ambetter. FROM superior healthplan

2022 Evidence of Coverage

Ambetter.SuperiorHealthPlan.com

Notice: Premium may be increased upon the renewal date. We will provide a written notice of increase in a charge for coverage not less than 60 days before the date the increase takes effect.

AMBETTER FROM SUPERIOR HEALTHPLAN

Evidence of Coverage

HEALTH MAINTENANCE ORGANIZATION

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

AMBETTER FROM SUPERIOR HEALTHPLAN

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 *CONTRACT*. THIS DOCUMENT DESCRIBES *YOUR* RIGHTS AND RESPONSIBILITIES IN RELATION TO *YOUR* COVERED HEALTH SERVICES AND BENEFITS.

Superior HealthPlan, Inc.
5900 E. Ben White Blvd.
Austin, Texas 78704
1-877-687-1196

IMPORTANT NOTICES:

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. PLEASE CONSULT WITH YOUR INSURANCE AGENT TO DISCOVER WHICH STATE-MANDATED HEALTH BENEFITS ARE EXCLUDED IN THIS EVIDENCE OF COVERAGE.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE.

If *you* are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Have a complaint or need help?

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

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

Ambetter from Superior HealthPlan

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

Call: Member Services at 1-877-687-1196

Toll-free: 1-877-687-1196

Online: Ambetter.SuperiorHealthPlan.com

Email: SHPMSCONTACTUS@CENTENE.COM

Mail: 5900 E. Ben White Blvd.
Austin, Texas 78741

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

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

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

Ambetter from Superior HealthPlan

Para obtener información o para presentar una queja ante su compañía de seguros o

HMO:

Llame a: Member Services al 1-877-687-1196

Teléfono gratuito: 1-877-687-1196

Correo electrónico: SHPMSCONTACTUS@CENTENE.COM

En línea: Ambetter.SuperiorHealthPlan.com

Dirección postal: 5900 E. Ben White Blvd.
Austin, Texas 78741

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Superior HealthPlan, Inc.

Evidence of Coverage

In this Evidence of Coverage (*contract*), the terms "*you*", "*your*" or "*yours*" will refer to the *enrollee* or any *dependent enrollees* enrolled in this *contract*. The terms "*we*," "*our*," or "*us*" will refer to Superior or Ambetter from Superior HealthPlan.

AGREEMENT AND CONSIDERATION

This document along with the corresponding Schedule of Benefits is your Contract and it is a legal document. It is the agreement under which benefits will be provided and paid. In consideration of *your* application and the timely payment of premiums, *we* will provide benefits to *you*, the *enrollee*, for covered *Healthcare Services* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

Annually, *we* must file this product, the *cost share* and the rates associated with it for approval. Guaranteed renewable means that *your* plan will be renewed into the subsequent year's approved product on the anniversary date unless terminated earlier in accordance with *contract* terms. *You* may keep this *contract* (or the new *contract you* are mapped to for the following year, whether associated with a discontinuance or replacement) in force by timely payment of the required premiums. In most cases *you* will be moved to a new *contract* each year, however, *we* may decide not to renew the *contract* as of the renewal date if: (1) *we* decide not to renew all *contracts* issued on this form, with a new *contract* at the same metal level with a similar type and level of benefits, to residents of the state where *you* then live or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of an *enrollee* in filing a claim for *covered services*.

In addition to the above, this guarantee for continuity of coverage shall not prevent *us* from cancelling or non-renewing this *contract* in the following events: (1) non-payment of premium; (2) an *enrollee* fails to pay premiums or contributions in accordance with the terms of this *contract*, including any timeliness requirements; (3) an *enrollee* has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact

relating to this *contract*; or (4) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.

This *Evidence of Coverage* contain *prior authorization* requirements. *You* will be required to obtain a *referral* from a *primary care practitioner* in order to receive care from a *specialist provider*. Failure to comply with the *prior authorization* requirements may result in denial of payment. Please refer to the *Summary of Benefits and Coverage (SBC)* and the Prior Authorization Section.

Superior HealthPlan, Inc.

Mark D. Sanders
Plan President & CEO

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INTRODUCTION

Welcome to Ambetter from Superior HealthPlan! *We* have prepared this *contract* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- How to access medical care.
- The healthcare services *we* cover.
- The portion of *your* healthcare costs *you* will be required to pay.

This *contract*, the *Schedule of Benefits*, 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 in its entirety. Because many of the provisions of this *contract* are interrelated, *you* should read this entire *contract* to gain a full understanding of *your* coverage. Many words used in this *contract* have special meanings when used in a healthcare setting: these words are *italicized* and are defined in the Definitions section. This *contract* also contains exclusions, so please be sure to read this entire *contract* carefully.

How To Contact Us:
Ambetter from Superior HealthPlan
5900 E. Ben White Blvd.
Austin, Texas 78741

Normal Business Hours of Operation - 8:00 a.m. to 8:00 p.m. CST, Monday through Friday
Member Services 1-877-687-1196
Relay Texas/TTY 1-800-735-2989
Fax 1-877-941-8077
Emergency 911
24/7 Nurse Advice Line 1-877-687-1196
Website: Ambetter.SuperiorHealthPlan.com

Interpreter Services
Ambetter from Superior HealthPlan has a free service to help *our enrollees* who speak languages other than English. These services ensure that *you* and *your provider* can talk about *your* medical or *behavioral health* concerns in a way that is most comfortable for *you*.

Our interpreter services are provided at no cost to *you*. *We* have representatives that speak Spanish and have medical interpreters to assist with languages other than English. *Enrollees* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation. To arrange for interpretation services, please call Member Services at 1-877-687-1196 or for hearing impaired (Relay Texas/TTY 1-800-735-2989).

Your Provider Directory
A listing of *network providers* is available online at Ambetter.SuperiorHealthPlan.com. *We* have plan *providers and hospitals* 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, languages spoken and whether or not they are currently accepting new patients. *Your* search will produce a list of *providers* based on *your* search criteria and will give *you* other information such as name, address, phone number, office hours, specialty and board certifications.

At any time, *you* can contact Member Services to request a Provider Directory, or for assistance in finding a *provider*.

Your Enrollee ID Card

When *you* enroll, *we* will mail *you* an *enrollee* ID card after *we* receive *your* completed enrollment materials, which includes receipt of *your* initial premium payment. This card is proof that *you* are enrolled in Ambetter. *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 Member Services. *We* will send *you* another ID card.

Our Website

Our website can answer many of *your* frequently asked questions and has resources and features that make it easy to get quality care. *Our* website can be accessed at Ambetter.SuperiorHealthPlan.com. It also gives *you* information on *your* benefits and services such as:

1. Finding a *network provider*.
2. Locate other *providers* (e.g., hospitals and pharmacies).
3. *Our* programs and services, including programs to help *you* get and stay healthy.
4. A secure portal for *you* to check the status of *your* claims, make payments and obtain a copy of *your enrollee* ID card.
5. *Enrollee's* Rights and Responsibilities.
6. Notice of Privacy.
7. Current events and news.
8. *Our* formulary or Preferred Drug List.
9. *Deductible* and *copayment* accumulators.
10. Selecting a *primary care provider* (also accessible through the use of mobile devices).

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 *providers* 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.

