Harbor Health

Evidence of Coverage (EOC)

Individual HMO Plan

Harbor Health G1

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

Important Notes:

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.

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.

A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network Physicians or Providers, except for specific situations as described below and in this EOC.

You have the right to an adequate network of Network Physicians and Providers.

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

If Harbor Health 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 Health Care Services, facility-based Providers and Ancillary Services received at certain Network facilities on a non-Emergency basis, we must, in most cases, resolve the out-of-Network Physician's or Provider's bill so that you only have to pay any applicable in-network Copayment, and Annual Deductible amounts.

You may obtain a current directory of Network Physicians and Providers at the following website: www.harborhealth.com or by calling the toll-free 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 Harbor, not dated more than 30 days before you received the service.

This Evidence of Coverage (EOC) is underwritten by Harbor Health Insurance Company and is governed by federal law and the laws of Texas. This EOC is between Harbor Health (Harbor Health, Harbor, we, us or our) and the subscriber (you, your).

Coverage starts on your Effective Date of coverage and continues until it ends as described in this EOC. Your EOC provides coverage for servcies and supplies that are Covered Health Services. It describes your coverage only. If you receive medical procedures, medical services or Prescription Drug Products that might not be Covered Health Services under this EOC, you will be responsible for any charges. Please read your EOC and the Schedule of Benefits because these documents explain your benefits in detail.

Read Your EOC Carefully

Your EOC is a legal Contract between you and us. We agree to cover you under this EOC in return for your Premium payments. We will pay eligible Covered Health Services while this EOC is in force and after the EOC conditions are met.

Right to Examine the EOC

You have 10 days after you receive this EOC to read and review it. During that 10-day period, if you decide you don't want the EOC, you may return it to us or to the agent who sold it to you. As soon as it is returned, this EOC will be void from the beginning. We will return any Premium you paid to us.

Guaranteed Renewable

You may keep this EOC in force by meeting the EOC requirements and by paying the Premium on time. See the *When Coverage Begins and Premium* section for more information.

You can renew this EOC on January 1 of each Calendar Year ("guaranteed renewable"). On January 1st, we may make modifications in coverage if such modifications are made on a uniform basis for all individuals with the same product. In addition, we may make moficiations at any time if the modification is directly related to a State or Federal requirement and the modification is made within a reasonable time period after the State or Federal requirement is imposed or modified.

On January 1st of each Calendar Year, we may change the rate table used for this EOC. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the plan, tobacco use status of Members, type and level of Benefits and place of residence on the Premium due date, and age of Members as of the effecitve date or renewal date of coverage. Premium rates are expected to increase over time.

We will mail you a notice at least 60 days prior to any plan benefit modification or Premium rate change. This notice will explain any changes we are making to your plan. We will mail the notice to your last address as shown in our records.

We may decide to not review the EOC under certain conditions, which are explained in this EOC, or when required by law. See the *When Coverage Ends* section for more information.

Your Application

We relied on your answers to all questions in the application process when we issued the EOC to you.

By applying for coverage under this EOC, or accepting its Benefits, you (or the person acting for you) represent that all information in your application and statements given as part of your application for this EOC are true, correct, and complete, to the best of your knowledge; and you agree to all terms, conditions, and provision of the EOC.

It is your responsibility to make sure the application that you submitted is accurate and complete. It is important that you notify us immediately of any mistakes that you find in your application.

If we learn that you defrauded us or you intentionally misrepresented material facts when you gave information and answers in the application, or in the application process, we may decide to cancel the EOC. We may also report fraud to criminal authorities.

Brian Beutner
Brian Beutner
President

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 855-481-0225
Toll-free: 855-481-0225
Online: www.harborhealth.com
Mail: PO 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 855-481-0225
Teléfono gratuito: 855-481-0225
En línea: www.harborhealth.com
Dirección postal: PO 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

Welcome

At Harbor Health, your health goals lead the way, so we're joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. With the Harbor Health Plan, you have the freedom to see any Network Provider. However, we understand that navigating the health care system can be difficult and confusing. By choosing a Primary Care Physician, your Physician can help you navigate the health care system and determine the best next step for the symptoms you are currently experiencing or the condition you have been diagnosed with. When you select a Primary Care Physician and follow the agreed upon next steps and obtain Referrals or Medical Orders, you will be responsible for a lower cost share for certain services. See the *How Your Plan Works* section for more information.

Welcome to Harbor Health.

Introduction

This is your EOC. It describes your Covered Health Services – what they are and how to get them. The second document is the Schedule of Benefits. This document tells you how we share expenses for Covered Health Services and explains any limits – like when your EOC covers only a certain number of visits. Each may have riders or amendments attached to them. These change or add to the document.

This EOC is provided following your application for coverage through the Exchange. Coverage under this EOC is subject to any conditions and rights as set forth in this EOC and by the Exchange and/or the Federal Department of Health and Human Services. Individuals covered under this EOC agree to all its requirements.

The EOC, applications, if any, and any attachments constitute the entire Contract between the parties and that, to be valid, any change in the form must be approved by state and federal regulatory agencies, an officer of the HMO and attached to the affected form. No agent has the authority to change the form or waive any of the provisions.

How We Use Words

When we use:

- "You," "your" or "Member," we mean you as the Subscriber and any covered Dependents, if Dependent coverage is available under the EOC.
- "Us," "we," and "our," we mean Harbor Health.
- Words that are capitalized are defined terms in the *Definitions* section.

Important Contact Information

For questions about your Harbor Health benefit plan, you can contact us by:

- Calling Member Services at 1-855-481-0225
- Writing us at PO Box 211262, Eagan, MN 55121
- Visiting www.harborhealth.com to register and access your Member website

Harbor Health Member Services is available Monday – Friday, 7:00am – 8:00pm and Saturday, 8:00am – 5pm, CST. A Harbor Health Member Services representative can assist you with, but not limited to, the following:

- Explain the Covered Health Services available to you under the Harbor Health plan
- Answer claims questions
- Identify your service area
- Give you information about Network Providers contracted with Harbor Health
- Provide information on Harbor's plan features
- Record comments about Providers

The Harbor Health Member website is available 24 hours/day, 7 days/week. With your Member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a Provider, research Providers, care and treatment options
- Access forms
- View and manage claims
- Find information on health and wellness

ID Card

Your Member ID card tells Physicians, hospitals and other Providers that you are covered by Harbor Health. Show your ID card each time you get Covered Health Services from a Provider. Remember, only you and your covered Dependents can use your ID card. If you misuse your card, we may end your coverage. To get your digital ID card, you can go to www.harborhealth.com to log into your Member app. You can also print your ID card from your Member app or you can call Member Services at the telephone number on your ID card for assistance.

Available Programs

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs, administrative programs, and/or programs to seek care in a more cost-effective setting. In some instances, these programs may be offered in combination with a non-Harbor Health entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. We will notify you of the opportunity to participate in available programs and of any criteria for eligibility.

How to Get Language Assistance

Harbor Health offers a language assistance program to assist Members with limited English proficiency understand the health coverage provided under this EOC at no additional cost. We provide oral interpretation services, as well as written translation for written materials vital to understanding your health coverage.

This service also allows you and your Physician to talk about your medical or behavioral health concerns in a way you both can understand. We have representatives that speak Spanish and have medical interpreters to assist with other languages.

Requesting language assistance is easy. Just contact Member Services by calling the number on your ID card. Harbor also sends/receives TDD/TTY messages by using the National Relay Service through calling 711 or a number listed below. A special operator will get in touch with us to help with your needs.

