a medically recognized screening examination for the detection of colorectal cancer. Covered expenses include:

A. All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of “A” or “B” by the *United States Preventive Services Task Force* for average-risk individuals, including the services that may be assigned a grade of “A” or “B” in the future; and
B. An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

If any person covered under this plan has questions concerning the above, please call Harbor Health at the telephone number on your ID Card or write us at P.O. Box 211262, Eagan, MN 55121. You may also visit our website at www.harborhealth.com.

Disclosure of Provider Status

As required by Chapter 1456 of the Texas Insurance Code, this notice provides information regarding the status of Providers.

All facility-based Physicians, diagnostic imaging, laboratory services or other health care practitioners at contracted health care facilities may not be contracted with Harbor Health. Facility-based Physicians include radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, or assistant surgeons. A health care facility includes a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility that provides health care services.

In these situations, the out-of-Network facility-based Physician or other health care practitioners may balance bill you for amounts not paid by your health plan, unless balance billing for those services is prohibited.

If you receive a balance bill, you should call Harbor Health at the telephone number on your ID card.

Should you have a complaint regarding payments of health care services, you may contact the *Texas Department of Insurance Consumer Protection Division* at 1-800-252-3439 or email ConsumerProtection@tdi.texas.gov.

NOTICE: ALTHOUGH HEALTH CARE SERVICES MAY BE OR MAY HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU WILL ONLY BE RESPONSIBLE FOR ANY APPLICABLE COST SHARE FOR THOSE PROFESSIONAL SERVICES.

Texas Notice of Rights

- A health maintenance organization (HMO) plan provides no Benefits for services you receive form out-of-Network Physicians or Providers, with specific exceptions as described in your *Evidence of Coverage* and below.

- You have the right to an adequate Network of Physicians and Providers (known as Network Physicians and Providers).

- If you believe that the Network is inadequate, you may file a complaint with the Texas Department of Insurance at www.tdi.texas.gov/consumer/complfrm.html.

- If your HMO approves a referral for out-of-Network services because no Network Physician or Provider is available, or if you have received out-of-Network emergency care, the HMO must, in most cases, resolve the out-of-Network Physician's or Provider's bill so that you only have to pay any applicable Network cost share.

- You may obtain a current directory of Network Physicians and Providers at www.harborhealth.com or by calling the telephone number on your ID Card for assistance in finding available Network Physicians and Providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-Network Physician or Provider paid as if it were from a Network Physician or Provider, if you present a copy of the inaccurate directory information to the HMO dated not more than 30 days before you received the service.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-252-3439

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-252-3439

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

Schedule of Benefits
Harbor Health Plan

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in Evidence of Coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated benefits are excluded in this Evidence of Coverage.

How Your Plan Works

This plan is a Health Maintenance Organization health care plan and 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.

You can select a Network Primary Care Physician, or PCP, but it is not required to obtain Benefits. A Network Primary Care Physician will be able to coordinate all Covered Health Services you may require and submit Referrals online to Harbor Health for services from other Network Providers. If you are the custodial parent of a Dependent child, you can select a Network Primary Care Physician for that child.

You may designate a Network Physician who specializes in pediatrics as the Network Primary Care Physician for an enrolled Dependent child. For obstetrical or gynecological care, you do not need a Referral from a Network Primary Care Physician and may seek care directly from any Network Physician who specializes primarily in obstetrics or gynecology.

You can get a list of Network Primary Care Physicians, Network obstetricians and gynecologists and other Network Providers through www.harborhealth.com or by calling the telephone number on your ID Card.

If you have a chronic, disabling, or life-threatening illness, you may apply to our medical director through the Pre-Authorization process to use a non-Primary Care Physician Specialist as a Primary Care Physician.

You must reside, live or work within the Geographic Service Area. You must show your ID Card every time you request health care services from a Network provider. If you do not show your ID Card, Network Providers have no way of knowing that you are enrolled under a Harbor Health Contract. As a result, they may bill you for the entire cost of the service you receive.

Harbor encourages you to establish a relationship with a Network Primary Care Physician. If care from another Network Provider is needed, you are not required to obtain a Referral from

your Primary Care Physician. You can see any Network Provider who participates in the 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. 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. If you follow the agreed upon next steps and obtain a Referral or Medical Order from your Primary Care Physician, you will be responsible for a lower cost share for certain services. If you do not obtain a Referral or Medical Order from your Primary Care Physician, you will be responsible for a higher cost share.