Protection from Balance Billing

Under Federal law, effective January 1, 2022, *non-network providers* or *facilities* in are prohibited from *balance billing* health plan *enrollees* for:

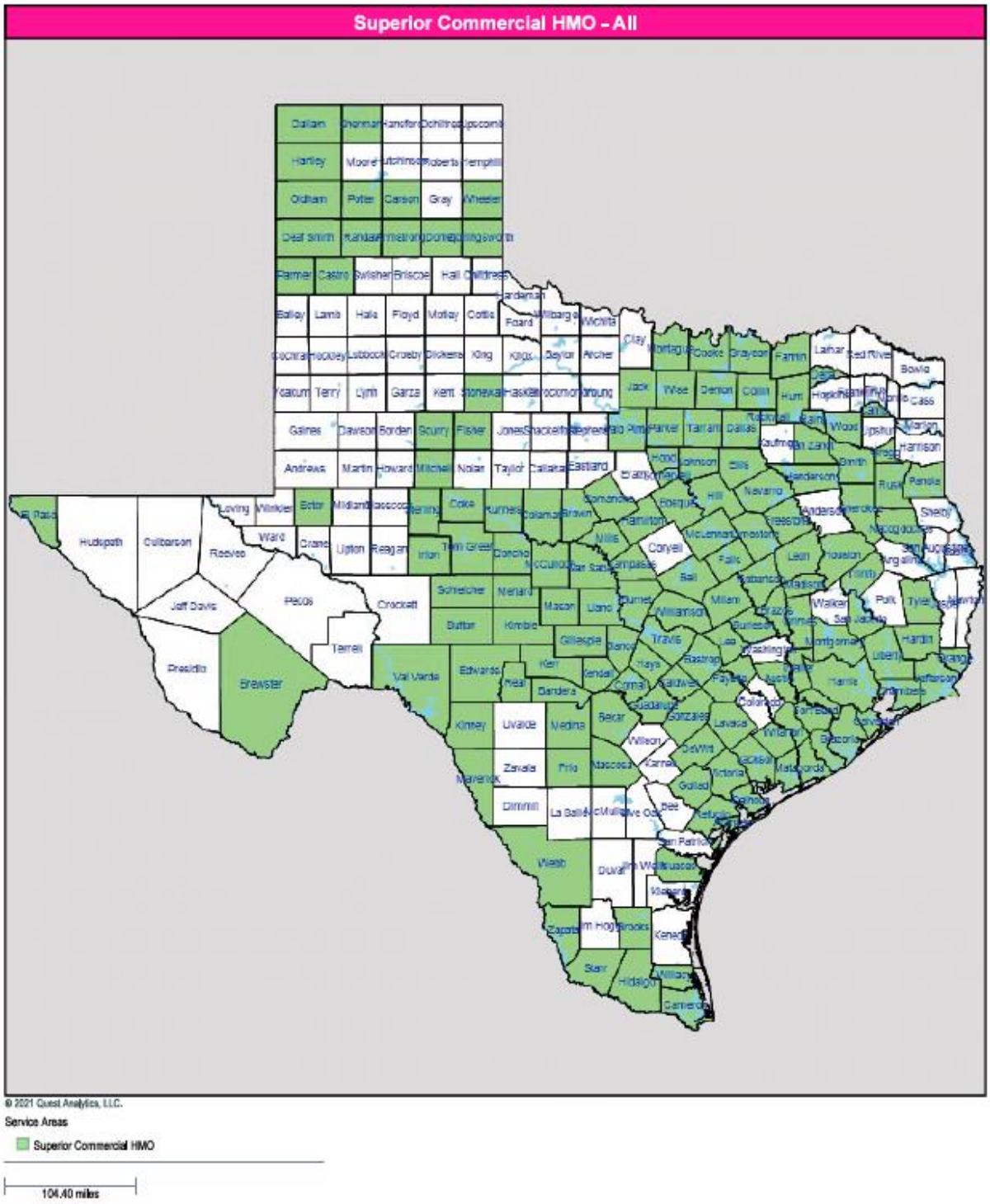
1. Emergency Services provided to an *enrollee*, regardless of plan participation; or
2. Non-emergency health care services provided to an *enrollee* at an in-network *hospital* or at a network health care *facility* if the *enrollee* did not give informed consent or *prior authorization* to be seen by the out-of-network provider pursuant to the federal No Surprises Act.

Please review the Access to Care and Covered Services sections of this Contract for detailed information.

SERVICE AREA MAP

Superior Commercial HMO

Service Area Map



DEFINITIONS

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

Wherever used in this *contract*:

Acute rehabilitation is rehabilitation for patients who will benefit from an intensive, multidisciplinary rehabilitation program. Patients normally receive a combination of therapies such as physical, occupational and speech therapy as needed and are medically managed by specially trained physicians. Rehabilitation services must be performed for three or more hours per day, five to seven days per week, by one or more *rehabilitation licensed practitioners* 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.

Advanced premium tax credit means the tax credit provided by the Affordable Care Act to help *you* afford health coverage purchased through the Health Insurance Marketplace. *Advanced premium tax credits* can be used right away to lower *your* monthly premium costs. If *you* qualify, *you* may choose how much *advanced premium tax credit* to apply to *your* premiums each month, up to the maximum amount. If the amount of *advanced premium tax credits you* receive for the year is less than the total premium tax credit *you're* due, *you'll* get the difference as refundable credit when *you* file *your* federal income tax return. If the amount of *advanced premium tax credits* for the year are more than the total tax credit that *you're* due, *you* must repay the excess *advanced premium tax credit* with *your* tax return.

Adverse determination means a determination by a utilization review agent made on behalf of any payor that the health care services provided or proposed to be provided to an *enrollee* are not *medically necessary* or appropriate or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Refer to the Complaint and Appeals Procedures section of this *contract* for information on *your* right to *appeal* an *adverse determination.*

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.

Allowed Amount **(also see *Eligible Service Expense*)** is the maximum amount we will pay a *provider* for a *covered service* when a *covered service* is received from a *network provider*, the *allowed amount* is the amount the *provider* agreed to accept from *us* as payment for that particular service. In all cases, the *allowed amount* will be subject to *cost sharing* (e.g., *deductible*, *coinsurance* and *copayment*) per the *enrollee's* benefits. This amount excludes agreed to amounts between the *provider* and *us* as a result of Federal or State Arbitration.

Please note, if you receive services from a *non-network provider*, *you* may be responsible for the difference between the amount the *provider* charges for the service (billed amount) and the *allowed amount* that *we* pay. However, *you* will not be responsible for *balance billing* for unanticipated out-of-network care that is otherwise covered under your plan and that is provided by a *non-network provider* at an in-network facility, unless you gave informed consent before receiving the services. *You* also will not be responsible for *balance billing* by a *non-network provider* or *non-network facility* for *emergency services* or air ambulance services. See *balance billing* and *non-network provider* definitions for additional information. If *you* are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.

Ambetter Telehealth means the preferred vendor who we have contracted with to provide *telehealth services* to *enrollees*. *Our* preferred vendor contracts with providers to render *telehealth services* to *enrollees*. These services can be accessed via https://ambetter.superiorhealthplan.com/benefits-services/telehealth-services.html.

Appeal is *our* or *our* Utilization Review Agent's formal process by which an *enrollee*, or an individual acting on behalf of an *enrollee*, or an *enrollee's provider* of record may request reconsideration of an *adverse determination*. *Appeal* means a *grievance* requesting the contractholder to reconsider, reverse, or otherwise modify an *adverse benefit determination*, service or claim.

Applied behavior analysis (ABA) is the application of behavioral principles to everyday situations, intended to increase or decrease targeted behaviors. *ABA* has been used to improve areas such as language, self-help, and play skills, as well as decrease behaviors such as aggression, self-stimulatory behaviors, and self-injury.

Authorization or Authorized (also "Prior Authorization" or "Approval") means *our* decision to approve the *medical necessity* or the appropriateness of care for an *enrollee* by the *enrollee's PCP* or *provider* prior to the *enrollee* receiving services.

Autism spectrum disorder refers to a group of complex disorders represented by repetitive and characteristic patterns of behavior and difficulties with social communication and interaction. The symptoms are present from early childhood and affect daily functioning and classified by the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders or the International Statistical Classification of Diseases and Related Health Problems (ICD).

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.

Balance billing means a *non-network provider* billing *you* for the difference between the *provider's* charge for a service and the *eligible service expense*. *Network providers* may not *balance bill you* for *covered service expenses* beyond *your* applicable cost sharing amounts.

If *you* are ever balance billed contact Member Services immediately at the number listed on the back of *your* ID card.

Behavioral Health includes both mental health and substance use disorder, encompassing a continuum of prevention, intervention, treatment and recovery support services.

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.

Billed charges are the charges for medical care or healthcare services included on a claim submitted by a *physician* or *provider*.

Care management is a program in which a registered nurse or licensed mental health professional, known as a care manager, assists an *enrollee* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and healthcare benefits available to an *enrollee*. *Care management* is instituted when mutually agreed to by *us*, the *enrollee* and the *enrollee's physician*.

Center of Excellence *is a designation conferred by Ambetter that* means a *hospital* has met specific qualitative measures in regards to transplant services:

1. Specializes in a specific type or types of 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 *enrollee's* brain-behavioral deficits.

