AMBETTER FROM SUPERIOR HEALTHPLAN, INC.

EVIDENCE OF COVERAGE

HEALTH MAINTENANCE ORGANIZATION

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHO HAVE ENROLLED IN

AMBETTER FROM SUPERIOR HEALTHPLAN, INC.

HEALTH BENEFIT PLAN. YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE PREMIUM AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR COVERED HEALTH SERVICES AND BENEFITS.

Superior HealthPlan, Inc.
2100 S. IH-35, Ste. 200
Austin, Texas 78704
1-877-687-1196

CONSUMER CHOICE HEALTH BENEFITS PLAN

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

IMPORTANT NOTICE

To obtain information or make a complaint:

Superior HealthPlan, Inc.

YOU may call our toll-free telephone number for information or to make a complaint at:

YOU may also write to us at:

2100 South IH-35, Suite 200
Austin, Texas 78704

YOU may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at:

1-800-252-3439

YOU may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX # 512/475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning YOUR premium or about a claim you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance (TDI).

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Superior HealthPlan, Inc.

Usted puede llamar al numero de telefono gratis de para informacion o para someter una queja' al:

Usted tambien puede escribir

2100 South IH-35, Suite 200
Austin, Texas 78704

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX # 512/475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. So no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Superior HealthPlan, Inc.

Individual Enrollee Contract

In this *contract, "you"* or *"your"* will refer to the *Enrollee* named on the Schedule of Benefits, and *"we," "our,"* or *"us"* will refer to Superior.

AGREEMENT AND CONSIDERATION

We issued this *contract* in consideration of the application and the payment of the first premium. A copy of *your* application is attached and is made a part of the *contract*. *We* will provide benefits to *you*, the *Enrollee*, for covered *Health Care Services* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

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INTRODUCTION

Welcome to Superior HealthPlan! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes how to access medical care, what health services are covered by *us*, and what portion of the health care costs *you* will be required to pay.

This *contract*, the application, and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How To Contact Us :
Superior HealthPlan
2100 South IH-35, Ste. 200
Austin, Texas 78704
Member Services 1-877-687-1189
TDD/TTY line 1-877-941-9237
Fax 1-877-941-8077
Website: www.superiorhealthplan.com/ambetter

Normal Business Hours of Operation - 8:00 a.m. to 5:00 p.m. in both Texas time zones
Enrollee Services 1-877-687-1196

Interpreter Services
We have bilingual representatives. *Our* interpreter services are provided at no cost to *you*. This includes sign language and other interpreter services. To arrange for interpretation services, call Enrollee Services at 1-877-687-1196.

Your Provider Directory
A listing of *network providers* is available online at www.superiorhealthplan/ambetter.com. *We* have plan *physicians*, *hospitals*, and other *providers* who have agreed to provide *you* with *your* healthcare services. You may find any of our *network providers* on *our* website. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can contact Enrollee Services to request a provider directory, or for assistance in finding a provider.

Your Enrollee ID Card
When *you* enroll, *we* mail an Enrollee ID card to *you* within 5 business days of *our* receipt of *your* enrollment confirmation. *You* need to keep this card with *you* at all times and present it to your providers.

The ID card shows *your* name, *Enrollee* ID number, helpful phone numbers, and *copayment amounts* you will have to pay at the time of service. If *you* lose your card, please call Enrollee Services; *we* will send *you* another ID card.

Our Website

Our website helps *you* get the answers to many of *your* frequently asked questions. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at www.superiorhealthplan.com/ambetter.

Quality Improvement
We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *Enrollee* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *Enrollees* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee which includes *network providers* to help us develop and monitor our program activities.
7. Investigating any *Enrollee* concerns regarding care received.

Ten-Day Right to Examine this *Contract*
You shall be permitted to return this *contract* within 10 days of receiving it and to have any premium *you* paid refunded if, after examination of the *contract*, *you* are not satisfied with it for any reason. If you return the *contract* to *us*, the *contract* will be considered void from the beginning and the parties are in the same position as if no *contract* had been issued. If any services were rendered or claims paid by *us* during the 10 days, *you* are responsible for repaying *us* for such services or claims.

DEFINITIONS

In this *contract*, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this *contract*:

Acute rehabilitation means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five to seven days per week, while the Enrollee is confined as an inpatient in a hospital, rehabilitation facility, or extended care facility.

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.

Advance payments of the premium tax credit means payment of the tax credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Health Insurance Marketplace in accordance with sections 1402 and 1412 of the Affordable Care Act.

Adverse determination means a determination by a health maintenance organization or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are experimental or investigational.

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

Bereavement counseling means counseling of Enrollees of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of *listed transplants* or other services such as cancer, bariatric or infertility; and
2. Has agreed with *us* or an entity designated by *us* to meet quality of care criteria on a cost efficient basis. The fact that a *hospital* is a *network provider* does not mean it is a *Center of Excellence.*

Chiropractic Care involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column and may include physical medicine modalities or use of *durable medical equipment*.

Cognitive Communication Therapy are services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitation Therapy are services designed to address therapeutic cognitive activities, based on an assessment and understanding of the insured person's brain-behavioral deficits.

Community Reintegration Services are services that facilitate the continuum of care as an affected insured person transitions into the community.

Complaint means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination under the Texas Insurance Code, Section 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or a provider's or enrollee's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy.
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Contract when *italicized,* means this *contract* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of *covered services* that must be paid by an *Enrollee* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered services* for that particular service under the *contract* or application of any *cost sharing percentage.*

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

Cost sharing percentage means the percentage of covered services that are payable by an enrollee.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an Indian enrolled in a QHP in the Health Insurance Marketplace.

Covered service* or *covered service expenses means services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or authorized by a *physician.* To be a *covered service* the service, supply or treatment must be

1. Provided or incurred while the *Enrollee's* coverage is in force under this *contract*;
2. Covered by a specific benefit provision of this *contract*; and
3. Not excluded anywhere in this *contract*.

Custodial Care is treatment designed to assist an *Enrollee* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Deductible amount means the amount of *covered expenses*, shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount*. For family coverage, once a *covered person* has met the individual *deductible amount*, the remainder of the family *deductible amount* can be met with the combination of any one or more covered persons' *eligible expenses*.

The *deductible amount* does not include any *copayment amounts*

Dental services means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental services* regardless of the reason for the services.

Dependent Enrollee means the *Enrollee's* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date an *Enrollee* becomes covered under this *contract* for *illness* or *injury*.

Eligible child means *you* or *your spouse's* child, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child and child for which the primary insured person must provide medical support under an order issued under Section 14.061, Family Code, or another order enforceable by a court in Texas ;
3. A child placed with *you* for adoption for whom you are a party in a suit in which the adoption of the child is sought; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify *us* if *your child* ceases to be an *eligible child*. *You* must reimburse *us* for any

benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*.

5. Any children of the Enrollee's children, if those children are dependents of the Enrollee for federal income tax purposes at the time of application.
6. A child whose coverage is required by a medical support order.

Eligible service expense means a *covered service* as determined below.

1. For *network providers* (excluding Transplant Benefits): When a *covered service* is received from a *network provider*, the *eligible service expense* is the contracted fee with that provider.
2. For non-*network providers*:
    a. When a *covered service* is received from a non-*network provider* as a result of an *emergency* or as otherwise approved by *us*, the *eligible service expense* is the usual and customary charge or a rate agreed upon with the non-*network provider* .
    b. When a *covered service expense* is received from a non-*network provider* because the service or supply is not of a type provided by any *network provider*, the *eligible service expense* is the usual and customary charge or a rate agreed upon with the non-*network provider* .

Emergency means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the *insured person's* health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; and
4. The case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.
2. An *unproven service.*
3. Subject to *USFDA* approval, and:
    a. It does not have *USFDA* approval;
    b. It has *USFDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has *USFDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *USFDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *USFDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *USFDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *Enrollee.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *USFDA* clinical trials.