Referrals or Medical Orders will indicate a specific Provider and the reason for the Referral or Medical Order. Referrals may also limit the timeframe and/or number of visits the Referral is good for. To be eligible for a reduced cost share for an office visit with a Network Specialist (for example, a cardiologist, orthopedist, neurologist, etc.), you must always obtain a Referral from your Primary Care Physician. Once you've been referred to a Network Specialist by your Primary Care Physician, the Network Specialist can write a Medical Order for certain services, such as lab, diagnostic tests, outpatient rehabilitation, and home care, and you be responsible for a lower cost share.

Cost share responsibility is outlined in the section labeled *Cost Share for Covered Health Services* below.

Note: Certain services require Pre-Authorization, even if you have a Referral to a Network Provider. Refer to the section *Pre-Authorization* below for more information.

Before obtaining services, you should always verify the Network status of a Provider. A Provider's status may change. You can verify the Provider's status by calling the telephone number on your ID Card. A directory of Providers is available by going to www.harborhealth.com or by calling the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network Provider. You might find that a particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to you, you must choose another Network Provider to get Benefits. However, if you are currently receiving treatment for Covered Health Services from a Provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the Provider's contract, you may be eligible to request continued care from your current Provider under the same terms and conditions that would have applied prior to termination of the Provider's contract for specified conditions and timeframes. This provision does not apply to Provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID Card.

If you are currently undergoing a course of treatment using an out-of-Network Provider when you first enroll into the Plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

If specific Covered Health Services are not available from a Network Provider, you may be eligible for Benefits when Covered Health Services are received from out-of-Network Providers. In this situation, your Primary Care Physician will notify us through the Pre-Authorization process and, if we confirm that care is not available from a Network Provider, we will work with you and your Primary Care Physician to coordinate care through an out-of-Network Provider. In this situation you will be responsible for the applicable Network cost share for the service(s) you receive. You should contact us if you receive a bill for anything above this amount.

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.

Please note that requests for Pre-Authorization are required even if you have a Referral submitted online from your Primary Care Physician to seek care from another Network Provider.

We recommend that you confirm with us that all Covered Health Services have been Pre-Authorized as required. Before receiving these services from a Network Provider, you may want to call us to verify that the hospital, Physician and other Providers are Network Providers and that they have obtained the required Pre-Authorization. Network facilities and Network Providers cannot bill you for Covered Health Services they do not Pre-Authorize as required. For more information about the Pre-Authorization process, please refer to *Section 4: Pre-Authorization and Utilization Management* in the *Evidence of Coverage*.

Cost Share for Covered Health Services

The table below summarizes the coverage available to you under the Plan, your cost share responsibility and benefit limitations for Covered Health Services.

Annual Deductible	**Amount**
The amount you pay for Covered Health Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Services under the Contract as indicated in this Schedule of Benefits, including Covered Health Care Services provided under the Outpatient Prescription Drug Rider.	No Annual Deductible
Out-of-Pocket Maximum	**Amount**
The out-of-pocket maximum is the most you pay per plan year for Copayments. Once you reach the out-of-pocket maximum, Benefits are payable at 100% of the Allowed Amount during the rest of the plan year. The out-of-pocket maximum applies to Covered Health	$5,000 per Covered Person, not to exceed $12,500 for all Covered Persons in a family.

Services under the Plan as indicated in this Schedule of Benefits, including Covered Health Services provided under the *Outpatient Prescription Drug Rider*. The out-of-pocket maximum does not include any of the following, and once the out-of-pocket maximum has been reached, you will still be required to pay the following: ● Any charges for non-Covered Health Services. ● Charges that exceed Allowed Amounts, when applicable.	

Copayment
Copayment is the amount you pay (calculated as a set dollar amount or a percentage of the Allowed Amount or Recognized Amount when applicable) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Allowed Amount when applicable.

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
Acquired Brain Injury	
	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Acupuncture	
Limited to 30 visits per plan year. Harbor Health will reimburse you up to $80 per visit, minus your cost share.	20%
Ambulance Services	
Emergency Ambulance	*Ground Ambulance* 20% *Air Ambulance* 20%

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
Non-Emergency Transportation	20%
Cellular and Gene Therapy	
We can help you select a Network transplant Provider for cellular and gene therapy which may be inside or outside your Geographic Service Area. If you are required to travel to obtain such Covered Health Services from a Network transplant provider, you may be eligible for reimbursement of certain travel expenses.	20%
Clinical Trials	
	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Diabetic Management Services	
Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per plan year for the prevention of complications associated with diabetes.	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Diagnostic Services	
Advanced Imaging **Lab Testing – Outpatient**	***With a Referral/Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20% *Genetic Testing, other than BRCA* 20% ***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician***

Covered Health Service Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.	Cost Share
X-ray and Diagnostic Ultrasound - Outpatient	*Allergy Testing* None *All Other Lab Testing, including BRCA* None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** *Allergy Testing* 20% *All Other Lab Testing, including BRCA* 20% ***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20%
All Other Diagnostic Testing - Outpatient	***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20%
Durable Medical Equipment (DME) and Supplies	