Coinsurance means the percentage of *covered service expenses* that *you* may be required to pay when *you* receive a service. *Coinsurance* amounts are listed in the *Schedule of Benefits*. Not all *covered services* have *coinsurance*.

Community reintegration services are services that facilitate the continuum of care as an affected *enrollee* transitions into the community.

Complaint 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 Texas Insurance Code Section 843.251,, 4201.204, and 4201.351, 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:
1. 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
2. A *provider's* or *enrollee's* oral or written expression of dissatisfaction or disagreement with an *adverse determination*.

Complications of pregnancy means:

1. conditions, requiring *hospital* confinement (when the *pregnancy* is not terminated), whose diagnoses are distinct from *pregnancy* but are adversely affected by *pregnancy* or are caused by *pregnancy*, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and

similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, *provider* prescribed rest during the period of *pregnancy*, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult *pregnancy* not constituting a nosologically distinct complication of *pregnancy*; and

2. non-elective cesarean section, termination of ectopic *pregnancy*, and spontaneous termination of *pregnancy*, occurring during a period of gestation in which a viable birth is not possible.

Continuing care patient means an individual who, with respect to a *provider* or *facility*, is (i) undergoing a treatment for a *serious and complex condition* from that *provider* or *facility*; (ii) is undergoing a course of institutional or inpatient care from that *provider* or *facility*; (iii) is scheduled to undergo non-elective surgery from that *provider*, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the pregnancy; or (v) is determined to be terminally ill and is receiving treatment for such illness.

Contract* or *Evidence of Coverage, when *italicized*, refers to this *contract*, as issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Copayment, Copay, or Copayment amount means the specific dollar amount that *you* may be required to pay when *you* receive *covered services*. *Copayment amounts* are shown in the *Schedule of Benefits*. Not all *covered services* have a *copayment amount*.

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 means the *deductible amount*, *copayment amount* and *coinsurance* that *you* pay for *covered services*. The *cost sharing* amount that *you* are required to pay for each type of *covered services* is limited in the *Schedule of Benefits*. When you receive *covered services* from a *non-network provider* in a network facility, or when you receive *covered emergency services* or air ambulance services from *non-network providers*, *cost-sharing* may be based on an amount different from the *allowed amount.*

Cost-sharing reductions lowers the amount *you* have to pay in *deductibles*, *copayments* and *coinsurance.* To qualify for *cost-sharing reductions,* an eligible individual must enroll in a silver level plan through the Health Insurance Marketplace or be a member of a federally recognized American Indian tribe and/or an Alaskan Native enrolled in a *QHP* through the Health Insurance Marketplace.

Covered service or ***covered service expenses*** means healthcare services, supplies or treatment as described in this *contract* which are performed, prescribed, directed or *authorized* by a *provider*. 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 are services designed to assist an *enrollee* with activities of daily living, often provided in a long term care environment where full recovery is not expected and can be provided by a layperson. *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 or ***deductible*** means the amount that *you* must pay in a calendar year for *covered expenses* before *we* will pay benefits. For family coverage, there is a family *deductible amount* which is two times the individual *deductible amount.* Both the individual and the family *deductible amounts* are shown in the *Schedule of Benefits*.

If *you* are a covered *enrollee* in a family of two or more *enrollees*, *you* will satisfy *your deductible amount* when:

1. *You* satisfy *your* individual *deductible amount*; or
2. *Your* family satisfies the family *deductible amount* for the calendar year.

If *you* satisfy *your* individual *deductible amount,* each of the other *enrollees* in *your* family are still responsible for the *deductible* until the family *deductible amount* is satisfied for the calendar year.

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*.

Diabetes self-management training means instruction enabling an *enrollee* and/or his or her caretaker to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

1. A subjective or objective abnormality detected by a physician or patient in a breast;
2. An abnormality seen by a physician on a screening mammogram;
3. An abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or
4. An individual with a personal history of breast cancer or dense breast tissue.

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 date an *enrollee* becomes covered under this *contract* for *covered services*.

Eligible child means the child of an *enrollee*, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A stepchild;

3. A legally adopted child and child for which the primary *enrollee* must provide medical support under an order issued under Section 14.061, Family Code, or another order enforceable by a court in Texas;
4. A child placed with *you* for adoption or for whom *you* are a party in a suit in which the adoption of the child is sought;
5. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify the entity with which *you* enrolled (either the Marketplace or *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*;
6. A child of an on-exchange *enrollee* who is a resident of United States or a full-time student at an accredited higher education institution;
7. A child of an on-exchange *enrollee* who is not eligible for coverage under Medicare;
8. Any children of the on-exchange *enrollee's* children, if those children are dependents of the *enrollee* for federal income tax purposes at the time of application; or
9. A child whose coverage is required by a medical support order.

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

1. For *network providers*: 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,* unless otherwise required by Federal or Texas law, the eligible service expense is as follows:
    a. When a *covered service* is received from a *non-network provider* as a result of an emergency, the *eligible service expense* is the lesser of: (1) the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full, or (2) the usual and customary rate for such service. *You* cannot be billed for the amount above the usual and customary rate. If *you* have received *emergency care* provided by a *non-network provider* and received a balance bill, notify the Texas Department of Insurance (TDI) or notify Ambetter from Superior HealthPlan by visiting *our* website and Ambetter will notify TDI. *You* must see a *network provider* for any post stabilization care and for all follow-up care.
    b. When a *covered* air ambulance service is received from a *non-network provider*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, unless otherwise required by applicable law, the *eligible service expense* is reimbursement as determined by us and as required by applicable law. Member *cost share* will be calculated from the recognized amount based upon applicable law. *You* will not be *balance billed* for the difference between the amount *we* pay and the *provider's* charges, but *you* may be subject to *cost-sharing* obligations. If *you* are *balance billed* in these situations, please contact Member Services immediately at the number listed on the back of *your* ID card.
    c. When a *covered service* is received from a *non-network* professional *provider* who renders non-*emergency* services at an in-network *facility,* including but not limited to diagnostic imaging or laboratory testing services, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full. If the *provider* has not agreed to accept a negotiated fee with *us* as payment in full, unless otherwise required by applicable law, the *eligible service expense* is reimbursement as determined by *us* and as required by applicable law. Unless you receive and sign the necessary written notice and consent document under federal law before the services are provided, *you* will not be *balance billed* for the difference between the amount we pay and

the *provider's* charges, but you may be subject to *cost-sharing* obligations. Member *cost share* will be calculated from the recognized amount based upon applicable law. If *you* are balance billed in these situations, notify Ambetter from Superior HealthPlan by visiting *our* website. Ambetter will notify TDI as appropriate.

d. When a *covered service* is not the result of an emergency, received from a *non-network provider* and a notice and disclosure statement was signed, *you* may be balance billed for the amount above the usual and customary rate. If *you* have received care provided by a *non-network provider* and signed a notice and disclosure statement 10 days prior to receiving care, *you* are responsible for the balance billed amount.

e. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from *us*, the *eligible service expense* is the negotiated fee, if any, that has been mutually agreed upon by *us* and the *provider* as payment in full (*you* will not be billed for the difference between the negotiated fee and the *provider's* charge). If there is no negotiated fee agreed to by the *provider* with *us,* the *eligible service expense* is the greatest of the following: (i) the amount that would be paid under Medicare; (ii) the amount for the covered service calculated using the same method we generally use to determine payments for *non-network* providers; or (iii) the contracted amount paid to *network providers* for the *covered service* (if there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts). In addition to applicable *cost-sharing*, you may be *balance billed* for these services

As used in this section, "usual and customary rate" is calculated based on usual, reasonable, or customary charges paid to and accepted by *providers*, and is based on generally accepted industry standards and practices for determining the customary charges for a service.

Emergency* (Medical and Behavioral Health) *care means healthcare services provided in a *hospital* emergency *facility*, freestanding emergency medical care *facility*, or comparable emergency *facility* to evaluate and stabilize a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, or psychiatric disturbances) such that a prudent layperson with an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. placing the recipient's (or, with respect to a pregnant woman, the health of the woman or her fetus) health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction or disfigurement of any bodily organ or part.

Services *you* receive from a *non-network provider* or *non-network facility* after the point *your* emergency medical/behavioral health condition is *stabilized* continue to meet the definition of *emergency services* until (1) you are discharged from the facility, or (2) both of the following circumstances are met, as well as any other criteria required by federal or state law: (a) the *provider* or facility determines *you* are able to travel using nonmedical transportation or nonemergency medical transportation, and (b) *your provider* obtains informed consent to provide the additional services.

