Harbor Health

Written Plan Description

Health Maintenance Organization Plan

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

If you have questions or need additional information, you may contact us at:

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

NOTE: If there is a conflict between this written plan description and the Evidence of Coverage, the Evidence of Coverage supersedes.

Benefits for Covered Health Services

The plan information provided in this document does not list every service that we cover or list every limitation or exclusion. After enrolling, you will receive an Evidence of Coverage (EOC) which contains detailed information regarding your health care benefits. Refer to the EOC to understand exact coverage for certain conditions, services, and supplies.

- **Acquired Brain Injury** - Benefits are provided for services as a result of and related to an acquired brain injury. Benefits include cognitive communication therapy; cognitive and neurocognitive rehabilitation therapy; community reintegration services; neurofeedback therapy; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment; post-acute transition services; and remediation.
- **Ambulance Services** – Emergency ambulance transportation is covered by a licensed ambulance service (either ground or air ambulance) to the nearest hospital where the required emergency health services can be performed. Non-emergency transportation may be covered when medically necessary.
- **Clinical Trials** – Routine patient care costs incurred during participation in a qualifying phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition are covered.

- **Dental Services – Accident Only** – Dental services are a Covered Health Benefit when treatment is needed because of accidental damage, you receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry, and the dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident.
- **Diabetic Management Services** – Benefits include diabetes equipment, diabetes supplies and diabetes self-management training programs.
- **Diagnostic Services** – Advanced imaging (e.g., MRI, MRA, nuclear medicine, PET scans, CT scans), laboratory tests, x-rays and all other diagnostic services are covered for sickness and injury-related diagnostic purposes received on an outpatient basis.
- **Durable Medical Equipment (DME) and Supplies** – Benefits are provided for equipment that is ordered or provided by a physician for outpatient use, used for medical purposes, and not consumable or disposable.
- **Emergency Health Care Service** – Benefits are available for services that are required to stabilize or initiate treatment in an Emergency.
- **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.
- **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.
- **Habilitative Services** – Benefits are available for skilled care services that are part of a prescribed plan of treatment to help a person with a disabling condition learn or improve skills and functioning for daily living.
- **Hearing Aids** – Benefits are available for the correction of a hearing impairment and include the associated fitting, testing and dispensing services, habilitation and rehabilitation as necessary for educational gain.
- **Home Health Care** – Benefits include skilled nursing by a registered nurse or licensed vocational nurse; physical, occupational, speech or respiratory therapy; the service of a home health aide, under the supervision of a registered nurse; and medical equipment and medical supplies other than drugs and medicines.
- **Hospice Care** – Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Member is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.
- **Hospital Admissions** – Benefits are available for supplies and non-physician services; room and board in a semi-private room; use of intensive care unit and services; use of operating room and related facilities; meals and special diets; general nursing care; private duty nursing; x-ray services; labs; drugs; medications, biologicals, anesthesia and oxygen services; radiation therapy; inhalation therapy; whole blood and the administration; and short term rehabilitation services.
- **Maternity Care** – Benefits for pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.
- **Mental Health Care and Substance-Related and Addictive Disorders Services** – Benefits include those received on an inpatient or outpatient basis in a hospital, an alternate facility or in a provider's office. Benefits include detoxification from abusive chemicals or substances, limited to physical detoxification when necessary to protect your physical health and well-being.
- **Oral Surgery** – Coverage for medically necessary oral surgery is limited to excision of non-dental related neoplasms, incision and drainage of facial abscess, surgical

procedures involving salivary glands and ducts, 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.