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
Note: Returning home with durable medical equipment, such as crutches, after an appointment with a health care provider or from an outpatient procedure or inpatient stay, may result in an additional cost share.	20%
Emergency Care	
If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under Hospital Admissions will apply. You will not have to pay the Emergency Care cost share. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. **Note:** Returning home with durable medical equipment, such as crutches, following an Emergency room visit may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	$500 per visit
Enteral Nutrition	
	$50 up to a 30-day supply
Fertility Preservation for Iatrogenic Infertility	

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
	20%
Habilitative Services	
Inpatient Inpatient services limits will be the same as, and combined with, those stated under Skilled Nursing Facility and Rehabilitation Facility Services. **Outpatient** For the below outpatient therapies, limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Chiropractic: ● Physical therapy. ● Occupational therapy. ● Speech therapy. ● Chiropractic treatment. ● Post-cochlear implant aural therapy. ● Cognitive therapy. Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code. Visit limits do not apply if the primary diagnosis is for a Mental Illness. Note: Returning home with durable medical equipment, such as a walker, following habilitative services may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of*	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. ***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** *Physical Therapy* None *Occupational Therapy* None *Speech Therapy* None *Chiropractic Treatment* None *Post-Cochlear Implant Aural Therapy* None *Cognitive Therapy* None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** *Physical Therapy* 20% *Occupational Therapy* 20% *Speech Therapy* 20%

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
Benefits.	*Chiropractic Treatment* 20% *Post-Cochlear Implant Aural Therapy* 20% *Cognitive Therapy* 20%
Hearing Aids	
Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	20%
Home Health Care	
Limited to 120 visits per year. One visit equals up to four hours of skilled care services. Visit limits above do not apply for the treatment of Mental Illness. In addition to the cost share stated in this section, you will also be responsible for the cost share stated under the *Enteral Nutrition* Benefit for enteral formulas and low protein modified food products. In addition to the cost share stated in this section, you will also be responsible for the cost share stated under the *Pharmaceutical Products – Outpatient* Benefit for pharmaceutical products.	***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20%
Hospice Care	
	Inpatient Hospice Care 20% *Home Hospice Care* ***With a Referral/ Medical Order from your***

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
	Primary Care or from a Specialist you were referred to by your Primary Care Physician None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20%
Hospital Admissions	
Note: Returning home with durable medical equipment, such as crutches, following an inpatient hospital admission may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	20%
Infertility Diagnostic Services	
	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Maternity Care	
Note: Returning home with durable medical equipment, such as a fetal monitor, following an office visit or inpatient admission may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Mental Health Care and Substance Use Disorder Services	
Benefits under this section are provided under the same terms and conditions without quantitative or non-quantitative treatment limitations that are more restrictive as are applicable to medical and surgical treatments. Cost share for procedures performed in an office setting, such as Transcranial Magnetic Stimulation, are subject to the *Outpatient Services* category.	*Inpatient* 20% *Residential Treatment* 20% *Subacute Detoxification Care* 20% ***With a Referral/ Medical Order from your Primary Care or from a Specialist you were***

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
	referred to by your Primary Care Physician *Office Visit – In Person/Telehealth/Telemedicine* None *Outpatient Services* None *Substance Use Disorder Medication Management* None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** *Office Visit – In Person/Telehealth/Telemedicine* None *Outpatient Services* 20% *Substance Use Disorder Medication Management* None
Obesity Surgery	
Benefits are limited to one procedure during the entire period of time a Member is enrolled under the Plan.	*Inpatient* 20% *Outpatient* ***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20%
Oral Surgery	
Note: Returning home with durable medical equipment, such as an oral	Depending on where the Covered Health Service is provided, Benefits will be the same as those

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
appliance, following orthognathic surgery may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	stated under each Covered Health Service category in this *Schedule of Benefits*.
Organ and Tissue Transplants	
We can help you select a Network transplant Provider which may be inside or outside your Geographic Service Area. If you are required to travel to obtain such Covered Health Services from a Network transplant provider, you may be eligible for reimbursement of certain travel expenses.	20%
Orthotics	
	20%
Ostomy Supplies	
	20%
Palliative Care	
Note: Returning home with durable medical equipment, such as a walker, following palliative care may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Pharmaceutical Products – Outpatient	
The following supply limits apply: ● As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits. When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-	20%