Enhanced Direct Enrollment (EDE) means an Ambetter tool that allows *you* to apply for coverage, renew and report life changes entirely on *our* website without being redirected to the Health Insurance Marketplace (Healthcare.gov). If *you* have utilized enroll.ambetterhealth.com to apply or renew, a consumer dashboard has been created for *you*. *You* can log into *your* consumer dashboard at enroll.ambetterhealth.com

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*.

Experimental or ***investigational treatment*** is a healthcare treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.

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

1. Is licensed as a *skilled nursing facility* o*r 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 *provider* 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 *provider*; and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing *generally accepted standards of medical practice* for that condition.

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

Facility means a *hospital*, *rehabilitation facility*, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, *skilled nursing facility*, or other healthcare *facility* providing health care services.

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 *provider* specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a healthcare service, supply, or drug is *medically necessary* and is a *covered service* under the *contract*. The decision to apply *provider* specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Habilitation *or* ***habilitation services*** means health care services that help *you* keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* or outpatient settings.

Health Management means a program designed specially to assist *you* in managing a specific or chronic health condition.

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 an *enrollee*.

Home health services 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 *provider*.

Home health care agency means a business that:

1. provides *home health services*; and
2. is licensed by Texas Health and Human Services under Chapter 142 of the Health and Safety Code.

Home infusion therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting.

Hospice means services designed for, elected by, and provided to *enrollees* who are *terminally ill*, as certified by an Ambetter physician. Ambetter works with certified Hospice programs licensed by the state to minimize patient discomfort and address 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 *providers*), 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;
2. Provide 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.);
3. Is an institution which maintains and operates a minimum of five beds;
4. Has x-ray and laboratory *facilities* either on the premises or available on a contractual prearranged basis; and
5. Maintain permanent medical history records.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *extended care facility, or residential treatment facility,* halfway house, or transitional *facility*, or a patient is moved from the emergency room in a short term observation status, an *enrollee* will be deemed not to be confined in a *hospital* for purposes of this *contract*.

Hospital Services means those *medically necessary covered services* that are generally and customarily provided by acute general *hospitals*; and prescribed, directed or authorized by *your primary care provider*. When an *enrollee* is admitted to an inpatient facility, a *physician* other than the *enrollee's primacy care provider* may direct and oversee the *enrollee's* care.

Illness means a sickness, disease, or disorder of an *enrollee*. 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*, *eligible child*, 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 services, supplies, or treatment, for medical or *behavioral health*, 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 for special care units.

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

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, EPO, 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, EPO, 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;
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in 26 CFR § 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; and
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* of *covered expenses*, as shown in the *Schedule of Benefits*. After the *maximum out-of-pocket amount* is met for an individual, *we* pay 100% of *eligible service expenses*. The family *maximum out-of-pocket amount* is two times the individual *maximum out-of-pocket amount*. For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any one or more *enrollees' eligible service expenses*. Both the individual and the family *maximum out-of-pocket amounts* are shown in the *Schedule of Benefits*.

For family coverage, the family *maximum out-of-pocket amount* can be met with the combination of any covered *enrollees' eligible service expenses*. A covered *enrollee's maximum out-of-pocket amount* will not exceed the individual *maximum out-of-pocket amount*.

If *you* are a covered *enrollee* in a family of two or more *enrollees*, *you* will satisfy *your maximum out-of-pocket* when:

1. *You* satisfy *your* individual *maximum out-of-pocket;* or
2. *Your* family satisfies the family *maximum out-of-pocket amount* for the calendar year.

If *you* satisfy *your* individual *maximum out-of-pocket, you* will not pay any more *cost-sharing* for the remainder of the calendar year, but any other eligible *enrollees* in *your* family must continue to pay *cost sharing* until the family *maximum out-of-pocket* is met for the calendar year.

The Dental out-of-pocket maximum limits do not apply to the satisfaction of the *maximum out-of-pocket* 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.

Medically necessary means healthcare services, items, or supplies needed to prevent, diagnose, or treat an *illness*, *injury*, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medically stabilized for non-emergency services 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*. Stabilize, with respect to an emergency medical condition, means to provide medical treatment of the condition as necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer* to a network *facility* or discharge of the individual from a *facility*, (*See Ambulance Service Benefits).

Mental disorder refers to a behavioral, emotional or cognitive pattern of functioning that is listed in the most recent edition of the International Classification of Diseases.

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 *providers* or *facilities* (including, but not limited to *hospitals*, inpatient mental healthcare facilities, medical clinics, behavioral health clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have contracts with *us*, or *our* contractor or subcontractor, and have agreed to provide healthcare services to *our members* for an agreed upon fee. *Members* will receive most, if not all, of their healthcare services by accessing the *network*.

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*.

Network provider (or ***participating provider)*** means any person or entity that has entered into a contract with Ambetter from Superior HealthPlan under the Ambetter Value TX network to provide *covered services* to *enrollees* under this *contract*, including but not limited to, *hospitals*, specialty hospitals, *urgent care* facilities, *physicians*, pharmacies, laboratories and other health professionals within our *service area*.

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 *enrollee*, 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 *enrollees* 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 Provider (or ***non-participating provider***) means a medical practitioner, *provider facility,* or other *provider* that does not have a contract with *us* to provide medical care or healthcare to the *enrollee*

through this *evidence of coverage*. These can also be referred to as *non-participating providers*. Services received from a *non-network provider* are "out-of-network" and are not covered except for:

1. Emergency services, as described in the Covered Services section of this *contract*;
2. Non-emergency healthcare services received at an in-network *facility*, as described in the Managing Your Healthcare section of this *contract*; or
3. Situation otherwise specifically described in this *contract*.

Orthotic device means a *medically necessary* device used to support, align, prevent or correct deformities, protect a body function, improve the function and movable body part or assist with dysfunctional joints. Orthotics must be used for the therapeutic support, protection, restoration or function of an impaired body part for treatment of an *illness* or *injury*.

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 member contracts, self-insured group plans, prepayment plans, and Medicare when the *enrollee* is enrolled in Medicare. *Other plan* will not include Medicaid.

Other practitioner as used in your *Schedule of Benefits* and related to Mental Health/Substance Use Disorder services, refers to a mental health or substance use disorder *provider* licensed/certified by the state in which care is being rendered and performing services within the scope of that license/certification.

Outpatient day treatment services means structured services provided to address deficits in physiological, behavioral and/or cognitive functions.

Outpatient services include *facility*, ancillary and professional charges when given as an outpatient at a *hospital*, alternative care *facility*, Retail Health Clinic, or other *provider* as determined by the plan. These *facilities* may include a non-*hospital* site providing diagnostic and therapy services, *surgery*, or *rehabilitation*, or other *provider facility* as determined by *us*. Professional charges only include services billed by a *physician* or other professional.

Outpatient surgical facility means any *facility* with a medical staff of *providers* 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 *provider* 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 healthcare system. A *pain management program* must be individualized and provide physical *rehabilitation*, education on pain, relaxation training, and medical evaluation.

Physician or ***provider*** 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. A physician does NOT include someone who is related to a covered person by blood, marriage, or adoption or who is normally a member of the covered person's household.

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 *provider* or each *authorized* refill or such requests.

Primary care provider or ***PCP*** means a *provider* who gives or directs health care services for *you*. *PCPs* include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), pediatricians and obstetrician/gynecologist (OB/GYN) or any other practice allowed by the plan. A *PCP* supervises, directs and gives initial care and basic medical services to *you* and is in charge of *your* ongoing care.

Prior Authorization **or** ***Preauthorization*** means a determination by *us* that the health care services proposed to be provided to an *enrollee* are *medically necessary* and appropriate. *Preauthorization* process will conducted in accordance with Texas Insurance Code, Chapter 843, or in accordance with the law in the state of Texas.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It may include, but is not limited to, claim forms, medical bills, or records, *other plan* information, payment of claim, *network* re-pricing information, bank statements, and police reports. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Prosthetic device means a *medically necessary* device used to replace, correct or support a missing portion of the body, to prevent or correct a physical deformity or malfunction, or to support a weak or deformed portion of the body.