Extended care facility means an institution, or a distinct part of an institution, that:

1. Is licensed as a *skilled nursing facility* or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of *substance abuse, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

Home health aide services means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *Enrollee.*

Home health care means care or treatment of an *illness* or *injury* at the *Enrollee's* home that is:

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. 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 *illness* requiring the *home health care.*

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Hospice means an institution that:

1. Provides a *hospice care program*;

2. Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home health care agency,* mental health facility, *extended care facility,* or any other licensed health care institution;
3. Provides care for the *terminally ill;* and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill Enrollee* and those of his or her *immediate family.*

Hospital is a licensed institution and operated pursuant to law that:
1. Is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
2. Provide 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
3. Is an institution which maintains and operates a minimum of five beds; and
4. Have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
5. Maintain permanent medical history records

Hospital does NOT include institutions where care is not directed toward treatment of the condition for which the patient is hospital confined, such as nursing homes, extended care facilities, skilled nursing facilities or psychiatric or substance abuse facilities or any other institution used mainly for convalescence, nursing, rest, housing the elderly or providing custodial care or educational care.

Illness means a sickness, disease, or disorder of an *Enrollee*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *Enrollee*, or any person residing with an *Enrollee*.

Injury means accidental bodily damage sustained by an *Enrollee* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a Cardiac Care Unit, or other unit or area of a *hospital*, which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three or more hours per day, five to seven days per week.

Listed transplant means one of the following procedures and no others:
1. Heart transplants

2. Lung transplants
3. Heart/lung transplants
4. Kidney transplants
5. Liver transplants
6. Bone marrow transplants for the following conditions:
    - *BMT* or *ABMT* for Non-Hodgkin's Lymphoma
    - *BMT* or *ABMT* for Hodgkin's Lymphoma
    - *BMT* for Severe Aplastic Anemia
    - *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia
    - *BMT* for Chronic Myelogenous Leukemia
    - *ABMT* for Testicular Cancer
    - *BMT* for Severe Combined Immunodeficiency
    - *BMT* or *ABMT* for Stage III or IV Neuroblastoma
    - *BMT* for Myelodysplastic Syndrome
    - *BMT* for Wiskott-Aldrich Syndrome
    - *BMT* for Thalassemia Major
    - *BMT* or *ABMT* for Multiple Myeloma
    - *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma
    - *BMT* for Fanconi's anemia
    - *BMT* for malignant histiocytic disorders
    - *BMT* for juvenile

Loss of Minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual.
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount is the sum of the deductible amount, *prescription drug deductible amount*(if applicable), *copayment amount* and *coinsurance percentage* of *covered expenses*, as shown in the Schedule of Benefits. After the *maximum out-of-pocket amount* is met for an individual, Superior Health Plan pays 100% of eligible expenses. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For the family maximum out-of-pocket amount, once a *covered person* has met the individual *maximum out-of-pocket amount*, the remainder of the family *maximum out-of-pocket amount* can be met with the combination of any one or more covered persons' eligible expenses.

The Dental out-of pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum per calendar year as shown in the Schedule of Benefits.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in an *Enrollee's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner means a *physician*, nurse anesthetist, physician's assistant, physical therapist, or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, rolfer, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, marriage counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to an *Enrollee*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary means any medical service, supply or treatment authorized by a *physician* to diagnose and treat an *Enrollee 's illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *Enrollee*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible service expenses*.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

Enrollee means *you*, *your* lawful *spouse* and each *eligible child*:

1. Named in the application; or

2. Whom *we* agree in writing to add as an *Enrollee*.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions

Necessary medical supplies means medical supplies that are:
1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *physicians* and providers who have contracts that include an agreed upon price for health care services or expenses.

Network eligible service expense means the *eligible service expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible service expense* that is provided at and billed by a *network* facility for the services of either a *network* or non-*network provider*. *Network eligible service expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

Non-Network Provider means a *physician* or provider who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are not covered, except as specifically stated in this policy.

Network provider means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

Neurobehavioral Testing is an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the *insured person*, family, or others.

Neurobehavioral Treatment is interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation are services designed to assist cognitively impaired *insured person's* to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy are services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback Therapy are 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 is an evaluation of the functions of the nervous system.

Neurophysiological Treatment means interventions that focus on the functions of the nervous system.

Neuropsychological Testing is 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 means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Non-network eligible service expense means the *eligible service expense* for services or supplies that are provided and billed by a non-*network provider.*

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization Enrollee contracts, self-insured group plans, prepayment plans, and Medicare when the *Enrollee* is enrolled in Medicare. *Other plan* will not include Medicaid.

Out-of-pocket service expenses means those expenses that an *Enrollee* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Pain management program means a program using interdisciplinary teams providing coordinated, goal-oriented services to an *Enrollee* who has chronic pain that significantly interferes with physical, psychosocial, and vocational functioning, for the purpose of reducing pain, improving function, and decreasing dependence on the health care system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law.

Post-Acute Transition Services are services that facilitate the continuum of care beyond the initial neurological consult through rehabilitation and community reintegration.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician obstetrician/gynecologist (OB/GYN) or Internal Medicine physician.

Facility means a *hospital, rehabilitation facility*, or *skilled nursing facility*.

Psychophysiological Testing is an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment are interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to an Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a *qualified health plan* in the individual market.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible. This includes craniofacial abnormalities for children younger than 18 years of age.

Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy* and *pain management programs*. An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy* or treatment under a *pain management program*.

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care*,* or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address (not a P.O. Box) shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:

1. Is not a *hospital, extended care facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Respite care means home health care services provided temporarily to an *Enrollee* in order to provide relief to the *Enrollee's immediate family* or other caregiver.

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half hour to two hours per day, five to seven days per week, while the *Enrollee* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *extended care facility*.

Substance abuse means alcohol, drug or chemical abuse, overuse, or dependency.

Surgery or ***surgical procedure*** means:

1. An invasive diagnostic procedure; or
2. The treatment of an *Enrollee's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *Enrollee* is under general or local anesthesia.

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
   Pelvic examination.

Telehealth Service means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Terminal illness counseling means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Terminally ill means a *physician* has given a prognosis that an *Enrollee* has six months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *Enrollee* for payment of any of the *Enrollee's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *Enrollee* is entitled to benefits as a named insured

person or an insured *dependent Enrollee* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Tobacco use or ***use of tobacco*** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this *contract* was completed by the *Enrollee*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Unproven service(s) means services, including medications, which are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
2. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care center means a facility, not including a *hospital emergency* room or a *physician's* office, that provides treatment or services that are required:

1. To prevent serious deterioration of a *Enrollee's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

DEPENDENT ENROLLEE COVERAGE

Dependent Enrollee Eligibility
Your dependent Enrollees become eligible for coverage under this *contract* on the latter of:

1. The date *you* became covered under this *contract;* or
2. The first day of the premium period/first full calendar month after the date of becoming *your dependent Enrollee*.

Effective Date For Initial Dependent Enrollees
The *effective date* for *your* initial *dependent Enrollees,* if any, is shown on the Schedule of Benefits. Only *dependent Enrollees* included in the application for this *policy* will be covered on *your effective date*.

Adding A Newborn Child
An *eligible child* born to *you* or a family *member* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given with the 31 days from birth, *we* will charge an additional premium from the date of birth. If notice is given by the Marketplace within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless *we* have received notice by the Marketplace of the child's birth.

Adding An Adopted Child
An *eligible child* legally placed for adoption with *you* or *your spouse* will be covered from the date of *placement* until the 31st day after *placement,* unless the *placement* is disrupted prior to legal adoption and the child is removed from *your* or *your spouse's* custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where we are notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless *we* have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement; and (B) any additional premium required for the addition of the child within 90 days of the date of *placement.*

As used in this provision, *"placement"* means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or
2. The date of entry of an order granting *you* or *your spouse* custody of the child for the purpose of adoption and any child for whom you are a party in a suit in which the adoption of the child is sought,

Adding Other Dependent Enrollees

If *you* apply in writing for coverage on a *dependent Enrollee* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent Enrollee* is covered.

ONGOING ELIGIBILITY

For All Enrollees
An *Enrollee's* eligibility for coverage under this *contract* will cease on the earlier of:

1. The date that an *Enrollee* accepts any direct or indirect contribution or reimbursement, by or on behalf of an employer, for any portion of the premium for coverage under this *contract*; or
2. The date an *Enrollee's* employer and an *Enrollee* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.