- **Organ and Tissue Transplants** – Organ and tissue transplants are available when ordered by a physician and when the transplant meets the definition of a covered health service and is not experimental or investigational.
- **Orthotics** – Orthotics are covered when medically necessary to adequately meet the medical needs of the Member to participate in Activities of Daily Living as determined by your treating physician or prosthetist.
- **Pharmaceutical Products** – Benefits include pharmaceutical products that are administered on an outpatient basis in a hospital, alternate facility, physician's office, or in a Member's home. Benefits are provided only for pharmaceutical products which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional.
- **Physician's Office Services – Sickness and Injury** – Benefits are available for services provided by a physician in the office for the diagnosis and treatment of a sickness or injury.
- **Preventive Care** – Benefits are available for medical services on an outpatient basis that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease and have been proven to have a beneficial effect on health outcomes.
- **Prosthetic Devices** – Benefits are available for only the most appropriate model of prosthetic device that meets your needs.
- **Reconstructive Surgery** – Reconstructive procedures are covered when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Benefits include surgery or other procedures which are associated with an injury, sickness or congenital anomaly.
- **Rehabilitation Services-Outpatient Therapy and Chiropractic** – Rehabilitation services that are performed by a physician or by a licensed therapy provider are covered.
- **Scopic Procedures-Outpatient Diagnostic and Therapeutic** – Benefits are available for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a hospital or alternate facility.
- **Skilled Nursing Facility and Inpatient Rehabilitation Services** – Benefits are available for supplies and non-physician services, room and board, and physician services for skilled are (skilled nursing, skilled teaching and skilled rehabilitation services).
- **Surgery-Outpatient** – Benefits include the facility charge and the charge for supplies and equipment for surgery and related services received on an outpatient basis at a hospital or alternate facility.
- **Telehealth, Telemedicine and Teledentistry Services** – Benefits include telehealth services, telemedicine medical services and teledentistry dental services.
- **Therapeutic Treatments-Outpatient** – Treatments received on an outpatient basis at a hospital or alternate facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology are covered.
- **Urgent Care** – Benefits include services received at an urgent care center.
- **Vision Care Services** – Benefits include annual routine vision exams for adults and children and coverage for glasses or contacts for children under the age of 19.

Emergency, After Hours or Urgent Medical Services

Emergency Services

Emergency care means health care services to treat 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.

In an emergency, call 911 or go to the nearest emergency room. Benefits are available for network or out-of-network providers when emergency care is received.

After Hours Care

For care after hours, first call your network physician. Network physicians provide either an answering service or detailed answering message that gives instructions for accessing care after hours.

Urgent Care Services

Urgent care health services are covered when provided by a network physician or provider when immediate treatment of a medical condition is necessary. Urgent care centers provide medical care with less wait time and at a much lower cost than an emergency department of a local hospital.

Out-of-Area Services

Harbor Health arranges for Network physicians and providers within your service area. Benefits for Covered Health Services provided by out-of-Network facility-based physicians, emergency care and referrals when network services are not available within your service area will be covered subject to the Network cost share listed in your *Schedule of Benefits.*

With the exception of emergency services or other specific services authorized by your Network physician or Harbor Health, when you are out of your geographic area, you are not covered for any other medical or hospital services.

Required Disclosure: Health Benefit Plan

Some facility-based physicians or other health care practitioners at contracted health care facilities may not be contracted with Harbor Health.

In these situations, the out-of-network facility-based physician or other health care practitioner may balance bill you for amounts not paid by your health plan.

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

Financial Responsibility

Annual Deductible

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

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

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

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

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

Limitations and Exclusions

Not all services are covered under your plan. The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in the *Evidence of Coverage* or through a rider. The following is a summary of services that are not covered. Refer to your *Evidence of Coverage* for a complete list of limitations and exclusions.

- Any services, supplies or drugs that are not Medically Necessary and essential to the diagnosis and direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
- 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 the EOC in the *What Your Plan Covers* section and in the *Schedule of Benefits*.
    - Not otherwise excluded in the *EOC* under the *Exclusions and Limitations* section.