Provider facility means a *hospital*, rehabilitation facility, skilled nursing facility, or other healthcare 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 a 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.

Referral means specific directions on instructions from *your primary care provider*, in conformance with *our* policies and procedures that direct *you* to a *participating provider* for *medically necessary* care.

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 includes *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 *enrollee* 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 licensed practitioner means, but is not limited to, a *provider*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed 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 *contract* means a determination by a contractholder 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 healthcare services provided temporarily to an *enrollee* in order to provide relief to the *enrollee's immediate family* or other caregiver.

Routine patient care costs means the costs of any *medically necessary* healthcare service for which benefits are provided under a health benefit plan, without regard to whether the *enrollee* is participating in a clinical trial. *Routine patient care costs* do not include:

1. the cost of an *investigational* new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;

2. the cost of a service that is not a healthcare service, regardless of whether the service is required in connection with participation in a clinical trial;
3. the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. a cost associated with managing a clinical trial; or
5. the cost of a healthcare service that is specifically excluded from coverage under a health benefit plan.

Schedule of Benefits means a summary of the *deductible*, *copayment*, *coinsurance*, *maximum out-of-pocket*, and other limits that apply when *you* receive *covered services* and supplies.

Serious and complex condition means, in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Service area means a geographical area, made up of counties, where *we* have been authorized by the State of Texas to sell and market *our* health plans. Those counties are: Fort Bend, Harris and Montgomery. *You* can receive precise *service area* boundaries from *our* website or Member Services.

Specialist is a *physician* who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or illnesses. Specialists may be needed to diagnose, manage, prevent or treat certain types of symptoms and conditions related to their specific field of expertise.

Spouse means the person to whom *you* are lawfully married.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation licensed 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 Use Disorder means alcohol, drug or chemical abuse, overuse, or dependency. *Substance use disorders* are those listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Diseases.

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 *provider* while the *enrollee* is under general or local anesthesia.

Surrogacy Arrangement means an understanding in which a woman (the *Surrogate*) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the *Surrogate* receives payment for acting as a Surrogate.

Surrogate means an individual carrier who, as part of a *Surrogacy Arrangement*, (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in her body but the egg is not her own.

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound;
3. Pelvic examination; or
4. Conventional Pap smear screening or screening using liquid based cytology methods.

Telehealth service means a health service, other than a *telemedicine medical service* or a *teledentistry dental service*, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology to facilitate the diagnosis, consultation, treatment, education, *care management*, and self-management of a patient's health care.

Telemedicine medical service means a healthcare service delivered by a *physician* licensed in this state, or a health professional acting under the delegation and supervision of a *physician* licensed in this state, and acting within the scope of the *physician's* or health professional's license to a patient at a different physical location than the *physician* or health professional using telecommunications or information technology to facilitate the diagnosis, consultation, treatment, education, *care management*, and self-management of a patient's health care.

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

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 *provider* has given a prognosis that an *enrollee* has an advanced stage of disease with an unfavorable prognosis that, without life-sustaining procedures, will soon result in death or a state of permanent unconsciousness from which recovery is unlikely.

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

Tobacco or nicotine use or ***use of tobacco or nicotine*** means use of *tobacco or nicotine* by individuals who may legally use *tobacco or nicotine* 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* and *nicotine* products, e-cigarettes or vaping devices, but excluding religious and ceremonial uses of *tobacco*.

Transcranial Magnetic Stimulation (TMS) means a non-invasive procedure in which a changing magnetic field is used to cause electric current to flow in a small targeted region of the brain via electromagnetic induction.

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 *provider's* office, that provides treatment or services that are required:

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

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, *care management*, discharge planning, or retrospective review.

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*;
2. The date of marriage to add a spouse;
3. The date of an eligible newborn's birth; or
4. The date that an adopted child is placed with the *enrollee* for the purposes of adoption or the *enrollee* assumes total or partial financial support of the child.

Effective Date for Initial Dependent Enrollees
The *effective date* for *your* initial *dependent enrollees* will be the same date as *your* initial coverage date. Only *dependent enrollees* included in the application for this *contract* will be covered on *your effective date*.

Coverage for 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, unless we have received notice from the entity that you have enrolled (either the Marketplace or us). Each type of *covered service* incurred by the newborn child will be subject to the cost sharing amount listed in the Schedule of Benefits.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Health Insurance 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 Health Insurance 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 from the entity in which *you* have enrolled (either the Health Insurance Marketplace or *us*).

Coverage for 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 *we* have received notification from the Health Insurance 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 Health Insurance 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* are enrolled in an off-exchange plan and apply in writing to add a *dependent enrollee* and *you* pay the required premiums, *we* will send *you* written confirmation of the added *dependent enrollee's effective date* of coverage and ID Cards for the added *dependent enrollee*.

ONGOING ELIGIBILITY

Please Note: *You* and *your dependent enrollees* must reside, live or work in the *service area* where the *contract* is issued. Additionally, *you* and *your dependent enrollees* must live in the same *residence*.

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

1. The date that an *enrollee* has failed to pay premiums or contributions in accordance with the terms of this *contract* or the date that *we* have not received timely premium payments in accordance with the terms of this *contract*;
2. The date the *enrollee* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
3. The date of termination that the Health Insurance Marketplace provides *us* upon *your* request of cancellation to the Health Insurance Marketplace, or if *you* enrolled directly with us, the date *we* receive a request from *you* to terminate this contract, or any later date stated in *your* request;
4. The date *we* decline to renew this *contract*, as stated in the Discontinuance provision; or
5. The date of an *enrollee's* death.

For Dependent Enrollees
A *dependent enrollee* will cease to be an *enrollee* at the end of the premium period in which he/she ceases to be *your dependent enrollee*. For *eligible children*, coverage will terminate the thirty-first of December the year that the dependent turns 26 years of age.

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.

If *you* have material modifications (examples include a change in life event such as marriage, death or other change in family status), or questions related to *your* coverage, contact the Health Insurance Marketplace (Marketplace) at www.healthcare.gov or 1-800-318-2596. If *you* enrolled through Ambetter, please contact 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

Prior Coverage
If an *enrollee* is confined as an *inpatient* in a *hospital* on the *effective date* of this agreement, and prior coverage terminating immediately before the *effective date* of this agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this agreement for that *enrollee* until the *enrollee* is discharged from the *hospital* or benefits under the prior coverage are exhausted, whichever is earlier. "Discharge" means a formal release of an enrollee from an inpatient hospital stay when the need for continued care at an inpatient hospital has concluded. Transfers from one inpatient hospital to another shall not be considered a discharge.

If there is no prior coverage or no continuation of Inpatient coverage after the Effective Date, your Ambetter coverage will apply for covered benefits related to the Inpatient coverage after your Effective Date. Ambetter coverage requires you notify Ambetter within 2 days of your Effective Date so we can review and Authorize Medically Necessary services. If services are at a non-contracted Hospital, claims will be paid at the Ambetter allowable and you may be billed for any balance of costs above the Ambetter allowable.

Open Enrollment
There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2021 and extends through December 15, 2021. *Qualified individuals* who enroll on or before December 15, 2021 will have an *effective date* of coverage on January 1, 2022.

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 *advanced 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 *advanced premium tax credit* and *cost-sharing reduction* payments until the first of the next month. *We* will send written annual open enrollment notification to each *enrollee* no earlier than September 1st, and no later than September 30th.

Special Enrollment
A *qualified individual* has sixty (60) days to report a qualifying event to the Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool, and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. A *qualified individual* or dependent *loses minimum essential coverage*, non-calendar year group or individual health insurance coverage, pregnancy-related coverage, access to healthcare services through coverage provided to a pregnant *enrollee's* unborn child, or medically needed coverage;
2. A *qualified individual* gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order;
    a. In the case of marriage, at least one *spouse* must demonstrate having minimum essential coverage as described in 26 CFR § 1.5000A-1(b) for 1 or more days during the 60 days preceding the date of marriage.
3. An individual, who was not previously a citizen, national, or lawfully present individual, gains such status;
4. An individual who is no longer incarcerated or whose incarceration is pending the disposition of charges;
5. 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;
6. 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's* decision to purchase the *qualified health plan* based on plan benefits, *service area* or premium;
7. An individual is determined newly eligible or newly ineligible for *advanced 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*;
8. A *qualified individual* or *enrollee* gains access to new *qualified health plans* as a result of a permanent move;
9. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;

a. The qualifying events for employees are:
    i. Voluntary or involuntary termination of employment for reasons other than gross misconduct; or
    ii. Reduction in the number of hours of employment.
b. The qualifying events for *spouses* are:
    i. Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
    ii. Reduction in the hours worked by the covered employee;
    iii. Covered employee's becoming entitled to Medicare;
    iv. Divorce or legal separation of the covered employee; or
    v. Death of the covered employee.
c. The qualifying events for dependent children are the same as for the *spouse* with one addition:
    i. Loss of dependent child status under the plan rules.