For Dependent Enrollees
A *dependent Enrollee* will cease to be an *Enrollee* at the end of the premium period in which he or she ceases to be *your dependent Enrollee* due to divorce or if a child ceases to be an *eligible child*.

We must receive notification within 90 days of the date a *dependent Enrollee* ceases to be an eligible *dependent Enrollee*. If notice is received by *us* more than 90 days from this date, any unearned premium will be credited only from the first day of the *policy*/calendar month in which *we* receive the notice.

An *Enrollee* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental retardation or physical disability; and
2. Mainly dependent on *you* for support and maintenance.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014. *Qualified individuals* who enroll prior to December 15, 2013 will have an effective date of coverage on January 1, 2014. *Qualified individuals* that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage effective date of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month between December 2013 and March 31, 2014, will have a coverage effective date of the first day of the second following month.

For years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year. *Qualified individuals* who enroll prior to December 7, 2013 will have an effective date of coverage on January 1 of the following year.

The Health Insurance Marketplace may provide a coverage effective date for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month. Starting in 2014, *we* will send written annual open enrollment notification to each *Enrollee* no earlier than September 1, and no later than September 30.

Special And Limited Enrollment
A *Qualified individual* has 60 days to enroll as a result of one of the following events:

1. A *Qualified individual* or *dependent loses minimum essential coverage*;
2. A *Qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A *Qualified* individual's enrollment or non-enrollment in a *Qualified* health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
5. An enrollee adequately demonstrates to the Health Insurance Marketplace that the *Qualified* health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *Qualified* health plan;
7. A *Qualified individual* or enrollee gains access to new *Qualified* health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
9. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *Qualified* health plan or change from one *Qualified* health plan to another one time per month; or
10. A *Qualified individual* or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide. *Qualified individuals* that enroll between the first and fifteenth day of the month will have a coverage *effective date* of the first day of the following month. *Qualified individuals* that enroll between the sixteenth and last day of the month will have a coverage *effective date* of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but *advance payments of the premium tax credit* and *cost-sharing reductions*, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month In the case of marriage, or in the case where *Qualified individual* loses minimum essential coverage, the effective date is the first day of the following month.

With respect to individuals enrolled in non-calendar individual health insurance policies, there will be a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy ends in 2014.

The Health Insurance Marketplace may provide a coverage *effective date* for a *Qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *Qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *Qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

PREMIUMS

Premium Payment
Each premium is to be paid to *us* on or before its due date. A due date is the last day of the period for which the preceding premium was paid.

Grace Period
When a member is receiving a premium subsidy:

After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advance payment of the premium tax credits* are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *Enrollee* during the first month of the grace period, and may pend claims for *covered services* rendered to the *Enrollee* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *Enrollee*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect advance premium tax credits on behalf of the *member* from the Department of the Treasury, and will return the advance premium tax credits on behalf of the *member* for the second and third month of the grace period if the *Enrollee* exhausts their grace period as described above. An *Enrollee* is not eligible to re-enroll once terminated, unless an *Enrollee* has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When an *Enrollee* is not receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, claims may pend for *covered services* rendered to the *Enrollee* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *Enrollee*, as well as providers of the possibility of denied claims when the *Enrollee* is in the grace period.

Misstatement Of Age
If an *Enrollee's* age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change Or Misstatement Of Residence
If *you* change *your residence*, *you* must notify *us* of *your* new *residence* within 60 days of the change. *Your* premium will be based on *your* new *residence* beginning on the first premium due date/first day of the next calendar month after the change. If *your residence* is misstated on *your* application, or *you* fail to notify *us* of a change of *residence*, *we* will apply the correct premium amount beginning on the first premium due date/first day of the first full calendar month *you* resided at that place of *residence*. If the change results in a lower premium, *we* will refund any excess premium. If the change results in a higher premium, *you* will owe *us* the additional premium.

Misstatement Of Tobacco Use
The answer to the tobacco question on the application is material to *our* correct underwriting. If an *Enrollee's use of tobacco* has been misstated on the *Enrollee's* application for coverage under this *contract, we* have the right to rerate the *contract* back to the original effective date.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

Premium Rate Increases
If *we* increase the premium to be paid for coverage under this *contract*, *we* will provide *you* with written notice of such increase not less than 60 days before the date on which such increase shall take effect. Our written notice shall provide (1) the effective date of the increase in premium; and (2) a table that clearly lists: (A) the actual dollar amount of the premium charged on the date of the notice; (B) the actual dollar amount of the premium to be charged after the premium increase; and (C) the percentage change between paragraphs (A) and (B).

DEDUCTIBLE, COINSURANCE, COPAYMENTS

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Benefits. The Deductibles are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under "Deductibles" on your Schedule of Benefits must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

1. If you have several covered Dependents, all charges used to apply toward an "individual" Deductible amount will be applied toward the "family" Deductible amount shown on your Schedule of Benefits.
2. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual.
3. Deductible amounts to the "family" Deductible amount.

The *deductible amoun*t does not include any *copayment amount*.

Coinsurance Stop–Loss Amount

Most of your Eligible Expense payment obligations, including Copayment Amounts, are considered Coinsurance Amounts and are applied to the Coinsurance Stop–Loss Amount maximum.
Your Coinsurance Stop–Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when Superior is the Secondary Plan for purposes of coordination of benefits;
- Any Deductibles;
- Penalties applied for failure to Preauthorize;
- Any Copayment Amounts paid under the Pharmacy Benefits;
- Any remaining unpaid Medical–Surgical Expense in excess of the benefits provided for Covered Drugs

Individual Coinsurance Stop–Loss Amount

When the Coinsurance Amount for the In–Network or Out–of–Network Benefits level for a Participant in a Calendar Year equals the "individual" "Coinsurance Stop–Loss Amount" shown on your Schedule of Benefits for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Coinsurance Stop–Loss Amount

When the Coinsurance Amount for the In–Network or Out–of–Network Benefits level for all Participants under your coverage in a Calendar Year equals the "family" "Coinsurance Stop–Loss Amount" shown on your Schedule of Benefits for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to

contribute more than the individual Coinsurance Amount to the family Coinsurance Stop–Loss Amount.

Cost Sharing Percentage
We will pay the applicable *cost sharing percentage* in excess of the applicable deductible amount(s) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered service expense* under one or more benefit provisions; and
2. Is received while the *Enrollee's* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible service expense*.

When the annual out-of-pocket maximum has been met, additional *covered service expenses* will be provided or payable at 100% of the allowable expense.

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *contract*;
2. A determination of *eligible service expenses*; and

The applicable *deductible amount(s), cost sharing percentage,* and *copayment amounts* are shown on the Schedule of Benefits.

Note: The bill *you* receive for services or supplies from a non-*network provider* may be significantly higher than the *eligible service expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *cost sharing percentage*, *you* are responsible for the difference between the *eligible service expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible service expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Changing the Deductible
You may increase the deductible to an amount currently available. A request for an increase in the deductible between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

Coverage Under Other Policy Provisions
Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *contract.*

MANAGING YOUR HEALTH CARE

Continuity of Care

In the event a Enrollee is under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, the Enrollee has *special circumstances* such as a (1) disability, (2) acute condition, (3) life–threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, Superior will continue providing coverage for that Provider's services at the In–Network Benefit level.

Special circumstances means a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the Enrollee. *Special circumstances* shall be identified by the treating Physician or health care Provider, who must request that the Enrollee be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the Enrollee of any amounts for which the Enrollee would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Enrollee has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Enrollees past the 24th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow–up check–up within the first six (6) weeks of delivery.

Primary Care Physician

In order to obtain benefits, *you* must designate a *network primary care physician* for each *Enrollee. You* may select any *network primary care physician* who is accepting new patients. However, you may not change your selection more frequently than once each month. If *you* do not select a *network primary care physician* for each *Enrollee,* one will be assigned. *You* may obtain a list of *network primary care physicians* at *our* website or by calling the telephone number shown on the front page of this *contract.*

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. *For all other network specialist physicians, you may be required to* obtain a referral from *your network primary care physician* in order to be eligible for maximum benefits under this *contract.* However, should *medically necessary* covered health care services not be available through *network providers*, upon the request of a *network primary care physician*, within the time appropriate to the circumstances relating to the delivery of the health care services and your condition, but in no event to exceed five business days after receipt of reasonably requested documentation, we shall allow a referral to a *non-network provider* and shall fully reimburse the *non-network provider* at the usual and customary rate or agreed rate.