- Any Experimental or Investigational Services, supplies, or drugs. The fact that an Experimental or Investigational Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational Services in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in the *What Your Plan Covers* section.
- Room and board charges incurred during a hospital admission for diagnostic or evaluation procedures if the tests could have been covered on an outpatient basis without adversely affecting the Member's physical condition or the quality of medical care provided.
- The following items are excluded, even if prescribed by a Physician:
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Trusses.
    - Ultrasonic nebulizers.
- Devices and computers to help with communication and speech.
- Oral appliances for snoring.
- Repair or replacement of prosthetic devices or DME items due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as in the *What Your Plan Covers* section of the *EOC*.
- Non-covered Durable Medical Equipment includes, but not limited to, air conditioner, air purifier, cryogenic machine, humidifier, physical fitness equipment, and whirlpool bath equipment.
- Powered and non-powered exoskeleton devices.
- Cosmetic Procedures. Examples include:
    - Abdominoplasty.
    - Blepharoplasty.
    - Breast enlargement, including augmentation mammoplasty and breast implants.
    - Body contouring, such as lipoplasty.
    - Brow lift.
    - Calf implants.
    - Cheek, chin, and nose implants.
    - Injection of fillers or neurotoxins.
    - Face lift, forehead lift, or neck tightening.
    - Facial bone remodeling for facial feminizations.
    - Hair removal or replacement by any means.
    - Hair transplantation.
    - Lip augmentation.
    - Lip reduction.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in the *What Your Plan Covers* section of the *EOC*.
    - Mastopexy.
    - Pectoral implants for chest masculinization.
    - Pharmacological regimens, nutritional procedures or treatments.

    - Rhinoplasty.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins, unless Medically Necessary.
    - Skin abrasion procedures performed as a treatment for acne.
    - Skin resurfacing.
    - Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
    - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins.
    - Voice modification surgery.
    - Voice lessons and voice therapy.
- Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed a mastectomy. See *Reconstructive Procedures* in the *What Your Plan Covers* section of the *EOC*.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Home Infusion Therapy unless Medically Necessary.
- Any services, supplies or drugs provided for custodial care, long term care, respite care. This exclusion does not apply to services for which Benefits are provided as described under *Hospice Care* in in the *What Your Plan Covers* section of the *EOC*.
- Any services, supplies and drugs provided for any medical social services, bereavement counseling (except as provided under *Hospice Care* in in the *What Your Plan Covers* section of the *EOC*), and vocational counseling.
- Acupuncture services
- Private duty nursing unless Medically Necessary.
- Nursing and Home Health Aide services, unless Medically Necessary.
- Weight loss drugs, food products, and exercise programs or equipment, unless Medically Necessary.
- Over-the-counter home tests.
- Bariatric surgery.
- Food and nutritional items. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in in the *What Your Plan Covers* section of the *EOC*.
- Any services, supplies or drugs supplied to increase or decrease height or alter the rate of growth, including surgical procedures or devices to stimulate growth (except for certain endocrine conditions).
- Any services, supplies or drugs supplied to increase or decrease height or alter the rate of growth, including surgical procedures or devices to stimulate growth (except for certain endocrine conditions).
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
- All expenses related to dental care. This exclusion does not apply to *Dental Services-Accidental Only* in the *What Your Plan Covers* section of the *EOC*.
- Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to eyeglasses or contacts required due to cataract surgery, aphakia, acute or chronic corneal pathology or keratoconus for which Benefits are provided.

This exclusion also does not apply to *Pediatric Vision Care Services* in the *What Your Plan Covers* section of the *EOC*.

- Educational testing and therapy, motor or language skills, or services that are educational in nature or are for vocational testing or training (i.e. including, but not limited to, dyslexia, early childhood intervention (ECI), typing, language, or learning courses.)
- Alternative / Optional Therapies (including, but not limited to, recreational therapy, exercise programs, hypnotherapy, art therapy, music therapy, reading therapy, sensory integration therapy, vision therapy, vision training, orthoptic therapy, behavioral vision therapy, integration vision therapy, orthotripsy, chelation therapy, Cryotherapy, aromatherapy, massage therapy, hair replacement or removal regardless of indication.
- Physical exams, treatment and evaluations required or requested by employers, insurers (other than this Harbor Health Plan), schools, camps, courts, licensing authorities, flight clearance and other third parties.
- Athletic performance enhancing drugs.
- Strength equipment or drugs.
- Personal comfort and convenience items, including, but not limited to, heating pads, air purifier, blood pressure cuffs.
- Support garments including, but not limited to, compression support hose, compression socks, over the counter orthotic.
- Home and mobility improvements including, but not limited to, widening doorways, ramps or home modification.
- Infertility treatment includes medical services, artificial insemination and all drugs associated with the treatment of infertility or any assisted reproductive technology or related treatment. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iotrogenic Infertility* in the *What Your Plan Covers* section of the *EOC*.
- Costs of donor eggs and donor sperm.
- Services related to Mental Illness and/or Substance-Related and Addictive Disorder Services that are provided by half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long term social needs, even if counseling is provided in such facilities. Harbor Health requires that any facility providing healthcare for Mental Illness and/or a Substance-Related and Addictive Disorder Services treatment program be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children.
- Any portion of a charge for a service, supply or drug that is in excess of the Allowed Amount as determined by Harbor Health.
- Any benefits in excess of specified benefit maximums in the *Schedule of Benefits*.
- Any services, supplies or drugs provided in connection with an occupational sickness, or an injury sustained in the scope of and in the course of any employer whether or not benefits are, or could upon proper claim be, provided under a Worker's Compensation plan.
- Any services, supplies or drugs provided for injuries sustained as a result of war (declared or undeclared), insurrection, participation in a riot, or from a criminal felonious activity.