After Hours Care

If you need care after normal business hours, your Physician may have several options for you. You should call your Physician's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency room.

How Your Plan Works

Harbor Health Network

The Network for this Plan is the Harbor Health IFP Network. The Harbor Health IFP Network has been specially curated to contain the best Providers that we're confident will serve all your needs. You can access up-to-date lists of our Network Providers and other Harbor Network information at www.harborhealth.com. Printed directories are available upon request, without charge. Except as described in the *Out-of-Network Providers* section below, Members must obtain Covered Health Service and supplies from Harbor Network Providers to receive Benefits under this Plan.

Before obtaining Covered Health 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 going to www.harborhealth.com or by calling Member Services at the number on your ID card for assistance. 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 Harbor, not dated more than 30 days before you received the service.

Out-of-Network Providers

If you receive care from a Provider who does not participate in the Harbor Network, you generally will not be covered for those services, and you will be financially responsible. However, out-of-Network Providers may be covered in the situations outlined below.

No Surprises 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.

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 would cause you harm. Special circumstances include Members with a disability, acute condition, Life-Threatening or terminal 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 through the Pre-Authorization process. If continuity of care is approved, the Provider will receive continued reimbursement not less than the contracted rate until:

- The expiration of the 12-month period after the Effective Date of termination if the Member has been diagnosed with a terminal illness; or
- Through delivery of the child and immediate postpartum care within the six-week period after delivery; or
- The 90th day after the Effective Date of the termination for all other conditions.

Transition of Care
If you are 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 a limited period of time. A request for transition of care must go through the Pre-Authorization process. If you would like to start the Pre-Authorization process, or you have questions regarding this transition of care request, call the telephone number on your ID card.

Network Provider Not Available
You may be able to receive Covered Health Services from an out-of-Network Provider if an appropriate Network Provider is not reasonably available, or you have a complex medical problem that cannot be taken care of by a Network Provider. You or your Provider must request approval from us through the Pre-Authorization process before you get care. If we confirm that care is not available from a Network Provider and we approve the request, you will be responsible for the applicable Network cost share for the Covered Health Service(s) you receive.

If you have, please contact us at the telephone number on your ID Card.

Primary Care Physicians

You can select a Network Primary Care Physician, or PCP. While we do not require you to select a Primary Care Physician in order to obtain Benefits, we strongly encourage you to do so. A Network Primary Care Physician can help you navigate the health care system and determine the best next step for the symptoms you are currently experiencing or the condition you have been diagnosed with. A Primary Care Physician can treat most symptoms and conditions, but when specialty care is needed, your PCP can refer to Network specialists or other health care Providers. When you select a Primary Care Physician and follow the agreed upon next steps and obtain Referrals or Medical Orders, you will be responsible for a lower cost share for certain services. See the *Referrals and Cost Share Reduction* section below for more information.

If you are a custodial parent of a Dependent Child, you can select a Network Primary Care Physician who specializes in pediatrics for your 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.

Referrals and Cost Share Reduction

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 will be responsible for a lower cost share.

Cost share responsibility and the Covered Health Services eligible for reduced cost share with Referrals and Medical Orders are outlined in the *Schedule of Benefits*.

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.

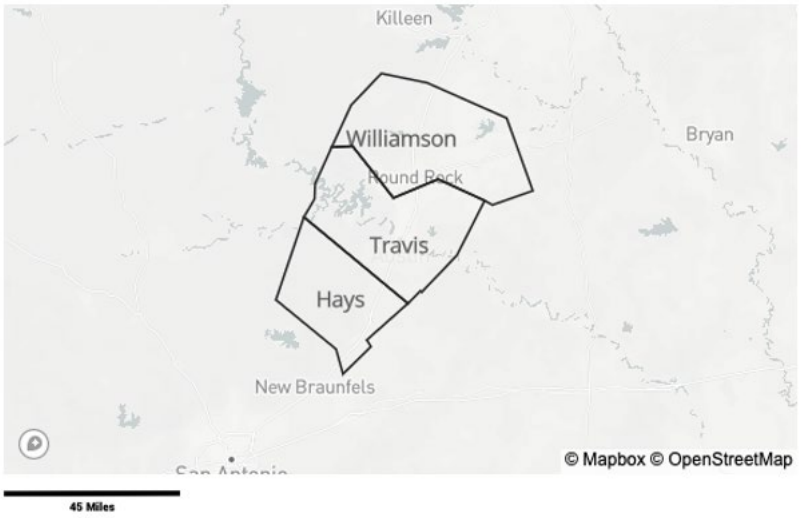
Geographic Service Area

The Geographic Service Area is the geographic area in which Harbor Health is licensed to arrange for medical and hospital services in the state of Texas. You must work, reside or live in the Geographic Service Area. The Harbor Health 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 related to our Network Providers, you can call us at the number on your ID card.

Geographic Overview



Premium Responsibility

Premium Payment

This EOC requires the Subscriber to make Premium payments. We will not pay Benefits under this EOC for services obtained after coverage ends if Premium payments are not made by the end of the grace period. Any Benefit payment denial is subject to our appeals procedure. See the *Questions, Complaints and Appeals* section of this EOC.

The first Premium payment is due on or before your Effective Date. When we calculate the Premium you owe, we use our records to determine who is covered under the EOC. You owe Premium for each person covered under the EOC starting with the first Premium due date on or after the day the Member's coverage starts. You stop paying Premium as of the first Premium due date on or after the day the Member's coverage ends.

After your first Premium payment is made, Premium payments are due on the 1st of each month based on your Effective Date. Each Premium payment is to be paid to us on or before the due date.

We provide this EOC to you and you pay Premium to us. We may choose not to accept Premium that is paid for you by someone else unless we are required to by applicable law.

Grace Period

You have a grace period of 31 days after the due date for the payment of each Premium due after the first Premium payment. If Premiums are not paid within this 31-day grace period, coverage may be canceled after the 31st day and the Subscriber will be held liable for the cost of services required during the grace period. In no event shall the grace period extend beyond the date the Contract terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these sources.

Important Note: If you are currently receiving an Advance Payment of Tax Credit, as determined by the Exchange, the grace period above does not apply to you. Instead, the following applies:

If you are receiving advanced payment of the Premium tax credit now, you will have a three-month grace period during which you may pay your Premium and keep your coverage in force. We will pay for Covered Health Services during the first month of the grace period. You are responsible for paying the grace period Premium. Prior to the last day of the three-month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the first month of the grace period until all Premiums are paid for the full three-month grace period.

If Premium is not paid by the end of the three-month period, your coverage will end on the last day of the first month of the grace period. If we pay Benefits for any claims during the first month of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these sources.

Reinstatement

We can end this EOC because you have not paid your Premium. If this happens, we can reactivate ("reinstate") the EOC without a break in coverage. You must ask us to do so within 30 days of the EOC end date. But, for us to do this, you must pay us the total Premium you already owe plus the new Premium. We can decide not to reinstate the EOC.

Premium Agreement

Your Premium rate will not change during the EOC term as long as there are no changes to this EOC. Changes include things like the area you live in, the benefit plan or adding Dependents to the EOC.

Your Premium rate is based on factors such as:

- The EOC in which you are enrolled
- Your age and the ages of covered Dependents
- The number of covered persons
- Tobacco use
- Where you live (primary residence)

Each Premium will be based on the rates that apply on that Premium due date.

In the event of any changes in Premium rates, payment of the Premium by you means that you accept the Premium changes.