You may change *your network primary care physician* by submitting a written request, online at *our* website, or by contacting *Enrollee Services* at the number shown on *your* identification card. The change to *your network primary care physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Specialist as Primary Care Provider

If you have a chronic disabling or life-threatening illness, you may apply to the Health Plan Medical Director to request that your treating specialist become the coordinator of all of your care. Your specialist must agree to:

- become the coordinator of all your care;
- meet and accept all of our requirements and payment schedules for Primary Care Physicians; and
- sign your request

If you are not satisfied with the Health Plan Medical Director's response to your request, you may appeal the response as described in the Complaint section of this contract.

Prior Authorization

Some *covered service expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to an *Enrollee.* However, there are some *network eligible service expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *Enrollee:*

1. Receives a service or supply from a non-*network provider;*
2. Is admitted into a *network* facility by a non-*network provider;* or
3. Receives a service or supply from a *network provider* to which the *Enrollee* was referred by a non-*network provider.*

How To Obtain Prior Authorization

To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *Enrollee.*

Failure To Obtain Prior Authorization

Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *contract* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits

Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *contract.*

Verification of Benefits

Your provider may request a benefit verification. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to verify either coverage or benefits for any particular treatment or medical expense.

A review that shows one or more of the following may cause *us* to invalidate the verification of benefits:

1. The verification was based on incomplete or inaccurate information initially received by *us.*
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.

On receipt of a request for verification from a provider, the Plan will issue a verification or declination not later than:

- five calendar days after the date of receipt of the request for verification;
- If the request is related to a concurrent hospitalization, the response will be sent not later than 24 hours after receipt of the request;
- If the request is related to post-stabilization care or a life-threatening condition, the response will be sent not later than one hour after receipt of the request for verification.

The verification or declination will be delivered via telephone call, in writing, or by other means, including the Internet, and will include (1) enrollee name; (2) enrollee ID number; (3) requesting provider's name; (4) hospital or other facility name, if applicable; (5) a specific description, including relevant procedure codes, of the services that are verified or declined; (6) if the services are verified, the effective period for the verification, and any applicable deductibles, copayments, or coinsurance for which the enrollee is responsible; (7) a unique verification number; and (8) a statement that the proposed services are being verified or declined. If the verification is declined, the specific reason for the declination will be provided.

COVERED HEALTH CARE SERVICES

The Plan provides coverage for health care services for you and your covered Dependents. Some services require preauthorization.

Copayment Amounts must be paid to your Network Physician or other Network Provider at the time you receive services.

The benefit percentages of your total eligible health care services shown on the Schedule of Benefits in excess of your Copayment Amounts, Coinsurance Amounts, and any applicable Deductibles shown the Health Plan's obligation. The remaining unpaid Medical−Surgical Expense in excess of the Copayment Amounts, Coinsurance Amounts, and any Deductibles is your obligation to pay.

To calculate your benefits, subtract any applicable Copayment Amounts and Deductibles from your total eligible Medical−Surgical Expense and then multiply the difference by the benefit percentage shown on your Schedule of Benefits. Most remaining unpaid health care services in excess of the Copayment Amounts and Deductible is your Coinsurance Amount.

Acquired Brain Injury Services

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post−acute transition services and community reintegration services, including outpatient day treatment services, or any other post−acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post−acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate *services* or *therapies* may be provided. *Service* means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury. *Therapy* means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

To ensure that appropriate post−acute care treatment is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

1. Has incurred an Acquired Brain Injury;
2. Has been unresponsive to treatment; and
3. Becomes responsive to treatment at a later date.

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

Ambulance Services

Covered service expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *Enrollee's illness* or *injury*.

2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:
1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *Enrollee* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:
1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* air ambulance.
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Ambulance services provided for an *Enrollee's* comfort or convenience.

Autism Spectrum Disorder Benefits

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Member's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner..

Individuals providing treatment prescribed under that plan must be a health care practitioner:
- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United
- States; or
- who is certified as a provider under the TRICARE military health system.

For purposes of this section, generally recognized services may include services such as:
- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Eligible Expenses, as otherwise covered under this contract, will be available. All provisions of this contract will apply, including but not limited to, defined terms, limitations and exclusions, Preauthorization and benefit maximums.

Mental Health and Substance Use Disorder Benefits

You do not need a referral from your PCP in order to initiate treatment. Deductibles, copayment or coinsurance amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and substance use disorder are included on a non-discriminatory basis for all Members for the diagnosis and treatment of mental, emotional, and substance use disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

When making coverage determinations, Cenpatico utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Cenpatico utilizes "*Interqual*" criteria for mental health determinations and "*ASAM*" criteria for substance use disorder determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional.

Covered Inpatient, Intermediate and Outpatient mental health and substance use disorder services are as follows:

Inpatient

1. Inpatient psychiatric treatment;
2. Detoxification at a hospital or chemical dependency treatment center;
    i. C*overage provided for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital*.
3. Observation;
4. Crisis Stabilization;
    ii. *Treatment provided to a Member by a crisis stabilization unit licensed or certified by the Texas Department of Mental Health and Mental Retardation shall be reimbursed.*
5. Electroconvulsive Therapy (ECT); and
6. Psychiatric residential treatment for children and adolescents.

Intermediate

1. Intensive Outpatient Program (IOP); and
2. Day Treatment.

Outpatient

1. Traditional outpatient services, including individual and group therapy services, medication management services and psychological testing; and
2. Applied Behavior Analysis (ABA) for a covered Dependent child.

Expenses for these services are covered, if medically necessary and may be subject to prior authorization. Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any.

Emergency Care and Treatment of Accidental Injury

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest

emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

In–Network and Out–of–Network Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on your Schedule of Benefits. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room/treatment room visit as indicated on your Schedule of Benefits. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived. If admitted for the emergency condition immediately following the visit, Preauthorization of the inpatient Hospital Admission will be required, and Inpatient Hospital Expenses will apply.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In–Network Benefits. After 48 hours, In–Network Benefits will be available only if you use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if you can safely be transferred to the care of a Network Provider but are treated by an Out–of–Network Provider, only Out–of–Network Benefits will be available.

Benefits for Urgent Care
Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Benefits. A Copayment Amount, in the amount indicated on your Schedule of Benefits, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk–in care outside of a hospital emergency room/treatment room department or physician's office. The necessary medical care is for a condition that is not life–threatening.

Habilitation, Rehabilitation And Extended Care Facility Expense Benefits

Covered service expenses include services provided or expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered service expenses* available to an *Enrollee* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay.
3. *Covered service expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.
4. *Covered service expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:

1. The *Enrollee* has reached *maximum therapeutic benefit*.
2. Further treatment cannot restore bodily function beyond the level the *Enrollee* already possesses.
3. There is no measurable progress toward documented goals.

4. Care is primarily *custodial care*.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Home Health Care Service Expense Benefits
Covered service expenses for *home health care* are limited to the following charges:

1. *Home health aide services*.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care.*
3. I.V. medication and pain medication.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. *Necessary medical supplies*.
6. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing.
    b. Infusion pump or cassette.
    c. Portable commode.
    d. Patient lift.
    e. Bili-lights.
    f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase. If the equipment is purchased, the *Enrollee* must return the equipment to *us* when it is no longer in use.

Please refer to the Schedule of Benefits for cost sharing, and any limitations associated with this benefit.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Benefits

This provision only applies to a *terminally ill Enrollee* receiving *medically necessary* care under a *hospice care program*.

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a *hospice* while the *Enrollee* is an *inpatient.*
2. Occupational therapy.
3. Speech-language therapy.
4. The rental of medical equipment while the *terminally ill Enrollee* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *Enrollee* had been confined in a *hospital.*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.

6. Counseling the *Enrollee* regarding his or her *terminal illness.*
7. *Terminal illness counseling* of the *Enrollee's immediate family.*
8. Up to $250 for *bereavement counseling*.