- Services related to a disaster. In the event of a major disaster, services shall be provided insofar as practical, according to the best judgment of health professionals and within the limitations of facilities and personnel available, but neither the Plan, nor any health professionals shall have any liability for delay or failure to provide or to arrange for services due to lack of available facilities or personnel.
- Court ordered services. Healthcare services provided solely because of the order of a court or administrative body are excluded. Charges for a Provider to appear in court are also excluded.
- 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.
- Health care services during active military duty or for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Reimbursement for services, supplies or drugs provided by an out-of-Network Provider, except in cases of Emergency Health Care Services or when services are arranged by us.
- Any services, supplies or drugs provided to a Member incurred outside of the United States, even if the Member traveled to the location for the purpose of receiving medical services, supplies, or drugs. This exclusion does not apply to Benefits described under *Emergency Care* in the *What Your Plan Covers* section of the *EOC*.

Pre-Authorization of Services

We require Pre-Authorization of services before you receive certain Covered Health Services. Your Network Provider is responsible for submitting a request for Pre-Authorization before the services are received. The purpose of Pre-Authorization is to establish, in advance, the medical necessity of certain care and services covered under the plan.

To confirm Pre-Authorization has been obtained, call the telephone number on your ID card.

Continuity of Care and Transition of Care

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 receive Benefits. However, if you have a special circumstance and 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 is called Continuity of Care. Special circumstance means you have a condition in which the treating Provider reasonably believes that discontinuing care by that Provider could cause you harm. Examples of a special circumstance include a Member with a disability, acute condition, life threatening illness, or who is past the 12th week of pregnancy.

Please Note: This provision does not apply to Provider contract terminations for failure to meet applicable quality standards or for fraud.

The treating Provider must submit the Continuity of Care request by providing notification to

Harbor Health so we can confirm you have a special circumstance. If Continuity of Care is approved, the Provider will receive continued reimbursement not less than the contracted rate, unless otherwise negotiated, 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.

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 is called Transition of Care. This transition period is available for specific medical services and for limited periods of time.

New members should request Transition of Care through the Pre-Authorization process within 30 days from the time their Harbor Health coverage becomes effective. If the Transition of Care request is approved, and the provider agrees to a negotiated reimbursement amount, Transition of Care will be approved for up to 30 days from the effective date of coverage or through completion of the current active course of treatment period, whichever comes first. This timeframe may be extended in certain circumstances.

If you would like help to find out if you are eligible for Continuity of Care or Transition of Care Benefits, please call Member Services at the telephone number on your ID Card.

Network Provider Not Available

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 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. You will be responsible to the out-of-Network Provider for your Network cost share. You should contact us if you receive a bill for anything above this amount.

Questions, Complaints and Appeals

If you have a question, complaint or appeal, call the telephone number shown on your ID card. If we are unable to resolve your question or complaint over the phone, you will need to submit a written request to the address at the beginning of this summary. We will notify you of the outcome within 30 days of receiving all the information related to your request.