Premium Changes In Rates

We may change the Premium rates as of a Premium due date during the initial term only if there is a change in factors that materially affects the risk we assumed with this coverage. We will explain these changes in factors in our rate quote to you.

We may change the Premium rates as of a Premium due date during any following term. Any rate change, however, will not be applied more frequently than annually or as allowed by federal or state law or regulation.

We will let you know in writing of any change in Premium rates 60 days before they take effect.

When Coverage Begins

The eligibility process and enrollment process are subject to any rules or other standards of the Exchange and/or the Federal Department of Health and Human Services.

Eligibility

You will find information in this section about:

- Who can receive coverage in this EOC (who can be your Dependent)
- Special or limited enrollment periods
- Adding new Dependents
- Effective Date of coverage for your Dependent

Who is Eligible

You are enrolled as the Subscriber after you complete the eligibility and enrollment process with the Exchange. You must pay the initial Premium for your coverage to be effective. The Exchange determines your Effective Date of coverage.

Dependent Coverage

You can enroll eligible Family members (these are your "Dependents"). You can enroll the following Family members:

- Your legal spouse
- Your Domestic Partner who meets eligibility requirements
- Your Dependent children, your own or those of your Spouse or Domestic Partner. The term "child" includes:
    - Natural children
    - Stepchildren
    - Adopted children, including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical or dental support order or court order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - A grandchild who is your Dependent for federal tax purposes
    - Any children approved by the Exchange

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the year following the date the child reaches age 26 except as provided in *Coverage for a Disabled Dependent Child* in the *When Coverage Ends* section.
- A Dependent includes 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.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

You can enroll your Dependents:
- At initial enrollment
- At other special times during the year as listed below

A Dependent must live in the Geographic Service Area where the EOC was issued and be approved by the Exchange.

Adding New Dependents

You can add the following new Dependents to your EOC:

Dependent	Enrollment Process
Spouse	If you marry, you can enroll your Spouse on your EOC: • The Exchange must receive your completed enrollment information not more than 60 days after the date of your marriage • Coverage will be effective on the first day of the month following receipt of enrollment information
Domestic Partner	If you enter a Domestic Partnership, you can enroll your Domestic Partner on your EOC: • The Exchange must receive your completed enrollment information not more than 60 days after the date you file a Declaration of Domestic Partnership • Coverage will be effective on the first day of the month following receipt of enrollment information
Newborn Child	Your newborn child is covered on your EOC for the first 31 days after birth. • To keep your newborn covered, the Exchange must receive your completed enrollment information or you can call to notify us. You must provide the information within 31 days of birth • You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional Premium for the covered Dependent • If you miss this deadline, your newborn will not have Benefits after the first 31 days

Adopted Child	You may put an adopted child on your EOC when you become a party in a suit for adoption, the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child: • The Exchange must receive your completed enrollment information within 60 days after you become a party in a suit for adoption, the date the adoption or the date the child was placed for adoption, whichever is earlier • Benefits for your adopted child will begin on the date of the adoption (or placement).
Foster Child	You may put a foster child on your EOC when the child is placed with you in foster care. A foster child is a child whose care, comfort, education, and upbringing is left to persons other than the natural parents: • The Exchange must receive your completed enrollment information within 60 days after the child is placed with you • Benefits for your foster child will begin on the date you legally become a foster parent.
Stepchild	You may put a child of your Spouse or Domestic Partner on your EOC: • You must complete your enrollment information and send it to the Exchange within 60 days after the date of your marriage or Declaration of Domestic Partnership with your stepchild's parent
Court Order	You can put a child you are responsible for under a qualified medical or dental support order or court-order on your EOC: • You must complete your enrollment information and send it to the Exchange within 60 days after the date of the court order

Effective Date of Coverage for Your Dependent

Your Dependent's coverage will start on your Effective Date, if you enrolled them at that time, otherwise:

- As shown above under the *Adding New Dependents* section
- No later than the first day of the month following the date the Exchange receives your completed enrollment information
- In accordance with the Effective Date of a court order
- An appropriate date based on the circumstances of the special enrollment period

Special or Limited Enrollment Periods

Federal law allows you and your Dependents to enroll in a new EOC outside of the annual enrollment period under some circumstances. These are called special or limited enrollment periods. You can enroll in these situations when:

- You or your Dependent have lost minimum essential coverage.
- You have added a Dependent because of marriage, birth, adoption, placement for adoption, or placement in foster care. See the *Adding New Dependents* section (above) for more information.
    - To qualify for a special enrollment period due to marriage, at least one Spouse must prove they were enrolled in a Plan with minimum essential coverage for at least one day in the 60 days before the date of marriage, or one of the following:
        - Lived in a foreign country or US territory at least one day in the 60 days before the date of marriage
        - Is an American Indian or Alaskan Native
- You or your Dependents are enrolled in any non-Calendar Year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement.
- You or your Dependent's enrollment or non-enrollment in a Plan through the Exchange was not intended, was by accident or a mistake, and is because of an error, false information, or delay by the Exchange.
- You or your Dependent have proven to the Exchange that their plan did not honor or maintain an important provision of its Contract with you or that you meet other unusual circumstances.
- You did not enroll a Dependent in this EOC before because they had other coverage and now that other coverage has ended.
- A court orders you to cover a current Spouse, Domestic Partner, or a child on your health EOC.
- You or your Dependent are newly eligible or not eligible for the Premium tax credit or change in eligibility for cost share reduction, for Exchange coverage.
- You or your Dependent are eligible for new policies because you have moved to a new permanent location.
- You or your Dependent are the victim of domestic abuse or spousal abandonment.
- You or your Dependent become a citizen, a national, or lawfully present in the United States.
- You are an American Indian or Alaska Native as defined by the Indian Health Care Improvement Act. In this situation:
    - You, or you and your Dependents, can enroll in a qualified health plan (QHP) or change from one QHP to another
    - You can do this one time per month
- You or your Dependent become eligible for state Premium assistance under Medicaid or an S-CHIP plan for the payment of your Premium contribution for coverage under this EOC.
- You or your Dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- You or your Dependent are released from incarceration.
- You no longer receive employer contributions or government subsidies for COBRA coverage.

Regulatory changes may occur that impact and expand special enrollment periods which will apply to this EOC. Please visit http://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ for up-to-date information. The completed enrollment form must be submitted within 60 days of the event. However, if you did not receive notice of your triggering event, you will have 60 days from the time you are made aware of the event.

Notification of Change in Status

If there are any changes which will affect your EOC or the eligibility of anyone covered under the EOC, you must contact the Exchange within 30 days of the date of the change. This may include changes in:

- Address
- Telephone number
- Marital status
- Dependent status
- Health coverage through a job-based plan or program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) for you or your Dependent.

When Coverage Ends

When Your Coverage Will End

Coverage can end for a number of reasons. This section tells you how and why coverage ends. The next section tells you when you may be able to continue coverage.

Termination by the Subscriber

The Subscriber may terminate this EOC by giving notice to the Exchange in writing at least 14 days before the date you want your coverage to end. Termination of the EOC by the Subscriber will result in the individual rights to Benefits and services awarded under this EOC to cease as of the Effective Date of termination, except as set forth in the *Special Coverage Options After Your Coverage Ends* section below.