Exclusions And Limitations:
Any exclusion or limitation contained in the *contract* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill Enrollee* for one continuous period up to 180 days in a *Enrollee's* lifetime. For each day the *Enrollee* is confined in a *hospice,* benefits for room and board will not exceed:

1. For a *hospice* that is associated with a *hospital* or nursing home, the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.
2. For any other *hospice,* the lesser of the billed charge or $200 per day.

Medical And Surgical Benefits

1. *Hospital Services*
   a. Hospital inpatient daily room and board and general nursing care, not to exceed the *hospital's* most common semi-private room rate.
   b. Hospital inpatient Daily room and board and general nursing care while confined in an *intensive care unit*.
   c. *Inpatient* use of an operating, treatment, or recovery room.
   d. Outpatient use of an operating, treatment, or recovery room for surgery.
   e. Services and supplies, including drugs and medicines that are routinely provided by the hospital to persons for use only while they are inpatients.
   f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. However, charges for use of the emergency room itself for treatment of an *illness* may be reduced unless the *Enrollee* is directly admitted to the *hospital* for further treatment of that *illness*.
   g. Short-term *rehabilitation therapy* services in the *inpatient hospital* setting
2. *Surgery* in a physician's office or at an outpatient surgical facility, including services and supplies.
3. *Physician professional services,* including surgery.
4. *Assistant surgeon*, limited to 20 percent of the eligible expense for the surgical procedure.
5. *Professional services* of a non-physician medical practitioner.
6. *Medical supplies* that are medically necessary, including dressings, crutches, orthopedic splints, braces, casts, or other necessary medical supplies.
7. *Diagnostic testing using radiologic, ultrasonographic, or laboratory services* (psychometric, behavioral and educational testing are not included).
8. *Chemotherapy, radiation therapy* or treatment (inpatient or outpatient), and inhalation therapy.
9. *Hemodialysis*, *and the charges by a hospital for processing and administration of blood or blood components.*
10. *Anesthetic* cost and administration.
11. *Oxygen* and its administration.
12. *Dental service expenses* when an Enrollee suffers an injury, after the Enrollee's effective date of coverage, that results in:
    - Damage to his or her natural teeth; and

- Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing.

13. *Surgery to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint,* to include necessary tooth extractions.
14. *Cosmetic, Reconstructive, or Plastic Surgery*- The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Benefits:
    1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
    2. Treatment provided for reconstructive surgery following cancer surgery; or
    3. Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
    4. Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19; or
    5. For the treatment or correction of a congenital defect other than conditions of the breast; or
    6. Reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas, are covered at all stages of mastectomy.
15. *Two mastectomy bras* per year if the Enrollee has undergone a covered mastectomy.
16. *Diabetic equipment and supplies* that are medically necessary and prescribed by a physician, including:
    a. Blood glucose monitors, including noninvasive glucose monitors designed to be used by or adapted for the legally blind;
    b. Test strips specified for use with a corresponding glucose monitor;
    c. Lancets and lancet devices;
    d. Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
    e. Insulin and insulin analog preparations;
    f. Injection aids, including devices used to assist with insulin injection and needless systems;
    g. Insulin syringes;
    h. Biohazard disposal containers;
    i. 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;
    j. 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;
    k. Prescription medications and medications available without a prescription for controlling the blood sugar level;
    l. Podiatric appliances, including up to two pairs of therapeutic footwear per calendar year, for the prevention of complications associated with diabetes;
    m. routine foot care such as trimming of nails and corns
    n. Glucagon emergency kits;
    o. On approval of the United States Food and Drug Administration, any new or improved diabetes equipment or supplies if medically necessary and appropriate as determined by a physician or other health care practitioner.

17. *Outpatient chiropractic* treatment that is medically necessary. See the Schedule of *Benefits* for benefit levels or additional limits. Covered service expenses are subject to all other terms and conditions of the contract, including the *deductible* amount and *coinsurance* percentage provisions.
18. *Maternity care* of the Enrollee or Enrollee's spouse: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other medically necessary reasons (less any applicable copayments, deductible amounts, or cost sharing percentage). An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery.
    - Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
    - If services provided or expenses incurred for *hospital* confinement in connection with childbirth are otherwise included as *covered Service expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.
    - Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered service expenses* incurred for a shorter stay if the attending provider (e.g., *your* physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
    - The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to *covered service expenses* for childbirth.

19. Tissue transplants:
    a. Cornea transplants.
    b. Artery or vein grafts.
    c. Heart valve grafts.
    d. Prosthetic tissue replacement, including joint replacements.
    e. Implantable prosthetic lenses, in connection with cataracts.
20. Artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the Enrollee and the item cannot be modified). If more than one prosthetic device can meet an Enrollee's functional needs, only the charge for the most cost effective prosthetic device will be considered a covered expense.
21. *Genetic blood tests* that are medically necessary.
22. *Immunizations to prevent respiratory syncytial virus (RSV) that are medically necessary*
23. *Durable Medical Equipment - Rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator.*
24. *Continuous Passive Motion (CPM) machine; one per Enrollee following a covered joint surgery.*
25. *One wig per Enrollee necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.*
26. *Occupational therapy following a covered treatment for traumatic hand injuries.*
27. *One pair of eyeglasses or contact lenses per Enrollee following a covered cataract surgery.*
28. Benefits for Speech and Hearing Services Benefits as shown on your Schedule of Benefits are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function. Any benefit payments made for hearing aids will apply toward the benefit maximum amount.

29. *Benefits for Routine Patient Costs for Participants in Certain Clinical Trials*- Benefits for Eligible Expenses for Routine Patient Care Costs, as defined in the Definitions Section, are provided 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 and is approved by:
    - the Centers for Disease Control and Prevention of the United States Department of Health and
    - Human Services;
    - the National Institutes of Health;
    - the United States Food and Drug Administration;
    - the United States Department of Defense;
    - the United States Department of Veterans Affairs; or
    - an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

Outpatient Prescription Drug Benefits

Covered service expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug.*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*

Such *covered service expenses* shall include those for prescribed, orally administered anticancer medications. The *covered service expenses* shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this *contract*.
See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for an *Enrollee* is a determination that is best made by the *Enrollee* and his or her *physician.*

Non-Covered Services And Exclusions:
No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance.
2. For immunization agents, blood, or blood plasma.
3. For medication that is to be taken by the *Enrollee,* in whole or in part, at the place where it is dispensed.
4. For medication received while the *Enrollee* is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a *physician's* order.
6. Due to a *Enrollee's* addiction to, or dependency on foods.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.

10. For a *prescription drug* that contains (an) active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (a 90-day supply when dispensed by mail order).
12. In excess of the cost of the generic equivalent, if any, regardless of whether the physician specifies name brand on the written prescription.
13. For prescription drugs for any Enrollee who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.

Medical Foods
We cover medical foods and formulas when medically necessary for the treatment of Phenylketonuria (PKU). Covered service expenses for amino acid-based elemental formulas for treatment of an *Enrollee* who is diagnosed with the following disease or disorders:

- 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; andimpaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Preventive Care Services

Covered services include the charges incurred by an *Enrollee* for the following preventive health services if appropriate for that *Enrollee* in accordance with the following recommendations and guidelines:

Benefits for Routine Exams and Immunizations
Benefits for routine exams are available for the following Preventive Care Services as indicated on your Schedule of Benefits:

a. *Well−baby care* (after newborn's initial examination and discharge from the Hospital);
b. *Routine annual physical examination;*
c. *Annual vision examination;*
d. *Annual hearing examinations*, except for benefits as provided under Required Benefits for Screening Tests for Hearing Impairment. Screening tests for hearing impairment from birth through the date the child is 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. Charges are not subject to the deductible amount.t;
e. *Immunizations*. Deductibles will not be applicable to immunizations of a Dependent child age seven years of age or younger. Immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and any other immunization that is required by law for the child. Charges for immunization are not subject to deductible, coinsurance or copayment requirements. Charges for other services rendered at the same time as immunizations are subject to deductible, coinsurance and copayment in accordance with regular policy provisions.

Benefits are not available for Inpatient Hospital Expense or Medical−Surgical Expense for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer
Benefits are available for certain tests for the detection of Human Papillomavirus and Cervical Cancer, for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown on your Schedule of Benefits. Coverage includes, at a minimum, 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.

Benefits for Mammography Screening
Benefits are available for a screening by low−dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older, as shown on your Schedule of Benefits, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis
If a Participant is a *Qualified Individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis, as shown on your Schedule of Benefits.