10. 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;
11. 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;
12. A *qualified individual* or dependent is a victim of domestic abuse or spousal abandonment and would like to enroll in coverage separate from the perpetrator of the abuse or abandonment;
13. A *qualified individual* or dependent is determined to be potentially eligible for Medicaid or Children's Health Insurance Program (CHIP), but is subsequently determined to be ineligible after the open enrollment period has ended or more than 60 days after the qualifying event; or
14. At the option of the Health Insurance Marketplace, a *qualified individual* provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a *qualified health plan* through the Health Insurance Marketplace following termination of Marketplace enrollment due to a failure to verify such status within the time period specified in 45 CFR § 155.315 or is under 100 percent of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.
15. A *qualified individual* newly gains access to an employer sponsored individual coverage HRA or a Qualified Small Employer Health Reimbursement Arrangement (HRA).

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 *advanced 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 *advanced premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date*, although an extension may be provided during the annual Open Enrollment period.

Grace Period
When an *enrollee* is receiving a premium subsidy:

> Grace Period: A grace period of 90 days will be granted for the payment of each premium due after the first premium. During the grace period, the *contract* continues in force.
>
> 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 *advanced premium tax credits* are received.
>
> *We* will continue to pay all appropriate claims for *covered services* rendered to the *enrollee* during the first and second month of the grace period, and may pend claims for *covered services* rendered to the *enrollee* in the 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 *enrollee* is in the third month of the grace period. *We* will continue to collect *advanced premium tax credits* on behalf of the *enrollee* from the Department of the Treasury, and will return the *advanced premium tax credits* on behalf of the *enrollee* 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:

> Grace Period: A grace period of 60 days will be granted for the payment of each premium due after the first premium. During the grace period, the *contract* continues in force.
>
> 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. 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.

Third Party Payment of Premium or Cost Sharing
Ambetter requires each *enrollee* to pay his or her premiums and this is communicated on *your* monthly billing statements. Ambetter payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting *third party* premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay Ambetter premiums on *your* behalf:

1. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
2. Indian tribes, tribal organizations or urban Indian organizations;
3. State and Federal Government programs;

4. Family members; or
5. Private, not-for-profit foundations which have no incentive for financial gain, no financial relationship, or affiliation with *providers* of *covered services* and supplies on behalf of *enrollees*, where eligibility is determined based on defined criteria without regard to health status and where payments are made in advance for a coverage period from the *effective date* of eligibility through the remainder of the calendar year.

Upon discovery that premiums were paid by a person or entity other than those listed above, *we* will reject the payment and inform the *enrollee* that the payment was not accepted and that the subscription charges remain due.

Similarly, if we determine payment was made for Deductibles or Cost Sharing by a third party, such as a drug manufacturer paying for all or part of a medication, may not be counted towards your Deductible or Maximum Out-of-Pocket costs.

Misstatement of Age
If an *enrollee's* age has been misstated, the *enrollee's* premium may be adjusted to what it should have been based on the *enrollee's* actual age, *we* have the right to rerate the *contract* back to the original *effective date*.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Health Insurance Marketplace of *your* new *residence* within 60 days of the change. As a result *your* premium may change and *you* may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco or Nicotine Use
The answer to the tobacco or nicotine question on the application is material to *our* correct underwriting. If an *enrollee's use of tobacco or nicotine* 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.

COST SHARING FEATURES

Cost Sharing Features
We will pay benefits for *covered services* as described in the *Schedule of Benefits* and the *covered services* sections of this *contract*. All benefits *we* pay will be subject to all conditions, limitations, and *cost sharing* features of this *contract*. *Cost sharing* means that *you* participate or share in the cost of *your* healthcare services by paying *deductible amounts*, *copayments* and *coinsurance* for some *covered services*. For example, *you* may need to pay a *deductible*, *copayment* or *coinsurance* amount when *you* visit *your physician* or are admitted into the *hospital*. The *copayment* or *coinsurance* required for each type of service as well as *your deductible* is listed in *your Schedule of Benefits*.

When you, or a covered dependent, receive health care services from a *provider*, there may be multiple claims for that episode of care. An episode of care means the services provided by a health care facility or *provider* to treat a condition or an illness. Each claim that *we* receive for services covered under this *contract* are adjudicated or processed as *we* receive them. Coverage is only provided for eligible service expenses. Each claim received will be processed separately according to the cost share as outlined in the *contract* and in *your* S*chedule of Benefits*.

Copayments
A copayment is typically a fixed amount due at the time of service*. Enrollees* may be required to pay *copayments* to a provider each time services are performed that require a copayment. Copayments are due as shown in the *Schedule of Benefits*. Payment of a *copayment* does not exclude the possibility of a provider billing you for any non-*covered services*. *Copayments* do not count or apply toward the *deductible amount*, but do apply toward your *maximum out-of-pocket amount*.

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 *enrollee* under *your* coverage each calendar year.

This *deductible*, unless otherwise indicated, will be applied to all categories of *eligible service 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 *enrollee* will contribute more than the individual *deductible amounts* to the "family" *deductible amount*.

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

Coinsurance Percentage
We will pay the applicable *coinsurance* 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* plan 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*.

The applicable *deductible amount(s)*, *coinsurance*, 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 *coinsurance*, *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 only if enrolled through a special enrollment period. 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 Contract 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 HEALTHCARE

HMO Referral

HMO *referrals* are a formal recommendation made by your *primary care provider (PCP)* to see an in-network *specialist* or other *providers* for additional healthcare services deemed *medically necessary*. A *referral* is required prior to a non-emergent in-person visit with a practitioner outside of your *PCP*. Failure to obtain a *referral* will result in denial of benefit coverage or *enrollees* may not be able to make an appointment.

Referrals are required for all *medically necessary* healthcare services not provided by your PCP, excluding *emergency care*. If a referral is not obtained for non-emergent care, services will be denied. *Emergency care* does not require a referral or need to be in-network.

Services performed by a *specialist* may have a higher out of pocket *enrollee* costs than a *PCP*.

For any additional questions please contact Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

Continuity of Care

Under the No Surprises Act, if an *enrollee* is receiving a *covered service* with respect to an *network provider* or *facility* and: (1) the contractual relationship with the *provider* or *facility* is terminated, such that the *provider* or *facility* is no longer in network; or (2) benefits are terminated because of a change in the terms of the participation of the *provider* or *facility*, as it pertains to the benefit the member is receiving, then *we* will: (1) notify each enrollee who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the provider or facility; (2) provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and (3) permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a continuing care patient during the period beginning on the date on which the above notice is provided and ending on the earlier of (i) the 90-day period beginning on such date; or the (ii) date on which such individual is no longer a continuing care patient with respect to their *provider* or *facility*.

Non-Emergency Services

If *you* are traveling outside of the Texas service area *you* may be able to access *providers* in another state if there is an Ambetter plan located in that state. *You* can locate Ambetter *providers* outside of Texas by searching the relevant state in *our provider* directory at https://guide.ambetterhealth.com. Not all states have Ambetter plans. If *you* intend to seek care from an Ambetter *provider* outside of the service area, *you* may be required to obtain *prior authorization* from the originating state for non-emergency services. Contact Member Services at the phone number on *your* ID card for further information.

Emergency Services Outside of Service Area

We cover emergency care services when *you* are outside of *our* service area. If *you* are temporarily out of the service area and have medical or *behavioral health* emergency, call 911 or go to the nearest emergency room. Be sure to call *us* and report *your* emergency within one business day or as soon as reasonably possible. *You* do not need prior approval for emergency care services.