Termination by Harbor Health

Harbor Health may terminate this EOC for the following reasons:

- *Failure to pay by the Subscriber*
  In the event you don't pay the full Premium amount due to Harbor on behalf of yourself or any Dependent, coverage will terminate for the Subscriber and all Dependents. Refer to the *Premium* section for more information.
- *Fraud or Intentional Misrepresentation of a Material Fact*
  Fraud or an intentional misrepresentation of a material fact by any Member in an attempt to secure benefits or coverage will be deemed to be fraud in the inducement of your contractual relationship with Harbor and will result in termination of coverage for you subject to 31 days written notice by the Exchange to the Subscriber. For termination of coverage with a retroactive effect, 31 days advance written notice will be provided to you.

  Any Member who knowingly files an application or other form containing any false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act. Such act shall constitute an

intentional misrepresentation of a material fact, and is grounds for the termination of coverage subject to 31 days written notice by the Exchange to the Subscriber.

- *Misuse of Member ID Card*
  If any Member permits the use of their own or any other Member's ID card by any other person, or uses another Member's card, the card may be retained by any Network Provider or by us. Misuse of your ID card may constitute an intentional misrepresentation of a material fact and is grounds for the termination of coverage subject to 31 days written notice by the Exchange to the Subscriber.
- *Discontinuation by Us*
  In the event we stop offering the class of policies to which this Plan belongs, this EOC may be terminated by us by giving written notice to the Commissioner and Subscriber at least 90 days before the coverage will be discontinued. Should we discontinue your Plan, you will have the right to purchase any other individual insurance plan we offer at the time of discontinuation. If we stop offering all health insurance coverage in the individual market in Texas, this EOC may be terminated by us by giving written notice to the Commissioner and Subscriber at least 180 days before the coverage will be discontinued.
- *Failure to Continue to Meet Eligibility Requirements*
  If a Member ceases to meet the eligibility requirements under this EOC, coverage will terminate, subject to 31 days written notice by the Exchange to the Subscriber. However, you may be eligible to re-enroll as set forth in the *Special Coverage Options After Your Coverage Ends* section below.
- *Residence Out of the Geographic Service Area*
  To be eligible to enroll and to continue enrollment in a Harbor Health Plan, Members must live, reside or work in the Geographic Service Area. If Members spend fewer than 6 months at the address provided to us, or provide an address that is an Airbnb, hotel, or similar lodging, they will generally no longer be considered a permanent resident of the Geographic Service Area and coverage will be terminated upon 31 days' written notice by the Exchange to the Subscriber. We reserve the right to audit your enrollment based on the address you provide.
- *Failure of Adoptions, Legal Guardianship or Legal Custodianship Proceedings*
  Any adoption, legal guardianship or legal custodianship that fails or is terminated will result in termination of coverage with respect to the child, subject to 31 days written notice by the Exchange to the Subscriber.
- *Divorce*
  Coverage under this EOC will end as of the date of the divorce except as set forth in the *Special Coverage Options After Your Coverage Ends* section below.
- *Any Other Reason Permitted by State or Federal Law*

When Dependent Coverage Ends

Dependent coverage ends when:

- They no longer meet the eligibility requirements of the Exchange.
- You stop making Premium contribution toward the cost of Dependent coverage.

- Your coverage ends for any of the reasons listed above.

Special Coverage Options After Your Coverage Ends

When Coverage May Continue Under the EOC
This section explains options you may have after your coverage ends under this EOC. Your individual situation will determine what options you will have. To request an extension of coverage, call Member Services at the number on your ID card.

Coverage for Disabled Dependent Child
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 this EOC.

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.

Continued Coverage Due to Change in Marital Status
If a Member loses coverage due to a change in marital status, you may be issued coverage that most nearly approximates the coverage of the Contract that was in effect prior to the change in marital status. In order to convert, you must continue to reside in the Geographic Service Area, submit an application within thirty-one days after the date of the change in marital status, and submit Premium payments required under such Contract. The effective date of such coverage shall be the effective date of coverage under the prior Contract.

What Your Plan Covers

Covered Health Services

Benefits are available only when all of the following are true:

- You receive the Covered Health Service while the EOC is in effect.
- You receive Covered Health Services prior to the date that any of the individual termination conditions listed in the *When Coverage Ends* section occurs.
- The person who receives the Covered Health Service is a Member and meets all eligibility requirements specified in this EOC.

This EOC provides coverage for many kinds of Covered Health Services, such as Physician's care and hospital stays, but some services are not covered at all or are limited. For other services, the EOC pays more of the expense. For example:

- Physician care is generally covered but Physician care for cosmetic surgery is never covered. Cosmetic care is an exclusion, as noted in the *Exclusions and Limitations* section.
- Home health care is generally covered but it is a Covered Health Service only up to a set number of visits a year. This is a limitation that appears in your *Schedule of Benefits*.
- Your Provider may recommend services that are considered Experimental, Investigational or Unproven Services. However, an Experimental, Investigational or Unproven Service is not covered and is also an exclusion unless it is recognized as part of an approved Clinical Trial. See the *Clinical Trials* benefit description below.
- Preventive services. Usually the EOC pays more and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive Care* benefit description below.

Some services require Pre-Authorization from us. For more information see the *Pre-Authorization and Utilization Management* section.

This section describes Covered Health Services for which Benefits are available. The Covered Health Services below appear alphabetically to make it easier to find what you are looking for. 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.

Note: Copayments will not exceed 50% of the total cost of services provided. Plus, the total Copayments will not exceed 200% of the annual Premium paid on your behalf (or, if you have Family covered, paid on behalf of all Members in your Family.) This limitation applies only if the enrollee demonstrates that Copayments in that amount have been paid in that year.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Acquired Brain Injury

Benefits are provided for Covered Health Services that are determined by a Physician to be Medically Necessary as a result of and related to an acquired brain Injury. Acquired brain Injury is 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.

Benefits are provided for the Covered Health Services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an acquired brain Injury, and provided by or under the direction of a Physician with the goal of returning the Member to, or maintaining the Member in, the most integrated living environment appropriate to the Member.

- **Cognitive communication therapy.** Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- **Cognitive rehabilitation therapy.** Services designed to address therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits.
- **Community reintegration services.** Services that facilitate the continuum of care as an affected individual transitions into the community.
- **Neurobehavioral testing.** An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, Family, or others.
- **Neurobehavioral treatment.** Interventions that focus on behavior and the variables that control behavior.
- **Neurocognitive Rehabilitation.** 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.
- **Neurocognitive therapy.** Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- **Neurofeedback therapy.** Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- **Neurophysiological testing.** An evaluation of the functions of the nervous system.
- **Neurophysiological treatment.** Interventions that focus on the functions of the nervous system.
- **Neuropsychological testing.** The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- **Neuropsychological treatment.** Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- **Outpatient day treatment services.** Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in

settings that include transitional residential, community integration, or non-Residential Treatment settings.

- **Post-acute care treatment services** - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
    - Post-Acute Care Services necessary as a result of and related to an acquired brain Injury are limited to the following: post-acute care treatment is limited to reasonable expenses related to periodic reevaluation of care provided to an individual who has incurred an acquired brain Injury, has been unresponsive to treatment and becomes responsive to treatment at a later date.
    - Reasonable costs may be determined by cost; the time that has expired since the previous evaluation; any difference in the expertise of the Physician or practitioner performing the evaluation; changes in technology and advances in medicine. For services provided by a licensed Assisted Living Facility through a program that includes an overnight stay, each overnight stay is equal to a visit.
- **Post-acute transition services.** Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- **Psychophysiological testing.** An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- **Psychophysiological treatment.** Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- **Remediation.** The process of restoring or improving a specific function.
- **Treatment facilities.** Treatment for an acquired brain Injury may be provided at a facility at which the services listed above may be provided including a hospital, acute or post-acute rehabilitation hospital and Assisted Living Facility.
    - Although Benefits may be available for services at Assisted Living Facilities, Benefits are not available for Custodial Care, Private Duty Nursing, domiciliary care, and personal care assistants as outlined in the *Exclusions and Limitations* section, regardless of where services are provided.