Qualified Individual means:

a. A postmenopausal woman not receiving estrogen replacement therapy;
b. An individual with:
    1. vertebral abnormalities,
    2. primary hyperparathyroidism, or
    3. a history of bone fractures; or
c. An individual who is:
    1. receiving long−term glucocorticoid therapy, or
    2. being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Certain Tests for Detection of Prostate Cancer
Benefits are available for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate−specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

1. 50 years of age and asymptomatic; or
2. 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Early Detection Tests for Cardiovascular Disease
Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

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

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits for Screening Tests for Hearing Impairment
Benefits are available for Eligible Expenses incurred by a covered Dependent child:

1. For a screening test for hearing loss from birth through the date the child is 30 days old; and
2. Necessary diagnostic follow–up care related to the screening tests from birth through the date the child is 24 months.

Deductibles indicated on your Schedule of Benefits will not apply to this provision.

Transplant Services

Covered Services For Transplant Service Expenses:
If *we* determine that an *Enrollee* is an appropriate candidate for a *listed transplant,* Medical Service Expense Benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize an *Enrollee* to prepare for a later transplant, whether or not the transplant occurs.
4. High dose chemotherapy.
5. Peripheral stem cell collection.
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a *Center of Excellence*).
7. Post transplant follow-up.

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *Enrollee* if:

1. They would otherwise be considered *covered service expenses* under the *contract;*
2. The *Enrollee* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

These medical expenses are covered to the extent that the benefits remain and are available under the Enrollee's *contract*, after benefits for the Enrollee's own expenses have been paid. In the event of such coverage, the otherwise existing coverage of a live donor shall be secondary to benefits under the Enrollee's *contract*.

Ancillary "Center Of Excellence" Service Benefits:
An *Enrollee* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered service expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow.
2. *We* will pay a maximum of $10,000 per lifetime for the following services:
    a. Transportation for the *Enrollee,* any live donor, and the *immediate family* to accompany the *Enrollee* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *Enrollee* while the *Enrollee* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Non-Covered Services And Exclusions:
No benefits will be provided or paid under these Transplant Service Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs.
3. For animal to human transplants.

4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
8. Related to transplants not included under this provision as a *listed transplant.*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"USFDA"*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

Limitations On Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered service expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *Enrollee*.
2. If a designated *Center of Excellence* is not used, *covered service expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
3. If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

Pediatric Vision Expense Benefits

Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is an *Enrollee*:

1. Routine vision screening, including dilation with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal, or lenticular) or initial supply of standard contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;
3. One pair of frames every calendar year. *We* offer a wide range of frames that are available at no cost to you.
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy;
2. Two pair of glasses as a substitute for bifocals.
3. Replacement of lost or stolen eyewear.
4. Any vision services, treatment or material not specifically listed as a covered service; or
5. Non-Network Providers.

Vision Services - Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are managed through AECC Total Vision Health Plan (TVHP). For information regarding your specific copayments and/or deductible please refer to your specific plan information listed in the Schedule of Benefits.

You may receive one routine eye exam and eyewear once every calendar year. Eyewear includes **either** one pair of eyeglasses **or** initial supply of standard contacts.

Eyeglasses - Covered lenses include single vision, lined bifocal, lined trifocal, or lenticular lenses, in glass

or plastic. Covered lens add-ons include standard polycarbonate lenses, scratch resistant, and anti-reflective coating.

If you require a more complex prescription lens, contact TVHP for prior authorization. Lens options such as progressive lenses, high index tints, and UV coating are not covered.

Covered frames are to be selected from TVHP's frame formulary, offering a wide range of frames that are available at no cost to you.

Should you elect to see a non-network provider, see ***Schedule of Benefits***. Should you select glasses that are more than your maximum benefit, you will be financially responsible for the difference.

Contact Lenses - Coverage includes evaluation, fitting, and initial supply of contact lenses. If you elect contact lenses in lieu of glasses, please refer to your specific plan information listed in the *Schedule of Benefits* for your maximum allowance for contacts. If contacts are purchased through a non-network provider, you will be financially responsible for any differences above the allowances.

For additional information about covered vision services, participating TVHP providers, call *Enrollee* Services at 877-687-1196.

Non-Routine Vision - Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a Health Plan participating provider (optometrist or ophthalmologist). Covered services include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision.

Excluded services for routine and non-routine vision include:

1. Visual Therapy
2. Any vision services, treatment or materials not specifically listed as a covered service.
3. Pharmaceuticals (including Visudyne, Macugen, Lucentis, Botox, etc.)
4. Low vision services and hardware for adults
5. Out of network care, except when pre-authorized

Dental Benefits – Adults 19 years of age or older

Coverage is provided for adults, age 19 and older, Basic (Class 1) and Comprehensive (Class 2) dental services from an *In-Network provider*. Covered services for restorative care are subject to a 6 month waiting period. Please refer to your Schedule of Benefits for a detailed list of cost sharing, annual maximum and appropriate service limitations. To see which dental providers are part of the network, please call 877-687-1196 or visit **:** www..superiorhealthplan.com/ambetter.

1. Basic (Class 1) benefits include:
    a. Routine Oral Exams;
    b. Routine Cleanings;
    c. Bite-wing X-rays;
    d. Full-Mouth X-Rays;
    e. Panoramic Film;
    f. Topical fluoride application; and
    g. Palliative Treatment for Relief of Pain (minor procedures).
2. Comprehensive (Class 2) benefits include:
    a. Basic Services – including silver filings and tooth colored filings;
    b. Endodontics – including therapeutic pulpotomy;
    c. Periodontics – including scaling, root planning and periodontal maintenance;

d. Oral Surgery – including simple extractions, surgical extractions, removal of impacted tooth and alveoloplasty; and
e. Prosthodontics – including relines, rebase, adjustment and repairs.

Services not covered for adult Basic (Class 1) and Comprehensive (Class 2) benefits include:

1. Out of network services;
2. Dental services that are not necessary or specifically covered;
3. Hospitalization or other facility charges;
4. Prescription drugs;
5. Any dental procedure performed solely as a cosmetic procedure;
6. Charges for dental procedures completed prior to the member's effective date of coverage;
7. Anesthesiologists services;
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition (wear), realignment of teeth, periodontal splinting, and gnathologic recordings;
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant procedures;
11. Surgical replacements;
12. Sinus augmentation;
13. Surgical appliance removal;
14. Intraoral placement of a fixation device;
15. Oral hygiene instruction, tobacco counseling, nutritional counseling;
16. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
17. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
18. Root canal therapy;
19. Analgesia (nitrous oxide);
20. Removable unilateral dentures;
21. Temporary procedures;
22. Splinting;
23. TMJ appliances, therapy, films and arthorograms;
24. Lab tests including, but not limited to viral culture, saliva diagnostics, caries testing;
25. Consultations by the treating provider and office visits;
26. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth or teeth extracted prior to the member's effective date;
27. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
28. Veneers (bonding of coverings to the teeth);
29. Orthodontic treatment procedures;
30. Corrections to congenital conditions, other than for congenital missing teeth;
31. Athletic mouth guards;
32. Retreatment or additional treatment necessary to correct or relieve the results of previous treatment; and
33. Space maintainers for anyone 19 years of age or older.

Wellness Program Benefits

Benefits may be available from time to time to *members* for participating in certain wellness programs that

we may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. You may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at http://ambetter.superiorhealthplan.com/ or by contacting Member Services by telephone at 877-687-1196. The benefits are available as long as coverage remains active. Upon termination of coverage, the wellness program benefits are no longer available, and any remaining or unused balance on the rewards card is removed at the time of termination. All members are automatically eligible for the wellness program benefits upon obtaining coverage. The wellness program is optional, and the benefits are made available at no additional cost.

Members will be able to earn reward dollars for doing three specific healthy behaviors for a total of $125 per calendar year

a. Annual Health Risk Screening: $50
b. Annual Well Visit: $50
c. Flu Shot: $25

Rewards will be loaded onto the member's "My Health Pays" Rewards card. The card is similar to a Health Reimbursement Account (HRA). Dollars are notional and expire after 12 months. Reward dollars can be used in two ways: a) Member cost share: copays, deductibles, coinsurance payments and b) Member Premiums. Cards will be mailed to the member automatically when the first reward is earned. The "My Health Pays" Rewards card will be attached to a single page mailer outlining the program, as well as the reward the generated the card, other ways to earn rewards, how to use the reward dollars, and where to go to find out more about the program. There is a $5 replacement fee for lost or stolen cards.