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
payment that applies will reflect the number of days dispensed.	
Physician Fees for Surgical and Medical Services	
	20%
Physician's Office Services – Sickness and Injury	
Cost share for the following services also apply when the Covered Health Service is performed as part of an office visit with a Primary Care Physician or Specialist: ● Advanced imaging, lab testing, x-ray and all other diagnostic services described under *Diagnostic Services*. ● Genetic testing described under *Diagnostic Services, Lab Testing – Outpatient* ● Outpatient pharmaceutical products described under *Pharmaceutical Products – Outpatient*. ● Diagnostic and therapeutic scopic procedures described under *Scopic Procedures – Outpatient Diagnostic and Therapeutic*. ● Outpatient surgery procedures described under *Surgery – Outpatient*. ● Outpatient therapeutic procedures described under *Therapeutic Treatments – Outpatient*. ● Rehabilitation therapy procedures described under *Rehabilitation Services – Outpatient Therapy and Chiropractic Treatment*. ● Habilitative therapy services described under *Habilitative*	*Primary Care –In Person/Telehealth/Telemedicine* None ***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** *Specialist – In Person/Telehealth/Telemedicine* None *Allergy Injections* None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** *Specialist – In Person/Telehealth/Telemedicine* 20% *Allergy Injections* 20%

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
Services. Note: Returning home with durable medical equipment, such as crutches, following an office visit may result in an additional cost share. Refer to the *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	
Preventive Care	
Preventive care includes physician office services, lab, x-rays or other tests and breast pumps. Refer to the Preventive Care section of your EOC for more information. Screenings received for diagnostic purposes (as billed by the provider or facility) are not considered to be Preventive Care and may be subject to cost share.	None
Prosthetic Devices	
	20%
Reconstructive Surgery	
Note: Returning home with durable medical equipment, such as walker, following a reconstructive procedure may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Refractive Vision Exams	
Refractive Vision Exams are limited to one visit per Plan year. Harbor Health will reimburse you up to $80 per visit, minus your cost share.	None
Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment	
Limits per year as follows: ● 30 visits of physical therapy.	***With a Referral/ Medical Order from your Primary Care or from a Specialist you were***

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
• 30 visits of occupational therapy. • 30 visits of speech therapy. • 30 visits of Chiropractic Treatment. Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code. Visit limits do not apply if the primary diagnosis is for a Mental Illness. Note: Returning home with durable medical equipment, such as a walker, following rehabilitation therapy may result in an additional cost share. Refer to the *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	***referred to by your Primary Care Physician*** *Physical Therapy* None *Occupational Therapy* None *Speech Therapy* None *Chiropractic Treatment* None *Pulmonary Rehabilitation Therapy* None *Cardiac Rehabilitation Therapy* None *Post-Cochlear Implant Aural Therapy* None *Cognitive Therapy* None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** *Physical Therapy* 20% *Occupational Therapy* 20% *Speech Therapy* 20% *Chiropractic Treatment* 20% *Pulmonary Rehabilitation Therapy*

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
	20% *Cardiac Rehabilitation Therapy* 20% *Post-Cochlear Implant Aural Therapy* 20% *Cognitive Therapy* 20%
Scopic Procedures – Outpatient Diagnostic and Therapeutic	
	With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician None ***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20%
Skilled Nursing Facility and Rehabilitation Facility Services	
Limited to 120 days per year. Note: Returning home with Durable Medical Equipment, such as a walker, following an admission may result in an additional cost share. Refer to the *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	20%
Surgery - Outpatient	
Note: Returning home with durable medical equipment, such as crutches, following outpatient surgery may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of*	***With a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** None

Covered Health Service **Note: Benefit limits listed below are calculated on a plan year basis unless otherwise specifically stated.**	Cost Share
Benefits.	***Without a Referral/ Medical Order from your Primary Care or from a Specialist you were referred to by your Primary Care Physician*** 20%
Telehealth, Telemedicine and Teledentistry Services	
	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Temporomandibular Joint (TMJ) Services	
	Depending on where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.
Therapeutic Treatments - Outpatient	
	20%
Urgent Care	
Note: Returning home with durable medical equipment, such as crutches, following an urgent care visit may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	*Harbor Health Express Care* None *All Other Urgent Care Clinics* $80 per visit
Wigs	
Limited to two wigs per Plan Year, for a total of $500 for each wig.	20%

Consolidation Appropriations Act Summary

The Plan complies with the applicable provisions of the Consolidation Appropriations Act (the "Act")(P.L. 116-260).

No Surprises Act

Balance Billing

Under the Act, the No Surprises Act prohibits balance billing by out-of-Network Providers in the following instances:

- When Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- When non-Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied.
- When Emergency Health Care Services are provided by an out-of-Network Provider.
- When Air Ambulance services are provided by an out-of-Network Provider.

In these instances, the out-of-Network Provider may not bill you for amounts in excess of your applicable cost share. Your cost share will be provided at the same level as if provided by a Network Provider and is determined based on the Recognized Amount.