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground, Air Ambulance or water vehicle) to the nearest hospital where the required Emergency Health Service can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as we determine 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.

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.

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.

Dental Services – Accident Only

Dental services are a Covered Health Benefit when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal Activities of Daily Living or extraordinary use of the teeth is not considered an Accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by Accidental Injury must follow these timeframes:

- Treatment must be completed within 24 months of the accident, or if not a Member at the time of the accident, within the first 24 months of coverage under the EOC.

Benefits for treatment of Accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

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.

Benefits for diabetes supplies will be provided under the *Outpatient Prescription Drug section.* All other diabetes 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.
- 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.
- 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 the *Preventive Care Services* section.

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

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.
- Ostomy supplies
- Insulin pumps and all related needed supplies as described above under the *Diabetic Management Services* section.

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 Necessary. Benefits also include external cochlear devices and systems, including external speech processor and controller with necessary components. We will decide if the equipment should be purchased or rented.

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 the *Exclusions and Limitations* section.

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 Health Care Service - Outpatient

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 the *Outpatient Prescription Drug* or *Pharmaceutical Products – Outpatient* sections.

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 to us:
- 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 the *Home Health Care section*. 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 the *Habilitative Services* and *Rehabilitation Services - Outpatient Therapy and Chiropractic* sections.

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.

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*. Bone anchored hearing aids are only available if:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss is severe enough that it would not be remedied by a wearable Hearing Aid.

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 the *Rehabilitation Services - Outpatient Therapy and Chiropractic* section.

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.
- Meals and special diets, when Medically Necessary
- Room and board in a semi-private room (a room with two or more beds).
- Physician services, including but not limited to radiologists, anesthesiologists, pathologists and Emergency room Physicians.
- 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.

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 and Substance-Related and Addictive Disorders Services

Mental Health and Substance-Related and Addictive Disorders 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 Provider 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 the *Definitions* section):
    - 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.

Oral Surgery

Benefits for oral surgery are 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;
- Services provided which are necessary for treatment or correction of a congenital defect;
- Removal of complete bony impacted teeth; or
- Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded in the *Exclusions and Limitations* section.

General dental services are NOT covered by the Harbor Health Plan, except for what's covered under the *Dental Services – Accident Only* section.

Organ and Tissue Transplant

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 EOC, 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.

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.

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 or order or refill are provided as described in the *Outpatient Prescription Drugs* section of this *EOC.*

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;
- Make death or harm probably;
- 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 different pharmay,

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 pharmacy Benefit instead of the medical Benefit 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.

- 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.

If you require certain Pharmaceutical Products, including Specialty Pharmaceutical Products, we can 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.

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

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* section 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 supply 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'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 the *Preventive Care* section.

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 the *Durable Medical Equipment (DME) and Supplies* section.

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 Procedures

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.

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 the *Home Health Care* section. 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.

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 the *Surgery – Outpatient* section.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services, including but not limited to radiologists, anesthesiologists and pathologists.

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

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/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, including but not limited to radiologists, anesthesiologists and pathologists.

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, including but not limited to radiologists, anesthesiologists and pathologists.

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.

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 including but not limited to anesthesiologists, pathologists and radiologists.

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.

Vision Care Services

Adult Vision Care

Routine vision exams received from a health care Provider in the Provider's office are a Covered Health Benefit for Members age 19 and older. Routine vision exams include refraction to find vision impairment.

Pediatric Vision Care

Vision care services are available for a Dependent Child under the age of 19. Coverage is available until the end of the month in which the Dependent Child turns 19. Benefits for vision care services will be provided for the following:

- One refractive vision exam of the eyes every 12 months, according to the standards of care in your area; and
- Your choice of one pair of eyeglass frames and prescription lenses every 12 months or a 12-month supply of contact lenses every 12 months.

Note: Benefits for eye exams for adults or children that are required for the diagnosis and treatment of a sickness or injury are provided under *Physician Office Services – Sickness and Injury*.

Exclusions and Limitations

To help you find exclusions, we use headings. The headings group services, treatments, items or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even If either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in the *What Your Plan Covers* section or through a Rider to the EOC.

When Benefits are limited within any of the Covered Health Service categories described in the *What Your Plan Covers* section, those limits are stated in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, animal assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Chiropractic Treatment for which Benefits are provided as described in the *What Your Plan Covers* section.

Dental

1. 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 dental services for which Benefits are provided in the *What Your Plan Covers* section.

Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Orthotics* in the *What Your Plan Covers* section.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.
8. Powered and non-powered exoskeleton devices.
9. Wigs.
10. Powered wheelchairs.

Drugs

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill. See the *Outpatient Prescription Drugs* section of this EOC for prescription drug products covered under the pharmacy Benefit.
2. Self-administered or self-infused medications that are covered under the *Outpatient Prescription Drugs* section of this EOC. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs, treatments and tests. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under *Diabetic Management Services* in the *What Your Plan Covers* section. This exclusion does not apply to PPACA Zero Cost Share Preventive Care Medications for which Benefits are provided under the pharmacy Benefit as described in the *Outpatient Prescription Drugs* section of this EOC.
5. Growth hormone therapy.
6. Compounded drugs that contain certain bulk chemicals

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven 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 or Unproven 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 the *What Your Plan Covers* section.

Foot Care

1. Routine foot care. Examples include:
   - Cutting or removal of corns and calluses.
   - Nail trimming, nail cutting, or nail debridement.
   - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease, such as diabetes.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Orthopedic shoes, inserts, modifications, and footwear except as described under *Diabetic Management Services* in the *What Your Plan Covers* section.
5. Arch supports

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Items routinely found in the home.
   - Urinary catheters.
   - Deoderants.
   - Filters.
   - Lubricants.
   - Tape
   - Appliance cleaners.
   - Adhesive and adhesive remover.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME) and Supplies* in the *What Your Plan Covers* section.
   - Diabetic Supplies for which Benefits are provided as described under *Diabetic Management Services* in the *What Your Plan Covers* section.
2. Tubings except when used with DME as described under *Durable Medical Equipment (DME) and Supplies* in the *What Your Plan Covers* section.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.

4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement under *Preventive Care* and *Physician's Office Services – Sickness and Injury* in the *What Your Plan Covers* section. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional 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.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in the *What Your Plan Covers* section.
3. Nutritional or dietary supplements, except as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist, or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

   This exclusion does not apply to:
   - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *What Your Plan Covers* section, which meet the definition of a Covered Health Service.
   - Enteral formulas for which Benefits are provided as described under *Enteral Nutrition* in the *What Your Plan Covers* section.
4. Services for dietary therapy including medically supervised formula weight-loss programs, unsupervised self-managed programs and over-the-counter weight loss formulas, except as listed in the Benefit plan.

Organ and Tissue Transplants

1. Health care services for organ and tissue transplants, except those described under *Organ and Tissue Transplant* in the *What Your Plan Covers* section.
2. 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 EOC.)
3. Health care services for transplants involving animal organs.
4. 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.

5. Living and/or travel expenses of the recipient or a live donor.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA) requirement.*
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot and cold compresses.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Safety equipment.
   - Treadmills.
   - Vehicle modifications such as van lifts.
   - Video players.