If we do not resolve your complaint to your satisfaction, you have the right to appeal our decision or adverse determination (medical necessity denial). The timeframe for completing the appeals process depends on the type of appeal you have submitted. If you are appealing an adverse determination, 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.

You also have the right to appeal an Adverse Determination through an Independent Review Organization (IRO). We will notify you when this option is available during your appeal process.

Any person, including persons who have attempted to resolve complaint and appeals through our complaint system process and who are dissatisfied with the resolution, may file a complaint with the Texas Department of Insurance at P.O. Box 149091, Austin, Texas 78714-9091. The Department's telephone number is 1-800-252-3439.

Refer to the *EOC* for a complete explanation of your complaint and appeal rights.

We shall not engage in any retaliatory action against any Member because the Member has filed a complaint against Harbor Health or appealed a decision. We shall not retaliate for any reason against a physician or provider because the physician or provider has, on behalf of the Member, reasonably filed a complaint against Harbor Health or appealed a decision.

Network Providers

A network provider is a hospital, physician or other health care provider who is contracted with us for the purpose of reducing health care costs by negotiating fees for services provided to Members. An out-of-network provider is a hospital, physician or other health care provider who is not contracted with us.

A list of network providers can be obtained by visiting the Harbor Health provider lookup on our website at www.harborhealth.com. This website will provide you with information regarding the location and availability of providers within the HMO network. If you would like a printed copy of the provider directory, contact us at the address or telephone number at the beginning of this summary, and we will send it free of charge upon request.

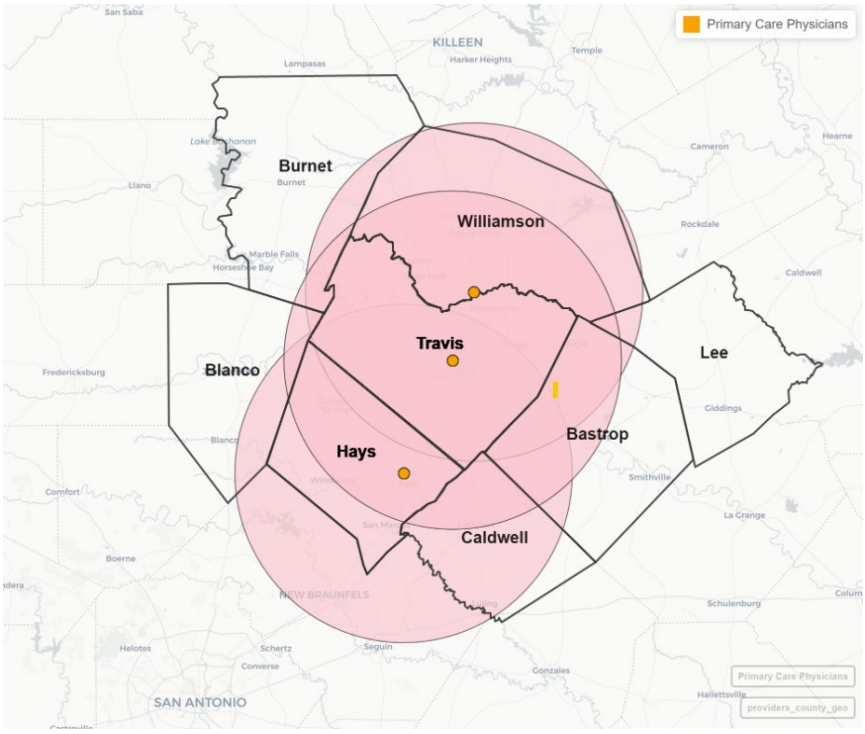
Notice of Rights

- A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Evidence of Coverage and below.
- You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network co-payment, cost share percentage, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: www.harborhealth.com or by calling the telephone number on your ID card for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

Service Area

Network providers may be found throughout your Service Area. The map below shows the counties that make up the service area within the state of Texas. A list of network providers within your service area can be obtained by contacting us at the address or telephone number

at the beginning of this summary or you may visit the Harbor Health provider lookup on our website at www.harborhealth.com/plans. If you would like a printed copy of providers, we will send it free of charge upon request.



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.