The Gym Reimbursement Program features two parts:

a. Discounted Gym memberships within the GlobalFit network
b. $20 per month reimbursement for Gym utilization
    - At least 8 visits per month
    - Reimbursement dollars loaded onto the My Health Pays Rewards card

Members will be able to log into the GlobalFit gym network to purchase a discounted gym membership if they do not already have a membership, or if they want a better rate. Additionally, members will have access to exclusive discounts for healthier lifestyles through the GlobalFit Store. Regardless of whether members purchase their gym membership through GlobalFit, they will be able to earn the Gym Reimbursement benefit. Members will have the ability to register their gym membership information on the GlobalFit portal, and will be able to load monthly utilization information with corresponding documentation to get reimbursed up to $20 per month, for a maximum of $240 per year. Members can upload proof of use via the member secure portal. For additional information or questions regarding this program, please visit *our* website at http://ambetter.superiorhealthplan.com/ or by contacting Member Services by telephone at 877-687-1196.

In the event we replace GlobalFit with a similar vendor or discontinue the gym reimbursement program, we will provide enrollees with 60-days advanced written notice of said change.

GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *Enrollee* or *Enrollee* in the absence of insurance covering the charge.
2. Expenses/surcharges imposed on the *Enrollee* or *Enrollee* by a provider (including a *hospital*) but that are actually the responsibility of the provider to pay.
3. Any services performed by an Enrollee of an *Enrollee's immediate family.*
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses.*

Even if not specifically excluded by this *contract,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract* , except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section.
2. For any portion of the charges that are in excess of the *eligible service expense.*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *Enrollee,* such as sex-change *surgery*.
6. The reversal of sterilization and vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses* of the Miscellaneous Medical Service Expense Benefits provision.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations or for failure to keep a scheduled appointment.
12. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission.
13. For stand-by availability of a *medical practitioner* when no treatment is rendered.
14. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery* , except as expressly provided for under Medical Service Expense Benefits.
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* from trauma, infection or diseases of the involved part that was covered under the

contract or is performed to correct a birth defect in a child who has been an *Enrollee* from its birth until the date *surgery* is performed.

16. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
17. For diagnosis or treatment of nicotine addiction.
18. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
19. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT,* except as specifically provided under the Transplant Service Expense Benefits.
20. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
21. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
22. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy , except as expressly provided for in this *contract*.
23. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.
24. For eyeglasses, contact lenses, hearing aids, except for a screening test for hearing loss for a covered child from birth through the date the child is 30 days old eye refraction, visual therapy, or for any examination or fitting related to these devices , except as expressly provided in this *contract,*.
25. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
26. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of (90) consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
27. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *Enrollee* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *Enrollee's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for an *Enrollee's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
28. As a result of:
    a. Intentionally self-inflicted bodily harm (whether the *Enrollee* is sane or insane).
    b. An *injury* or *illness* caused by any act of declared or undeclared war.
    c. The *Enrollee* taking part in a riot.
    d. The *Enrollee's* commission of a felony, whether or not charged.
29. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.
30. For any *illness* or *injury* incurred as a result of the *Enrollee* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*.
31. For or related to surrogate parenting.
32. For or related to treatment of hyperhidrosis (excessive sweating).
33. For fetal reduction surgery.

34. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
35. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or Semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the *Enrollee* is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the *Enrollee* is paid to participate or to instruct); rock or mountain climbing (if the *Enrollee* is paid to participate or to instruct); or skiing (if the *Enrollee* is paid to participate or to instruct).
36. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *Enrollee* is a pilot, officer, or Enrollee of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
37. As a result of any *injury* sustained while at a *residential treatment facility.*
38. For prescription drugs for any *Enrollee* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.
39. For the following miscellaneous items: artificial Insemination (except where required by federal or state law); biofeedback; blood and blood products; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*Enrollee* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins ; treatment of spider veins; smoking cessation drugs, programs or services, except where required by federal or state law; transportation expenses, unless specifically described in this *contract*;

CONTRACT TERMINATION

Termination Of Contract

All coverage will cease on termination of this *contract.* This *contract* will terminate on the earliest of:

1. Nonpayment of premiums when due, subject to the Grace Period provision in this *contract*.
2. The date *we* receive a request from *you* to terminate this *contract,* or any later date stated in *your* request.
3. The date *we* decline to renew this *contract,* as stated in the Discontinuance provision.
4. The date of *your* death, if this *contract* is an Individual Plan.
5. The date that a *Enrollee* accepts any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this *contract,* or the date an *Enrollee's* employer and a *Enrollee* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes.
6. The date an *Enrollee's* eligibility for coverage under this *contract* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *contract*.

We will refund any premium paid and not earned due to *contract* termination.

If this *contract* is other than an Individual Plan, it may be continued after *your* death:

1. By *your spouse*, if an *Enrollee;* otherwise,
2. By the youngest child who is an *Enrollee.*

This *contract* will be changed to a plan appropriate, as determined by *us,* to the *Enrollee(s)* that continue to be covered under it. *Your spouse* or youngest child will replace *you* as the primary Enrollee. A proper adjustment will be made in the premium required for this *contract* to be continued. *We* will also refund any premium paid and not earned due to *your* death. The refund will be based on the number of full months that remain to the next premium due date.

Discontinuance

90-Day Notice: If *we* discontinue offering and refuse to renew all contracts issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least 90 days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *contract*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If *we* discontinue offering and refuse to renew all individual contracts in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least 180 days prior to the date that *we* stop offering and terminate all existing individual contracts in the individual market in the state where *you* reside.

Portability Of Coverage

If a person ceases to be an *Enrollee* due to the fact that the person no longer meets the definition of *dependent Enrollee* under the *contract*, the person will be eligible for continuation of coverage. If elected, *we* will continue the person's coverage under the *contract* by issuing an individual policy. The premium rate applicable to the new policy will be determined based on the residence of the person continuing

coverage. All other terms and conditions of the new policy, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the state in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new contract to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family deductible which must be met by all *Enrollees* combined, only those expenses incurred by the *Enrollee* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

Notification Requirements

It is the responsibility of *you* or *your* former *dependent Enrollee* to notify *us* within 31 days of *your* legal divorce or *your dependent Enrollee's* marriage. *You* must notify *us* of the address at which their continuation of coverage should be issued.

Continuation of Coverage

We will issue the continuation of coverage:

1. No less than 30 days prior to an *Enrollee's* 26th birthday; or
2. Within 30 days after the date *we* receive timely notice of *your* legal divorce.

Reinstatement

If *your contract* lapses due to nonpayment of premium, it may be reinstated provided:

1. *We* receive from *you* a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

Changes may be made in *your contract* in connection with the reinstatement. These changes will be sent to *you* for *you* to attach to *your contract* In all other respects, *you* and *we* will have the same rights as before *your contract* lapsed.

Benefits After Coverage Terminates

Benefits for *covered service expenses* incurred after an *Enrollee* ceases to be covered are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *contract* is terminated because of:

1. A request by *you*;
2. Fraud or material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before coverage of the *Enrollee* ceases under this *contract*. No benefits are provided for *covered service expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *contract* is terminated because *we* refuse to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *contract* will not prejudice a claim for a *continuous loss* that begins before coverage of the *Enrollee*

ceases under this *contract.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. 12 months after the date renewal is declined.

During coverage for a *period of extended loss* or a *continuous loss,* as described above, the terms and conditions of this *contract,* including those stated in the Premiums section of this *contract,* will apply as though coverage had remained in force for that *illness* or *injury*.