For purposes of this Summary, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by state or federal law.

When Covered Health Services are received from out-of-Network Providers for the instances described above, Allowed Amounts, which are used to determine our payment to out-of-Network Providers, are based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by state law.
- The amount agreed to by the out-of-Network Provider and us.
- The amount determined by Independent Dispute Resolution (IDR).
- The usual and customary rate.

If you elect to use out-of-network Providers for non-Emergency Health Care Services and supplies available from Network Providers, benefits will not be covered.

Continuity of Care

If you are undergoing a course of treatment from a Network Physician, Provider or facility at the time that Network Physician's, Provider's or facility's contract terminates with us for any reason except for medical competence or professional behavior, you may be entitled to continue that care at the Network Benefit level. Continuity of care is available in special circumstances in which the treating Physician or health care Provider reasonably believes discontinuing care by the treating Provider could cause harm to the Member. Special circumstances include Members with a disability, acute condition, life-threatening illness, pregnant and undergoing a course of treatment for the pregnancy, undergoing inpatient care, or scheduled to undergo nonelective surgery, including receipt of postoperative care.

The treating Provider must submit the continuity of care request. If continuity of care is approved, it may not be continued beyond 90 days after the Physician's, Provider's or facility's contract is terminated, or nine months after the Physician's, Provider's or facility's contract is terminated, if the Member has been diagnosed as having a terminal illness at the time of termination. If the Member is pregnant and the time of termination, coverage at the Network level will continue through the delivery of the child, immediate postpartum care and the follow-up checkup within the six-week period after delivery.

If you have questions regarding this continuity of care policy or would like help determining whether you are eligible for continuity of care Benefits, please contact us at the telephone number on your ID Card.

Provider Directories

The Act provides that if you receive a Covered Health Service from an out-of-Network Provider and were informed incorrectly by us prior to receipt of the Covered Health Service that the Provider was a Network Provider, either through our database, our Provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing that would be no greater than if the service had been provided from a Network Provider.

Outpatient Prescription Drug Rider
Harbor Health Plan

This Rider to the Contract is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Evidence of Coverage (EOC) in Section 8: Glossary of Terms or in this Rider under Defined Terms.

When we use the words “we,” “us,” and “our” in this document, we are referring to Harbor Health Plan. When we use the words “you” and “your” we are referring to people who are Members, as the term is defined in the EOC in Section 8: Glossary of Terms.

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[Signature of authorized company officer]
[Title of authorized company officer]

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INTRODUCTION

The Harbor Health Plan provides coverage for Medically Necessary outpatient Prescription Drug Products at a Network Pharmacy based on the following:

- The outpatient Prescription Drug Product is included on our approved Formulary;
- It has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
- Is recognized by the following for treatment of the indication for which it is prescribed:
    - A prescription drug reference compendium approved by the Texas Department of Insurance; or
    - Substantially accepted peer-review medical literature.

We list all our covered outpatient Prescription Drug Products in a covered drug list, or Formulary. The drug list will show if your outpatient Prescription Drug Product is on the Formulary and what benefit level (or tier) it has been assigned. The Formulary is created by considering a number of factors including clinical and economical factors. Clinical factors may include review of the place in therapy or use as compared to other similar products or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or Pre-Authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

We may periodically change the placement of a Prescription Drug Product among the levels or remove a Prescription Drug Product from our Formulary. Coverage for Prescription Drug Products will be provided at the contracted benefit level for any Prescription Drug Product that was approved or covered, regardless of whether the drug was removed from the formulary before the plan renewal date. Changes to the formulary will occur no more often than annually on the Contract anniversary date. We will provide a 60-day written notice prior to the effective date to any change. To determine whether a specific drug is included under the Formulary, please contact us at www.harborhealth.com or the telephone number on your ID Card.

NOTE: The tier placement of a Prescription Drug Product may change based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.harborhealth.com or the telephone number on your ID Card for the most up-to-date tier placement. You can also request information on whether a specific Prescription Drug Product is included in the Formulary. This information will be provided to you no later than the third business day after the date of your request. However, the inclusion of a Prescription Drug Product in the Formulary does not guarantee that the Prescription Drug Product will be prescribed for you by your Physician for a particular medical condition or mental illness.

Any Member cost share, limitations and exceptions for a Prescription Drug Product is noted in the Outpatient Prescription Drug Cost Share section below. You are not required to make a payment for a Prescription Drug Product at the point of sale in an amount that is greater than the lesser of:

- The applicable Copayment;

- The allowable claim amount for the Prescription Drug Product;
- The amount you would pay if you purchased the Prescription Drug Product without using a health benefit plan or any other source of drug benefits or discounts.