Physical Appearance

1. Cosmetic Procedures, when not determined to be Medically Necessary. Examples include:
   - Membership costs and fees for health clubs and gyms.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

- Skin abrasion procedures performed as a treatment for acne.
- Lipsuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to lipsuction for which Benefits are provided as described under *Reconstructive Procedures* in the *What Your Plan Covers* section.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Sclerotherapy treatment of veins.
- Hair removal or replacement by any means.
- Abdominoplasty.
- Blepharoplasty.
- 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 transplantation.
- Lip augmentation.
- Lip reduction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

2. 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 mastectomy. See *Reconstructive Procedures* in the *What Your Plan Covers* section.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. This exclusion does not apply to Medically Necessary panniculectomy.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain Injury.
6. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-

diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.

7. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.
8. Surgical treatment of obesity.
9. Stand alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care Providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
10. Sex transformation surgery, including medical and hormonal therapy in preparation for and subsequent to any such surgery.

Providers

1. Services performed by a Provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.
2. Services performed by a Provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without a Medical Order written by a Physician or other Provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other Provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other Provider:
   - Has not been involved in your medical care prior to ordering the service, or
   - Is not involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services performed for the diagnosis and treatment of any underlying cause of infertility as described under *Physician's Office Services – Sickness and Injury* in the *What Your Plan Covers* section. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iotrogenic Infertility* in the *What Your Plan Covers* section.

   The following infertility treatment-related services are not covered:
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services.

2. The following services related to a Gestational Carrier or Surrogate:
   - All costs related to reproductive techniques including:
     - Assisted reproductive technology.
     - Artificial insemination.

- Intrauterine insemination.
- Obtaining and transferring embryo(s).

- Health care services including:
  - Inpatient or outpatient prenatal care and/or preventive care.
  - Screenings and/or diagnostic testing.
  - Delivery and post-natal care.

  The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Member.
- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
  - Surrogate insurance Premiums.
  - Travel or transportation fees.

3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iotrogenic Infertility* in the *What Your Plan Covers* section.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.
7. Costs to treat sexual dysfunction and/or impotency.
8. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). This exclusion does not apply to therapeutic abortion recommended by a doctor and performed to save the life of the mother.
9. Elective fertility preservation.

Services Provided Under Another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.
   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. 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.
3. Health care services for treatment of military service related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to organ and tissue transplants may be paid back as

determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in the *What Your Plan Covers* section.

Types of Care, Supportive Services, and Housing

1. Custodial Care or maintenance care.
2. Domiciliary care.
3. Private Duty Nursing, except as described under *Hospital Admissions* in the *What Your Plan Covers* section.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* and *Acquired Brain Injury* in the *What Your Plan Covers* section.
5. Rest cures.
6. Services of personal care aides.
7. Services in a Long-Term Acute Care Facility (LTAC), except to treat an acquired brain Injury.
8. Independent living services.
9. Assisted living services.
10. Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act*.
11. Vocational counseling, testing and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
12. Transitional Living services (including recovery residences).

Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses for adults age 19 years and older. This exclusion does not apply to:
   - One pair of prescription eyeglasses or contact lenses required following surgery to treat cataracts, aphakia, acute corneal pathology or keratoconus for which Benefits are provided.
   - Prescription eyeglasses and contact lenses for which Benefits are provided as described under *Vision Care Services, Pediatric Vision Care* in the *What Your Plan Covers* section.
2. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
3. Eye exercise or vision therapy, unless Medically Necessary.
4. 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.
5. Over-the-counter Hearing Aids.

All Other Exclusions

1. 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* in the *What Your Plan Covers* section and in the *Schedule of Benefits*.
- Not otherwise excluded in this *EOC* in the *Exclusions and Limitations* section.

2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered in the EOC when:
   - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. 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 the *What Your Plan Covers* section.
   - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by ware, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the EOC ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the EOC ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the EOC.
6. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
7. Long term storage:
   - Long term storage services are not a Covered Health Service.
   - This includes, but is not limited to, long term storage (cryopreservation) of tissue, blood, blood products, sperm, eggs, and any other body or body parts. For example, if a Member is entering the military, etc., we will not cover any long-term storage of the above.
   - Storage services related to infertility treatment usually only require short term storage which is generally covered as part of the retrieval and implantation charges for the infertility treatment.
8. Autopsy.
9. Foreign language and sign language interpretation services offered by or required to be provided by a Network or Out-of-Network Provider.
10. Health care services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if the service treats complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a “complication” is an unexpected or

unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

11. Blood tissue typing for paternity testing are not a covered service.
12. Specimen Provenance testing are not a covered service.
13. Services or supplies for teaching, vocational, or self-training purposes, except as listed in the Benefit plan.
14. Telephone consultations (except telehealth) or for failure to keep a scheduled appointment.
15. Stand-by availability of a medical practitioner when no treatment is rendered.
16. Services or supplies that are provided prior to the Effective Date or after the termination date of the EOC.

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 Network Provider is 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. If your Network Provider requests Pre-Authorization and we deny the request (Adverse Determination), and you still choose to get the care, you will be responsible for the entire cost of the care. 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. 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* section, 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 the *Questions, Complaints and Appeals* section.

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 the *Questions, Complaints and Appeals* section.

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, 7:00am – 8:00pm and Saturday, 8:00am – 5pm, 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, Members, Physicians, or other Providers with experience in the area of care to which your appeal is related.

No later than the fifth business day before the complaint appeal panel meets, we will provide 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; or
- 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 the *Definitions* section.

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.

Claims and Reimbursement

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. If a Network Provider bills you for any Covered Health Service, contact us at the telephone number on your ID card. However, you are required to pay the cost share obligation that is outlined in the *Schedule of Benefits.*

You may be required to file your own claims when you receive treatment or care from an out-of-Network provider for Emergency services or if we refer you to 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

Within fifteen (15) days of receipt of written notice of a claim, Harbor Health will acknowledge receipt of the claim and begin any necessary investigation. It may be necessary for us to request additional information from you. Claims will be acted upon within fifteen (15) business days of receipt of a completed claim, unless you are notified that additional time is needed and why. We will act on a completed claim no later than forty-five (45) days after the additional time notification is given to you. If we notify you that we will pay a claim or part of a claim, we will pay an approved claim not later than five (5) business days after the date notice is made.

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.

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 court proceedings 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.

General Provisions

Your Relationship with Us

It is important for you to understand our role with respect to the Contract and how it may affect you. We administer the Contract under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Contract will cover or pay for the health care that you may receive. The Contract pays for Covered Health Services, which are more fully described in this EOC.
- The Contract may not pay for all treatments you or your Physician may believe are needed. If the Contract does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* on our website at www.harborhealth.com for details.

Our Relationship with Providers

We have agreements in place that govern the relationship between us and Network Providers, some of which are affiliated Providers. Network Providers enter into an agreement with us to provide Covered Health Services to Members.

We do not provide health care services or supplies, or practice medicine. We arrange for health care Providers to participate in a Network and we pay Benefits. Network Providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the Providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any Provider.

Your Relationship with Providers

The relationship between you and any Provider is that of Provider and patient.

You are responsible for all of the following:

- Choosing your own Provider.
- Paying directly to your Provider any amount identified as a Member responsibility, including Copayments, any Annual Deductible or any amount that exceeds the Allowed Amount, when applicable.
- Paying directly to your Provider the cost of any non-Covered Health Service.
- Deciding if any Provider treating you is right for you. This includes Network Providers you choose and Providers that they refer.
- Deciding with your Provider what care you should receive.