New Technology

Health technology is always changing. If *we* think a new medical advancement can benefit *our enrollees*, *we* evaluate it for coverage. These advancements include:

- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

Sometimes, *our* medical director and/or medical management staff will identify technological advances that could benefit *our enrollees*. The Clinical Policy Committee (CPC) reviews requests for coverage and decides whether *we* should change any of *our* benefits to include the new technology.

If the CPC does not review a request for coverage of new technology, *our* Medical Director will review the request and make a one-time determination. The CPC may then review the new technology request at a future meeting.

As innovative technologies and solutions are established in market under expedited research and development, *we* may elect to offer, at *our* discretion, new services or preferred partnerships designed to improve access to care and enhance care management. Ambetter will provide access to third party services at preferred or discounted rate. The preferred or discounted rates to these services may be communicated to all *enrollees* by email, mail or phone promotions. The preferred partnerships are optional benefits to all *enrollees*.

Primary Care Provider

All *enrollees* must select a *primary care provider*. *You* may select any *network primary care provider* who is accepting new patients, or *you* may select a *network provider* of which *you* are a current patient. If *you* do not select a *network primary care provider* for each *enrollee*, one may be assigned. *You* may obtain a list of *network primary care providers* at *our* website or by contacting Member Services. Until a *primary care provider* is selected or assigned, benefits will be limited to coverage for *emergency care*.

Your primary care provider coordinates *your* medical care, as appropriate, either by providing treatment or by issuing *referrals* to direct *you* to *participating providers*. Except for *emergency care*, only those services which are provided by or referred by *your primary care provider* will be covered. It is *your* responsibility to consult with *your primary care provider* in all matters regarding *your* medical care. If *your primary care provider* performs, suggests, or recommends a course for treatment for *you* that includes services that are not *covered services*, the entire cost of any such non-*covered services* will be *your* responsibility.

In addition to a *PCP*, female *enrollees* may also select a participating Obstetrician/Gynecologist (OB/GYN Care) for gynecological and obstetric conditions, including annual well-woman exams and maternity care, without first obtaining a *referral* from a *PCP* or contacting *us*. *Enrollees* who have been diagnosed with a chronic, disabling or life threatening illness may request approval to choose a participating *specialist* as a *PCP* using the process described in the Specialist as a Primary Care Provider provision.

Specialist as a PCP

If *you* have been diagnosed with a chronic, disabling, or life-threatening illness, *you* may contact Member Services at the number listed on the back of *your* ID card to get information to submit for approval from *us*

to choose a participating *specialist* as *your PCP*. *We* require both *you* and the participating *specialist* interested in serving as *your PCP* to sign a certification of medical need, to submit along with all supporting documentation. The *participating specialist* must meet *our* requirements for *PCP* participation and be willing to accept the coordination of all *your* healthcare needs. If *your* request is denied, *you* may appeal the decision as described in Complaint and Appeal Procedures provision. If *your* request is approved, the *specialist's* designation as *your PCP* will not be effective retroactively.

Contacting Your Primary Care Provider

To make an appointment with *your PCP*, call his/her office during business hours and set up a date and time. If *you* need to cancel or change *your* appointment, call 24 hours in advance. At every appointment, make sure *you* bring *your* member ID card and a photo ID.

Should *you* need care outside of your *PCP*'s office hours, *you* should call *your PCP*'s office for information on receiving after hours care in *your* area. If *you* have an urgent medical problem or question or cannot reach *your PCP* during normal office hours, call our 24/7 nurse advice line at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). A licensed nurse is always available and ready to answer *your* health questions. In an emergency, call 911 or head straight to the nearest emergency room.

Your network primary care provider will coordinate all covered health services with other *network providers,* if necessary. Should *medically necessary* covered healthcare services not be available through *network providers*, upon the request of a *network primary care provider*, within the time appropriate to the circumstances relating to the delivery of the healthcare services and *your* condition, but in no event to exceed five (5) 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.

Prior Authorization

Ambetter reviews services to ensure the care you receive is the best way to help improve your health condition. Utilization review includes:

- Pre-service or u review – occurs when a medical service has been pre-approved by Ambetter
- Concurrent review – occurs when a medical service is reviewed as they happen (e.g., inpatient stay or hospital admission)
- Retrospective review – occurs after a service has already been provided.

Some medical, pharmaceutical and *behavioral health covered services* require *prior authorization*. In general, *network providers* do not need to obtain *authorization* from *us* prior to providing a service or supply to an *enrollee*. However, there are some *covered services* 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 *you* or *your dependent enrollee*:

1. Receives a service or supply from a *non-network provider*;
2. Are admitted into a *network facility* by a *non-network provider*; or
3. Receives a service or supply from a *network provider* to which *you* or *your dependent enrollee* were referred by a *non-network provider*.

We suggest that *prior authorization* (medical, pharmaceutical and *behavioral health*) requests are submitted to *us* by Provider Portal/efax/phone call as follows:

1. At least 5 days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, or *hospice facility*.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. Within 24 hours of any *inpatient* admission, including emergent *inpatient* admissions.
5. At least 5 days prior to the scheduled start of *home health services*, except those *enrollees* needing *home health services* after *hospital* discharge.

After *prior authorization* has been requested and all required or applicable documentation has been submitted, *we* will notify *you* and *your provider* if the request has been *approved* as follows:

1. For services that require *prior authorization*, within 3 calendar days of receipt.
2. For concurrent review, within 24 hours of receipt of the request.
3. For post-stabilization treatment or life-threatening condition, within the timeframe appropriate to the circumstances and condition of the *enrollee*, but not to exceed one hour of receipt of the request.
4. For post-service requests, within 30 calendar days of receipt of the request.

Please note: For more information on the *prior authorization* requirements and information on the *prior authorization* process, please visit Ambetter.SuperiorHealthPlan.com.

Prior Authorization Renewal Process
Medical Management will process requests for prior authorization renewals at least 60 days before the date the preauthorization expires. As reference in House Bill 3041, 86th Texas Legislature.
If the issuer receives a renewal request before the existing preauthorization expires, the issuer must, if practicable, review and issue a determination before the existing preauthorization expires.

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 or not covered.

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

Emergency care does not require *prior authorization*.

In cases of emergency, benefits will not be reduced for failure to comply with *prior authorization* requirements. 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 and is only a statement that proposed services are *medically necessary* and appropriate. If a *provider* materially misrepresents the proposed medical or healthcare services, or has substantially failed to perform the proposed medical or healthcare services, *we* may deny or reduce payment to the *provider*. Eligibility for

and payment of benefits are subject to all terms and conditions of the *contract*. *We* may not deny or reduce payment to the *physician* or *provider* once *prior authorization* is received.

Prior Authorization Denials
Refer to the Complaint and Appeals Procedures section of this *contract* for information on *your* rights to *appeal* a denied authorization.

Hospital Based Providers

When receiving care on or after 1/1/2020, at a *network hospital* or other *facility*, it is possible that some *hospital*-based *providers* (for example, anesthesiologists, emergency room *providers*, radiologists, pathologists) may not be under contract with Ambetter as *network providers*. If appropriate notice is provided to and acknowledged by you before rendering services, these *providers* cannot bill *you* for the difference between Ambetter's *eligible service expense* and the *provider's billed charge* – this is known as "*balance billing*", unless a notice and disclosure statement was signed ten days prior to receiving care. *We* encourage *you* to inquire about the *providers* who will be treating *you* before *you* begin *your* treatment, so *you* can understand their *network* status with Ambetter. *You* may not be balance billed for non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, diagnostic imaging, laboratory services, and neonatology, as well as diagnostic services (including radiology and laboratory services)) received from a *non-network provider* at a *network hospital* or *network* ambulatory facility. If *you* are ever balance billed contact Member Services immediately at the number listed on the back of *your* ID card.

Although healthcare services may be or have been provided to *you* at a healthcare *facility* that is a member of the *provider network* used by Ambetter, other professional services may be or have been provided at or through the *facility* by *physicians* and other medical practitioners who are not members of that *network*.

COVERED HEALTHCARE SERVICES AND SUPPLIES

The plan provides coverage for healthcare services for *you* and *your* covered dependents when received from *network providers*. Some services require *prior authorization*.

Copayment amounts, *deductibles*, and *coinsurance* must be paid to *your network provider* at the time *you* receive services.