NOTE: Some Prescription Drug Products will require Pre-Authorization, Step Therapy and Quantity Limitations, as described below.

Continuation of Prescription Drug Coverage

We will continue to provide Network Benefits for any Prescription Drug Product that has been approved or covered under the Contract for a medical condition or mental illness, regardless of whether the drug has been removed from the Formulary before the Contract renewal date. Your Physician or other health care Provider with authorization to prescribe a drug may prescribe an alternative drug if the Prescription Drug Product is covered under the Contract and if it is medically appropriate.

OUTPATIENT PRESCRIPTION DRUG COST SHARE

You are responsible for paying the applicable cost share described in the Benefit information table below, in addition to any Ancillary Charge. You are not responsible for paying a Copayment or Coinsurance for PPACA Zero Cost Share Preventive Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or your Provider's request and there is another drug that is Chemically Equivalent.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your EOC:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Specialty Prescription Drug Products The following supply limits apply: • As written by the provider, up to a consecutive 30-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the cost share that applies will reflect the number of days dispensed or days the drug will be delivered.	
Tier 1 Specialty Prescription Drug Products	20% of the Prescription Drug Charge. However, you will not pay more than $500 per Prescription Order or Refill.
Tier 2 Specialty Prescription Drug Products	20% of the Prescription Drug Charge. However, you will not pay more than $500 per Prescription Order or Refill.
Tier 3 Specialty Prescription Drug Products	20% of the Prescription Drug Charge. However, you will not pay more than $500 per Prescription Order or Refill.

Prescription Drug Product – Retail The following supply limits apply: • As written by the Provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described below.

- A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment or Coinsurance for each cycle applied.
- A 12-month supply of a contraceptive drug. You must fill the initial prescription for up to a three-month supply of the prescribed contraceptive drug, regardless of whether you were enrolled with Harbor Health the first time you obtained the contraceptive drug. For the same contraceptive drug, future fills may be filled up to a 12-month supply at one time. You may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copayment or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.

For insulin Prescription Drug Products on any tier, the total amount of Copayments you pay will not exceed $25 for an individual prescription up to a 30-day supply. At least one insulin Prescription Drug Product from each therapeutic class is available.

You are not responsible for paying a cost share for PPACA Zero Cost Share Preventive Care Medications.

Tier 1 Prescription Drug Products	***For a 30-Day Supply*** None
Tier 2 Prescription Drug Products	***For a 30-Day Supply*** $50 per Prescription Order or Refill
Tier 3 Prescription Drug Products	***For a 30-Day Supply*** $100 per Prescription Order or Refill

Prescription Drug Product – Mail Order
The following supply limits apply:

- As written by the Provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- A 12-month supply of a contraceptive drug. You must fill the initial prescription for up to a three-month supply of the prescribed contraceptive drug, regardless of whether you were enrolled with Harbor Health the first time you obtained the contraceptive drug. For the same contraceptive drug, future fills may be filled up to a 12-month supply at one time. You may obtain only one 12-month supply of a covered prescription contraceptive drug during each 12-month period.

To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Copayment or Coinsurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

For insulin Prescription Drug Products on any tier, the total amount of Copayments you pay will not exceed $25 for an individual prescription up to a 30-day supply. At least one insulin Prescription Drug Product from each therapeutic class is available.

Tier 1 Prescription Drug Products	***For a 90-Day Supply*** None
Tier 2 Prescription Drug Products	***For a 90-Day Supply*** $125 per Prescription Order or Refill
Tier 3 Prescription Drug Products	***For a 90-Day Supply*** $250 per Prescription Order or Refill

PLAN PROVISIONS

ID Card – Network Pharmacy

You must either show your ID Card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID Card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in Section 6: Claims in the EOC. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and Ancillary Charge.

Submit your claim to:

Capital Rx
Attn: Claims Dept.
9450 SW Gemini Dr., #87234
Beaverton, OR 97008

When a Brand-Name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand Name Prescription Drug Product may change. Therefore, your Copayment may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand Name Prescription Drug Product.

When a Biosimilar Product Becomes Available for a Reference Product

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Copayment may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product. Such determinations will occur no more often than annually on the Contract anniversary date.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the Schedule of Benefits section below. For a single cost share, you may receive a Prescription Drug Product up to the stated limit.

NOTE: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.harborhealth.com or the telephone number on your ID Card.

Pre-Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to submit a request for Pre-Authorization of services to us or our designee. The reason for submitting a request for Pre-Authorization to us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing Provider, the pharmacist, or you are responsible for submitting a request for Pre-Authorization of services to us.

If you do not obtain Pre-Authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring Pre-Authorization are subject to our review and may periodically change. You may find out whether a particular Prescription Drug Product requires Pre-Authorization by contacting us at www.harborhealth.com or the telephone number on your ID Card.