Your Provider is solely responsible for the quality of the services provided to you.

Contractual Arrangements with Providers

We pay Network Providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network Providers receives a monthly payment from us for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health care services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network Providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment will be calculated based on the Provider type that received the bundled payment. The Network Providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment may not be required if such follow up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment as described in your Schedule of Benefits.

We use various payment methods to pay specific Network Providers. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also call us at the telephone number on your ID card. We can advise whether your Network Provider is paid by any financial incentive, including those listed above.

Benefit Interpretation and Other Provisions under the Contract

We have the authority to do all of the following:

- Interpret Benefits under the Contract.
- Interpret the other terms, conditions, limitations and exclusions set out in the Contract including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make determinations related to the Contract and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of this Contract.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefit for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Contract

To the extent permitted by law, we have the right to change, interpret, withdraw or add Benefits or end the Contract. Any amendments to this Contract will comply with all notice requirements mandated by the Texas Insurance Code and other applicable state or federal laws. Such notice will include a clear explanation of the changes.

Any provision or part of a provision of the Contract which, on its Effective Date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Contract is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Contract unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Contract are effective upon renewal, except as otherwise permitted by law.
- No agent has the authority to change the Contract or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Contract.

How We Use Information and Records

We may use your individually identifiable health information as follows:

- To administer the Contract and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More details about how we may use or disclose your information is found in our *Notice of Privacy Practices* on our website at www.harborhealth.com/notice-of-privacy-practices.

By accepting Benefits under the Contract, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. We have the right to request this information at any reasonable time. This applies to all Members, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Contract.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Contract, we and our related entities may use and transfer the information gathered under the Contract in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices* on our website at www.harborhealth.com for details.

For complete listings of your medical records or billing statements, you may contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Examination of Members

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation Impact

Benefits provided under the Contract do not substitute for and do not affect any requirements for coverage by workers' compensation insurance. If you suffer a work-related injury or illness, workers' compensation insurance should provide primary coverage for such conditions. In the event Benefits are provided for an injury or illness for which workers' compensation coverage may be available, such Benefits will be subject to the *Subrogation* provision in the *Claims and Reimbursement* section of this Contract. The Plan's rights and your obligations regarding subrogation are fully described under *Subrogation* in the *Claims and Reimbursement* section of this Contract.

Refunds of Overpayments

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Contract.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Contract. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Contract. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part: (1) future Benefits that are payable in connection with services provided to other Members under the Contract; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in the *Questions, Complaints and Appeals* section. After completing that process, if you want to bring a legal action against us, you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Statements Made by Subscriber

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. A statement will not be used in a contest to void, cancel, non-renew coverage or reduce Benefits unless it is in a written enrollment application signed by the Subscriber that is or has been furnished to the Subscriber or the Subscriber's personal representative. We will not use any statement made by the Subscriber to void the Contract after it has been in force for two years unless it is a fraudulent statement.

Definitions

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-Related and Addictive Disorders 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 this EOC. 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.

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

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.

Behavioral Health Practitioner - means a Physician or a Provider who renders services for Mental Health Care, Serious Mental Illness or Substance-Related and Addictive Disorders.

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.

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 includes:

- Natural children
- Stepchildren
- Adopted children, including those placed with you for adoption
- Foster children

- Children you are responsible for under a qualified medical or dental support order or court order (whether or not the child resides with you)
- Grandchildren in your court-ordered custody
- A grandchild who is your Dependent for federal tax purposes
- Any children approved by the Exchange

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the year following the date the child reaches age 26 except as provided in *Coverage for a Disabled Dependent Child* in the *When Coverage Ends* section.
- A Dependent includes 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.

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.

Congenital Anomaly is a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

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

- Evidence of Coverage
- Schedule of Benefits
- Subscriber Application
- Riders
- Amendments

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

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.

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 the Subscriber's legal spouse, Domestic Partner, or any child covered under the Plan.

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 Subscriber 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 Subscriber. The Domestic Partner may be the same or opposite gender of the Member.

Domestic Partnership/Declaration of 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 Texas.
- 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 joint obligation on a loan.
  - 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 Person means a person who meets the eligibility requirements determined by the federal Health Insurance Marketplace. An Eligible Person must live, reside 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.

Enrolled Dependent means a Dependent who is properly enrolled under the Contract.

Exchange means the federal-facilitated Marketplace.

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.

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.

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.

Geographic Service Area/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 ordered by a Physician and

provided during 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. The Home Health Agency provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Injury or Sickness requiring the Home Health Care.

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).

Injury is traumatic damage to the body, including all related conditions and symptoms.

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-Related and Addictive Disorders or specializes in the treatment of co-occurring Mental Illness and Substance-Related and Addictive Disorders.

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 Order means one or more diagnostic or treatment directives 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 a Subscriber or Dependent and is eligible to receive Covered Health Services.

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.

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.

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.

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*.

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 Subscriber 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 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.

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.

Sickness is a physical illness, disease or Pregnancy. The term Sickness as used in the Contract includes Mental Illness or substance-related and addictive disorders.

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.

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.

Subscriber is the person (who is not a Dependent) to whom the Contract is issued.

Substance-Related and Addictive 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.

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.

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.

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

You or Your means a covered Member.

Outpatient Prescription Drugs

This section of the EOC provides Network Benefits for Prescription Drug Products.

Because this section 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 EOC in the *Definitions* section or in this section under the heading *Defined Terms for Outpatient Prescription Drugs*.

NOTE: The *Coordination of Benefits* section in the EOC applies to Prescription Drug Products covered through this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the Contract.

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 visit our website at [www.harborhealth.com] or call 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 *Schedule of Benefits*. 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.

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 the *Claims and Reimbursement* section of 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:
[PBM Name]
[PBM Address]
[PBM City, State, Zip Code]

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may provide assistance to your provider in choosing a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, your provider may contact us, and we will assist your provider in selecting another pharmacy to obtain that Prescription Drug Product.

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*. 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 going to our website at [www.harborhealth.com] or by calling the telephone number on your ID Card.

Pre-Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, your Physician or pharmacist 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 or the pharmacist 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 going to our website at [www.harborhealth.com] or by calling 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 the *Claims and Reimbursement* section.

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 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 going to our website at at [www.harborhealth.com] or by calling 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 the *Questions, Complaints and Appeals* section 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.

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 Deductible, 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 going to our website at [www.harborhealth.com] or by calling 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 - Outpatien*t in the *What Your Plan* Covers section.

Exclusions

Exclusions from coverage listed in the *Exclusions and Limitations* section 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 the *What Your Plan Covers* section. 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 the medical portion of the plan in the *What Your Plan Covers* section.
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 the *What Your Plan Covers* section. 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* in the *What Your Plan Covers* section.
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 the *What Your Plan Covers* section.
- Amino acid-based elemental formulas, as described under *Enteral Nutrition* in the *What Your Plan Covers* section.
- 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 in the *Schedule of Benefits*.

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.

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 Member 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 [3908 Avenue B, Suite 204, Austin, TX 78751]. You may also visit our website at [www.harborhealth.com].

Inpatient Stay Following Birth of a Child

For each Member 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 [3908 Avenue B, Suite 204, Austin, TX 78751]. 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 Member 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 [3908 Avenue B, Suite 204, Austin, TX 78751]. 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 [3908 Avenue B, Suite 204, Austin, TX 78751]. 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 [3908 Avenue B, Suite 204, Austin, TX 78751]. 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 [3908 Avenue B, Suite 204, Austin, TX 78751]. 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 [3908 Avenue B, Suite 204, Austin, TX 78751]. You may also visit our website at [www.harborhealth.com].