THIRD PARTY LIABILITY

If an *Enrollee's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *contract* benefits for the *Enrollee's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* provided or paid for the *illness* or *injury* if the *Enrollee* subsequently receives any payment from any *third party*. The *Enrollee* (or the guardian, legal representatives, estate, or heirs of the *Enrollee*) shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *Enrollee* or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause.
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of an *Enrollee* in connection with the *loss*.
3. To include the amount of benefits paid by *us* on behalf of an *Enrollee* in any claim made against any *third party*.
4. That *we*:
    a. Will have a lien on all money received by an *Enrollee* in connection with the *loss* equal to the benefit amount *we* have provided or paid.
    b. May give notice of that lien to any *third party* or *third party's* agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect *our* rights.
    d. Are subrogated to all of the rights of the *Enrollee* against any *third party* to the extent of the benefits paid on the *Enrollee's* behalf.
    e. May assert that subrogation right independently of the *Enrollee*.
5. To take no action that prejudices *our* reimbursement and subrogation rights.
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so.
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the third party's payment is expressly designated as a payment for medical expenses.
9. That we may reduce other benefits under the contract by the amounts an Enrollee has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *Enrollee* or the *Enrollee's* guardian (if the *Enrollee* is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the *Enrollee* is fully compensated by any recovery received from any *third party* by settlement, judgment, or otherwise.

We will not pay attorney fees or costs associated with the *Enrollee's* claim or lawsuit unless *we* previously agreed in writing to do so.

If a dispute arises as to the amount an *Enrollee* must reimburse *us*, the *Enrollee* (or the guardian, legal representatives, estate, or heirs of the *Enrollee*) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by *us* until the dispute is resolved.

ENROLLEE CLAIM REIMBURSEMENT

Notice Of Claim
We must receive a request for reimbursement through receipt of a claim within 90 days of the date of service.

Time For Payment Of Claims
We will review your request for reimbursement, and if eligible, will be processed for payment within 45 days of receipt of your claim.

COMPLAINT AND APPEAL PROCEDURES

Complaint Process

"Complaint" means any dissatisfaction expressed by *you* orally or in writing to *us* with any aspect of *our* operation, including but not limited to, dissatisfaction with plan administration;, procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. An *Enrollee* has 90 days from the date of the incident to file an appeal in Texas.

If *you* notify US orally or in writing of a Complaint, *we* will, not later than the fifth business day after the date of the receipt of the Complaint, send to *you* a letter acknowledging the date *we* received *your* Complaint. If the Complaint was received orally, *we* will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to *us* for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from *you*, *we* will investigate and send *you* a letter with our resolution. The total time for acknowledging, investigating and resolving your Complaint will not exceed thirty (30) calendar days after the date *we* receive *your* Complaint.

Y*our* Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of *your* Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

You may use the appeals process to resolve a dispute regarding the resolution of *your* Complaint.

Appeals to the HEALTH PLAN

1. If the Complaint is not resolved to *your* satisfaction, *you* have the right either to appear in person before a Complaint appeal panel where *you* normally receive health care services, unless another site is agreed to by *you*, or to address a written appeal to the Complaint appeal panel. *We* shall complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for appeal.
2. *We* shall send an acknowledgment letter to *you* not later the fifth day after the date of receipt of the request of the appeal.
3. *We* shall appoint Enrollees to the Complaint appeal panel, which shall advise *us* on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of our staff, Physicians or other Providers, and enrollees. An Enrollee of the appeal panel may not have been previously involved in the disputed decision.
4. Not later than the fifth business day before the scheduled meeting of the panel, unless *you* agree otherwise, *we* shall provide to *you* or *your* designated representative:
   a. any documentation to be presented to the panel by our staff;
   b. the specialization of any Physicians or Providers consulted during the investigation; and
   c. the name and affiliation of each of our representatives on the panel.
5. *You*, or *your* designated representative if *you* are a minor or disabled, are entitled to:
   a. appear in person before the Complaint appeal panel;
   b. present alternative expert testimony; and
   c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one business day after *your* request for appeal.
7. Due to the ongoing Emergency or continued Hospital stay, and at *your* request, *we* shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.
8. Notice of *our* final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Internal Appeal of 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 you are not medically necessary or appropriate.

If *you*, *your* designated representative or *your child's* Physician or Provider of record disagree with the Adverse Determination, you, your designated representative or *your child's* Physician or Provider may appeal the Adverse Determination orally or in writing.

Within 5 business days after receiving a written appeal of the Adverse Determination, *we* or *our* Utilization Review Agent will send *you*, *your* designated representative or *your child's* Physician or Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that *you*, *your* designated representative or your *child's* Physician or Provider should send to *us* or to our Utilization Review Agent for the appeal.

If *you*, *your* designated representative or *your child's* Physician or Provider orally appeal the Adverse Determination, *we* or our Utilization Review Agent will send *you*, *your* designated representative or *your child's* Physician or Provider a one-page appeal form. *You* are not required to return the completed form, but *we* encourage *you* to because it will help *us* resolve *your* appeal.

Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than 1 business day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than 30 calendar days after the date *we* or our Utilization Review Agent receives the appeal.

External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, *you*, *your* designated representative or *your child's* Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When *we* or our Utilization Review Agent deny the appeal, *you*, *your* designated representative or *your child's* Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, *your child* is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, *you*, *your* designated representative or *your child's* Physician or Provider of record may contact *us* or our Utilization Review Agent by telephone to request the review by the IRO and *we* or our utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, *we* will abide by the IRO's decision. *We* will pay for the IRO review.

The appeal procedures described above do not prohibit *you* from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if *you* believe that the requirement of completing the appeal and review process places *your child's* health in serious jeopardy.

Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. Complaints to the Texas Department of Insurance may also be filed electronically at www.tdi.texas.gov.

The Commissioner of Insurance shall investigate a complaint against *us* to determine compliance within sixty (60) days after the Texas Department of Insurance's receipt of the 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:

1. additional information is needed;
2. an on-site review is necessary;
3. *We* the Physician or Provider, or *you* do not provide all documentation necessary to complete the investigation; or other circumstances beyond the control of the Department occur.

Retaliation Prohibited

1. *We* will not take any retaliatory action, including refusal to renew coverage, against a child because the child or person acting on behalf of the child has filed a Complaint against *us* or appealed a decision made by *us*.
2. *We* shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a Physician or Provider, because the Physician or Provider has, on behalf of a child, reasonably filed a Complaint against *us* or has appealed a decision made by *us*.

ENROLLEE RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as an *Enrollee*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
8. Make recommendations regarding Enrollee's rights, responsibilities and policies.
9. Voice complaints or grievances about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. Participate in matters of the organization's policy and operations.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, Enrollee rights and responsibilities, and *our* other rules and

guidelines. *We* will notify *you* at least 60 days before the effective date of the modifications. Such notices shall include the following:
    a. Any changes in clinical review criteria
    b. A statement of the effect of such changes on the personal liability of the *Enrollee* for the cost of any such changes.
14. A current list of *network providers*. *You* can also get information on *your network providers'* education, training, and practice.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
19. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network physician*, at no cost to *you*, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
24. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
25. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help your *primary care physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders. Enrollees also have the right to refuse to make advance directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.

4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. You may change your *primary care physician* verbally or in writing by contacting *our* Enrollee Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.

NOTE: Let *our* customer service department know if *you* have any changes to *your* name, address, or family Enrollees covered under this *contract*.

GENERAL PROVISIONS

Entire Contract
This *contract,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *contract* will be valid unless it is approved by one of *our* officers and noted on or attached to this *contract.* No agent may:

1. Change this *contract*;
2. Waive any of the provisions of this *contract*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *contract*, that will not be considered a waiver of any rights under the *contract*. A past failure to strictly enforce the *contract* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding an *Enrollee* during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by an *Enrollee;*
2. A copy of the application, and any amendments, has been furnished to the *Enrollee(s)* or to the *Enrollee's* personal representative; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *Enrollee.* An *Enrollee's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment For Fraud, Misrepresentation Or False Information
During the first two years an *Enrollee* is covered under the *contract*, if an *Enrollee* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *Enrollee* under this *contract* or in filing a claim for *contract* benefits, *we* have the right to demand that *Enrollee* pay back to *us* all benefits that *we* provided or paid during the time the *Enrollee* was covered under the *contract*.

Conformity With State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Conditions Prior To Legal Action
On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *contract*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

1. Identify the coverage, benefit, premium, or other disagreement;
2. Refer to the specific *contract* provision(s) at issue; and
3. Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within 30 days after *we* receive *your* notice of intention to sue *us*.