If you do not obtain Pre-Authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Evidence of Coverage in Section 6: Claims.

When you submit a claim on this basis, you may pay more because you did not obtain Pre-Authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and Ancillary Charge.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

For certain Prescription Drug Products prescribed to treat an autoimmune disease, hemophilia, or Von Willebrand disease, you are only required to obtain Pre-Authorization one time annually.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.harborhealth.com or the telephone number on your ID Card.

When a step therapy requirement applies to a Prescription Drug Product, your Provider may request an exception.

- For non-urgent step therapy exception requests, a review will be completed within 72 hours once all information needed to process the request has been received. If the exception request is not denied within 72 hours, then the request will be considered granted.
- For urgent step therapy exception requests, a review will be completed within 24 hours once all the information needed to process the request has been received. If the exception request is not denied within 24 hours, then the request will be considered granted.

If your step therapy exception request is denied, the denial may be subject to an expedited appeal. Please refer to Section 5: Questions, Complaints and Appeals of your EOC for additional information on appealing an Adverse Determination.

In the case of FDA-approved drugs for the treatment of stage four advanced, metastatic cancer, Benefits will not be subject to step therapy requirements if the use of the drug is consistent with best practices for the treatment of stage four advanced, metastatic cancer and is supported by peer-reviewed medical literature.

If you are 18 years of age or older, you will not be required to fail to successfully respond to, or prove a history of failure of, more than one different drug for each drug prescribed to treat a serious mental illness, excluding the generic or pharmaceutical equivalent of the prescribed drug. We may require a trial of a generic or pharmaceutical equivalent of the prescribed drug as a condition of continued coverage once per plan year if the generic or pharmaceutical equivalent drug is added to the Prescription Drug List.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Formulary. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your cost share.

Coupons, Incentives and Special Programs

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-Harbor Health entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

We will apply any third-party payments, financial assistance, discounts, product vouchers, or any other reduction in out-of-pocket expenses made by you or on your behalf for covered Prescription Drug Products toward your Copayment or Out-of-Pocket Limit.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so drugs that are refilled at the same frequency may be refilled concurrently.

On the initial synchronization, a prorated cost share amount will be charged for a partial supply based on the number of days' supply of the drug actually dispensed if the following requirements are met:

- The pharmacy or prescribing Physician or health care Provider notifies us that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the prescription drugs.
- Is in the best interest of the Member.
- The Member agrees to the synchronization.

You may obtain additional information on these procedures by contacting us at www.harborhealth.com or the telephone number on your ID Card.

Insulin and Insulin-Related Equipment Supplies

Coverage is provided for Emergency refills of insulin and insulin-related equipment supplies, in accordance with Texas law, in this same manner as for a non-emergency refill of insulin and insulin related equipment or supplies. Your cost share for insulin will not exceed the amount allowed by applicable law.

Prescription Eye Drops

Refills of prescription eye drops are covered if the Member pays the pharmacy the maximum amount allowed. The original prescription must state that additional quantities of the eye drops are needed, the refill may not exceed the total quantity of dosage units authorized by the prescribing Provider on the original prescription, including refills.

Refills may be dispensed on or before the last day of the prescribed dosage period:

- Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed.
- Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed.
- Not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents that are provided under Pharmaceutical Products - Outpatient in Section 2: What Your Plan Covers.

EXCLUSIONS

Exclusions from coverage listed in Section 3: Limitations and Exclusions in this EOC also apply to this section. In addition, the exclusions listed below apply.

1. Prescription Drug Products, including New Prescription Drug Products, that we determine do not meet the definition of a Covered Health Service.
2. A Pharmaceutical Product for which Benefits are provided in Section 2: What Your Plan Covers in your Evidence of Coverage. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
3. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy.
4. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
5. Prescription Drug Products dispensed outside the United States.
6. Drugs which are prescribed, dispensed or intended for use during an inpatient stay. Benefits for these drugs are provided in your Evidence of Coverage under the medical portion of the plan.
7. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will apply to any off-label drug that is excluded from coverage under this section as well as any drug that the U.S. Food and Drug Administration (FDA) has determined to be contraindicated for the treatment of the disease or condition. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or life-threatening disease or condition if the drug:

    - Has been approved by the FDA for at least one indication.
    - Is recognized for the treatment of the indication for which the drug is prescribed in either of the following:
        - A prescription drug reference compendium approved by the Commissioner of the Texas Department of Insurance.
        - Substantially accepted peer-reviewed medical literature.

8. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
9. Prescription Drug Products for any condition, injury, sickness or Mental Illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or benefits are received.
10. Any product dispensed solely for the purpose of appetite suppression or weight loss.
11. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Evidence of Coverage. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. Certain unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic or convenience purposes.

14. Outpatient Prescription Products used to promote hair growth or to replace hair, including, but not limited to Rogaine or Minoxidil, unless Medically Necessary.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility as described in the Evidence of Coverage.
17. Prescription Drug Products not placed on the Formulary at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing benefits for a Prescription Drug Product that is not on an available tier of the Formulary, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID Card.
18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed.
19. Over-the-counter home tests.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our P&T Committee.
21. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of sickness or injury. This exclusion does not apply to:

    - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in Section 2: What Your Plan Covers in the Evidence of Coverage.
    - Amino acid-based elemental formulas, as described under Enteral Nutrition in Section 2: What Your Plan Covers in the Evidence of Coverage.
    - Formulas for phenylketonuria (PKU) or other heritable diseases.
    - Enteral formulas and other modified food products.

22. A Prescription Drug Product that contains marijuana, including medical marijuana.
23. Dental products, including but not limited to prescription fluoride topicals.
24. Diagnostic kits and products, including associated services.
25. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
26. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.
27. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Contract anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
28. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Contract anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
29. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations will occur

not more often than annually on the Contract anniversary date. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

30. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
31. Prescription Drug Products for the treatment of male sexual or erectile dysfunction/impotence.

DEFINED TERMS

Ancillary Charge is a charge, in addition to the Copayment, that you must pay when a covered Prescription Drug Product is dispensed at your or the Provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

Brand Name Drugs are Prescription Drug Products developed, patented, and sold under a trademarked name which typically will not be available as a Generic Drug until the patent has expired.

Copay (Copayment) means the charge, as stated as a set dollar amount or a percentage of the Allowed Amount, that you are required to pay for certain Prescription Drug Products. The Copayments are indicated under the *Payment Information* section above.

Please note that for covered Prescription Drug Products, you are responsible for paying the lesser of the following:

- The applicable Copayment;
- The allowable claim amount for the Prescription Drug Product; or
- The amount you would pay if you purchased the Prescription Drug Product without using a health benefit plan or any other source of drug benefits or discounts.

Formulary is a list of over the counter, generic, brand-name and Specialty Prescription Drug Products, devices and supplies that are covered and dispensed by a Pharmacy. The listing is developed based on the efficacy and safety of the drugs and is subject to our review and change. These changes will occur no more than annually on the Contract anniversary date. You may find out where your Prescription Drug Product is placed on the Formulary by contacting us at www.harborhealth.com or the telephone number on your ID Card.

Generic Drugs are medications that by law must have the same active ingredients and are subject to the same US Food and Drug Administration (FDA) standards for quality, strength, performance, and purity as their Brand Name counterpart. Generic drugs usually cost less than Brand Name drugs.

List of Preventive Medications is a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of sickness. You may find the List of Preventive Medications by contacting us at harborhealth.com or the telephone number on your ID Card.

List of Zero Cost Share Medications is a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the

List of Zero Cost Share Medications by contacting us at www.harborhealth.com or the telephone number on your ID card.

Network Pharmacy is a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Members.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product is a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is placed on a tier by our P&T Committee.
- December 31st of the following calendar year.

Oral Anticancer Drugs Harbor Health covers medically necessary Anticancer drugs that are used to treat cancer and are taken orally. They are typically part of the Specialty Prescription Drug Products category and are categorized either traditional, targeted or hormonal. Refer to the Harbor Health Formulary for the drugs that are covered in this category.

PPACA is the Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications are the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any cost share) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Certain immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Charge is the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Pharmacy & Therapeutics (P&T) Committee is the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product is a medication or product that has been approved by the U.S. Food and Drug Administration (FDA) that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Contract, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
    - standard insulin syringes with needles;
    - blood-testing strips - glucose;
    - urine-testing strips - glucose;
    - ketone-testing strips and tablets;
    - lancets and lancet devices; and
    - glucose meters, including continuous glucose monitors.

  Coverage for the above diabetic supplies will not be subject to step therapy if the Provider indicates "dispense as written."

Prescription Order or Refill is the directive to dispense a Prescription Drug Product issued by a duly licensed health care Provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Products are generally high cost, self-administered biotechnology drugs used to treat Members with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.harborhealth.com or the telephone number on your ID Card.

Usual and Customary Charge is the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

YOUR RIGHT TO REQUEST AN EXCLUSION REQUEST

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID Card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable cost share based on the Prescription Drug Product tier placement, or at the highest tier as described in the Schedule of Benefits section above, in addition to any applicable Ancillary Charge.

Urgent Requests
If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review
If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours.

Expedited External Review
If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.