Texas Notice of Rights

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

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

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

Your plan’s network

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

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

List of doctors

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

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

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

Bills for health care

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

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

Harbor Health

Schedule of Benefits

Individual HMO Plan

Harbor Health G1

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 when 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.

Harbor encourages you to establish a relationship with 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.

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.

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.

Referrals and Cost Share Reduction

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.

Pre-Authorization

Harbor Health requires advance approval (Pre-Authorizations) for certain types of Covered Health Services and outpatient prescription drugs, 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 the *Pre- Authorization and Utilization Management* section 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 calendar 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 section. Benefits for outpatient prescription drugs on the PPACA Zero Cost Share Preventive Care Medications are not	No Annual Deductible

subject to payment of the Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.	
Out-of-Pocket Maximum	**Amount**
The out-of-pocket maximum is the most you pay per calendar for the Annual Deductible and Copayments. Once you reach the out-of-pocket maximum, Benefits are payable at 100% of the Allowed Amount during the rest of that year. The out-of-pocket maximum applies to Covered Health Services under the Plan as indicated in this Schedule of Benefits, including Covered Health Services provided under the *Outpatient Prescription Drug* section. 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.	$10,150 per Member, not to exceed $20,300 for all Members in a family.
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. Note: The Copayments will not exceed 50% of the total cost of services provided. Plus your total Copayments will not exceed 200% of the annual Premium paid on your behalf (or, if you have family coverage, paid on behalf of all Members in your family).	

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar 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*.
Ambulance Services	
This includes ground or Air Ambulance for non-emergency transportation, as we determine appropriate.	50%
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*.
Dental Services – Accident Only	
	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 calendar 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	***Advanced Imaging*** *With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%
Lab Testing – Outpatient	***Genetic Testing, other than BRCA*** 50%

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar year basis unless otherwise specifically stated.**	Cost Share
All Other Diagnostic Testing - Outpatient	***All Other Lab Testing, including BRCA*** *With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50% ***All Other Diagnostic Testing - Outpatient*** *With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%
Durable Medical Equipment (DME) and Supplies	
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.	50%
Emergency Care	
Note: 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	50%

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar year basis unless otherwise specifically stated.**	Cost Share
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*.	
Enteral Nutrition	
	50% up to a 30-day supply
Fertility Preservation for Iatrogenic Infertility	
	50%
Habilitative Services	
Inpatient	***Inpatient*** 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.
Outpatient Habilitative services are limited to physical therapy, occupational therapy, chiropractic	***Outpatient*** *With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your*

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar year basis unless otherwise specifically stated.**	Cost Share
services, speech therapy, post-cochlear implant aural therapy, cognitive therapy. Limits per year as follows: ● 35 visits per year for any combination of physical therapy, occupational therapy, speech therapy and chiropractic treatment. 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*.	*Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%
Hearing Aids	
Benefits are limited to a single purchase per hearing impaired ear every 36 months. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	50%
Home Health Care	
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. Visit limits above do not apply for the treatment of Mental Illness. In addition to the cost share stated in this	*With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar year basis unless otherwise specifically stated.**	Cost Share
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.	
Hospice Care	
	Inpatient Hospice Care 50% ***Home Hospice Care*** *With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%
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*.	50%
Maternity Care	
Note: Returning home with durable medical equipment, such as a fetal monitor, following an office visit or	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

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar year basis unless otherwise specifically stated.**	Cost Share
inpatient admission may result in an additional cost share. Refer to *Durable Medical Equipment (DME) and Supplies* category in this *Schedule of Benefits*.	*Schedule of Benefits*.
Mental Health Care and Substance-Related and Addictive Disorders 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*** 50% ***Office Visit – In Person/Telehealth/Telemedicine*** None ***Outpatient Services*** *With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%
Oral Surgery	
Note: Returning home with durable medical equipment, such as an oral 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*.	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*.
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	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*.

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar year basis unless otherwise specifically stated.**	Cost Share
Covered Health Services from a Network transplant provider, you may be eligible for reimbursement of certain travel expenses.	
Orthotics	
	50%
Pharmaceutical Products – Outpatient	
	50%
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, and all other diagnostic testing 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*. Note: Returning home with durable	***Primary Care –In Person/Telehealth/Telemedicine*** None ***Specialist – In Person/Telehealth/Telemedicine*** *With a Referral from your Primary Care Physician* None *Without a Referral from your Primary Care Physician* 50%

Covered Health Service **Note: Benefit limits listed below are calculated on a calendar year basis unless otherwise specifically stated.**	Cost Share
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*.	
Prescription Drugs – Outpatient	
You are responsible for paying the Annual Deductible stated in this *Schedule of Benefits*, if applicable, before Benefits for Prescription Drug Products are available to you. Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible. You are responsible for paying the applicable cost share described in the table below. You are not responsible for paying a Copayment for PPACA Zero Cost Share Preventive Care Medications. **Prescription Drugs – Retail** The following supply limits apply: • As written by the Provider, up to a consecutive 30-day supply of a Prescription Drug Product or Specialty 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 or 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. 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. You are not responsible for paying a cost share for Prescription Drug Products on the List of Preventive Medications.	

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 cost share 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.

Prescription Drugs – Retail	***Prescription Drugs – Retail*** *Tier 1 – Generic Drug* $10 per Prescription Order or Refill *Tier 2 – Preferred Brand Drug* 50% of the Prescription Drug Charge *Tier 3 – Non-Preferred Brand Drug* 50% of the Prescription Drug Charge *Tier 4 – Specialty Drug* 50% of the Prescription Drug Charge
Prescription Drugs – Mail Order	***Prescription Drugs – 90-Day Supply Mail Order*** *Tier 1 – Generic Drug* $25 per Prescription Order or Refill *Tier 2 – Preferred Brand Drug* 50% of the Prescription Drug Charge *Tier 3 – Non-Preferred Brand Drug*

	50% of the Prescription Drug Charge
Preventive Care	
Preventive care includes physician office services, lab, x-rays or other tests and breast pumps. Refer to *Preventive Care* in the *What Your Plan Covers* 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	
	50%
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*.
Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment	
Rehabilitative 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. Limits per year as follows: ● 35 visits per year for any combination of physical therapy, occupational therapy, speech therapy and chiropractic treatment. Visit limits do not apply if the primary diagnosis is for a Mental Illness or Acquired Brain Injury.	*With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%

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*.	
Scopic Procedures – Outpatient Diagnostic and Therapeutic	
	With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* 50%
Skilled Nursing Facility and Rehabilitation Facility Services	
Limited to 25 days per Plan year in a Skilled Nursing Facility. Covered Health Services in an Inpatient Rehabilitation Facility are not subject to an annual limit. 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*.	50%
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 Benefits*.	*With a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician* None *Without a Medical Order from your Primary Care Physician or from a Specialist you were referred to by your Primary Care Physician*

	50%
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*.
Therapeutic Treatments - Outpatient	
	50%
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*** $50 per visit
Vision Care	
Adult Vision Care 1 routine vision exam every 12 months. *Pediatric Vision Care* 1 routine vision exam every 12 months. 1 pair of eyeglasses (frames and lenses) every 12 months **or** a 12-month supply of contact lenses every 12 months.	***Adult Routine Vision Exam*** None ***Pediatric Routine Vision Exam*** None ***Pediatric Glasses or Contacts*** 50%

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.