The benefit percentages of *your* total eligible healthcare services shown on the *Schedule of Benefits* in excess of *your copayment amounts*, *coinsurance* amounts, and any applicable *deductibles* shown are the plan's obligation.

All *covered services* are subject to conditions, exclusions, limitations, terms and provision of this *contract*. *Covered services* must be *medically necessary* and not *experimental* or *investigational*.

Benefit Limitations
Limitations may also apply to some *covered services* that fall under more than one *covered service* category. Please review all limits carefully. Ambetter from Superior HealthPlan will not pay benefits for any of the services, treatments, items or supplies that exceed benefit limits.

Acquired Brain Injury Services

Benefits for *eligible service 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 required for and related to treatment of an *Acquired Brain Injury*, 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.

Allergy Care

Covered Services for testing and treatment must be provided or arranged by *your PCP*.

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*, in cases of emergency.
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.
3. Transportation between *hospitals* or between a *hospital* and skilled nursing, *rehabilitation facility*, or hospice facility when *authorized* by Ambetter from Superior HealthPlan.
4. When ordered by an employer, school, fire or public safety official and the *enrollee* is not in a position to refuse; or
5. When an *enrollee* is required by *us* to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for emergency ambulance transportation. Note: Non-emergency ambulance transportation requires *prior authorization*. Please note: Unless otherwise required by Federal or state law, if *you* receive services from non-network ambulance providers for non-emergency services, *you* may be responsible for costs above the allowed charges.

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. Ambulance services provided for an *enrollee's* comfort or convenience.
3. Non-emergency transportation excluding ambulances.

Air Ambulance Service Benefits

Covered service expenses will include ambulance services for ground, water, fixed wing and rotary wing air transportation from home, scene of accident, or medical emergency:

1. To the nearest *hospital* that can provide services appropriate to the *member's illness* or *injury*, in cases of *emergency*.
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.
3. Transportation between *hospitals* or between a *hospital* and a skilled nursing, *rehabilitation facility,* and *member's* home when *authorized* by Ambetter from Superior HealthPlan.
4. When ordered by an employer, school, fire or public safety official and the *member* is not in a position to refuse; or
5. When a *member* is required by *us* to move from a *non-network provider* to a *network provider*.

Prior authorization is not required for *emergency* ambulance transportation. Please note: *You* should not be *balance billed* for services from a *non-network* ambulance *provider*, beyond your *cost share*, for air ambulance services.

Limitations: Coverage for air ambulance services is limited to the following scenarios:

1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *member* is in a location that cannot be reached by ground ambulance.
3. Transportation to the nearest *hospital* equipped and staffed for treatment of the *enrollee's* condition.

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 medical transportation.
3. Air medical transportation:
    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 a *member's* comfort or convenience.
5. Non-emergency transportation.

Autism Spectrum Disorder Benefits

Generally recognized services prescribed in relation to *autism spectrum disorder* by *your PCP in* a treatment plan recommended by that *physician* are covered.

Individuals providing treatment prescribed under that plan must be a healthcare practitioner:

1. who is licensed, certified, or registered by an appropriate agency of the state of Texas;
2. whose professional credential is recognized and accepted by an appropriate agency of the United States;
3. who is certified as a *provider* under the TRICARE military health system; or
4. who is acting under the supervision of a health care practitioner

For purposes of this section, generally recognized services may include services such as:

1. evaluation and assessment services;
2. *applied behavior analysis therapy*;
3. behavior training and behavior management;
4. speech therapy;
5. occupational therapy;
6. physical therapy;
7. psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
8. medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

Eligible service 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, *prior authorizations* and benefit maximums.

Mental Health and Substance Use Disorder Benefits

The coverage described below is intended to comply with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as well as House Bill 10, which was enacted by the 85th Texas legislature. Furthermore, coverage is provided in accordance with Texas Insurance Code Section 1355.254 (TIC §1355.254), which indicates:

(a) A health benefit plan must provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage.

(b) Coverage under Subsection (a) may not impose quantitative or nonquantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally

more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Mental health services will be provided on an *inpatient* and outpatient basis and include treatable mental health conditions. These conditions affect the *enrollee's* ability to cope with the requirements of daily living. If *you* need *mental health* and/or *substance use disorder* treatment, *you* may choose any *provider* participating in *our behavioral health network*. *Deductible amounts*, *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 *enrollees* for the diagnosis and *medically necessary* and active treatment of mental, emotional, or *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 or the International Statistical Classification of Diseases and Related Health Problems (ICD).

When making coverage determinations, *our* utilization management staff employ 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. They utilize McKesson's Interqual criteria for mental health and substance abuse 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* and outpatient *mental health* and/or *substance use disorder* services are as follows:

<u>Inpatient</u>

1. *Inpatient* psychiatric hospitalization;
2. *Inpatient* detoxification treatment;
3. Observation;
4. Crisis stabilization;
5. *Inpatient rehabilitation*;
6. *Residential treatment facility* for mental health and substance use; and
7. Electroconvulsive Therapy (ECT).

<u>Outpatient</u>

1. Individual and group therapy for mental health and substance use;
2. Partial Hospitalization Program (PHP);
3. Medication Management services;
4. Psychological and *neuropsychological testing* and assessment;
5. *Applied Behavior Analysis* (ABA) for treatment of *Autism spectrum disorders*;
6. *Telehealth services* and *telemedicine medical services*;
7. Electroconvulsive Therapy (ECT);
8. Intensive Outpatient Program (IOP);
9. Mental health day treatment;
10. Outpatient detoxification programs;
11. Evaluation and assessment for mental health and substance use; and

12. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*;
13. Transcranial Magnetic Stimulation (TMS);
14. Assertive Community Treatment (ACT).

In addition, Integrated Care Management is available for all of *your* healthcare needs, including *behavioral health* and substance use. Please call 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) to be referred to a care manager for an assessment.

Behavioral health covered services are only for the diagnosis or treatment of mental health conditions and the treatment of substance use/ chemical dependency.

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.

Chiropractic Services

Chiropractic services are covered when a participating chiropractor finds that the services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. 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 Deductibles and Coinsurance Percentage provisions.

Dialysis Services

Medically necessary acute and chronic dialysis services are covered benefits unless other coverage is primary, such as Medicare for dialysis. There are two types of treatment provided *you* meet all the criteria for treatment. *You* may receive hemodialysis in an in-network dialysis *facility* or peritoneal dialysis in *your* home from a *network provider* when *you* qualify for home dialysis.

Covered service expenses and supplies include:

1. Services provided in an outpatient dialysis *facility* or when services are provided in the home by a preferred *provider*;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a *hospital*;
4. Dialysis treatment of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.

After *you* receive appropriate training at an in-network dialysis *facility*, *we* will cover equipment and medical supplies that *you* or *your* caregiver require for home hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment or supplies that adequately meets *your* medical needs. *We* will determine if equipment is made available on a rental or purchase basis. 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.

Radiology, Imaging and Other Diagnostic Testing

Medically necessary radiology services, imaging and tests performed are a *covered service* (e.g., X-ray, MRI, CT scan, PET/SPECT, mammogram, ultrasound) when ordered, authorized or arranged by *your PCP* and provided by through a *network facility*. *Prior authorization* may be required, see the *Schedule of Benefits* for details. Note: Depending on the service performed, two bills may be incurred – both subject to any applicable *cost sharing* – one for the technical component (the procedure itself) and another for the

professional component (the reading/interpretation of the results by a physician or other qualified practitioner).

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 provider* or *behavioral health* practitioner before going to the *hospital* emergency room/treatment room. They 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* must notify *your PCP* or *behavioral health* practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he or she can recommend the continuation of any necessary medical services.

All treatment received from a *non-network provider* for an emergency medical condition prior to stabilization, and including services originating in an emergency *facility* following treatment or stabilization of an emergency medical condition, will be treated as *covered services* received from a *network provider*.

Treatment provided by *non-network providers* after stabilization of the emergency medical condition, and not originating in the emergency *facility*, requires *prior authorization*. *We* will facilitate transfer to a *network facility* for necessary *inpatient* care following stabilization of an emergency medical condition treated at a non-*network facility*. Please notify *us* as soon as reasonably possible upon receiving treatment for an emergency medical condition. Unless *authorized* by *us*, services received from a *non-network provider* following stabilization of an emergency medical condition are not *covered services*.

Benefits for Urgent Care

A *referral* from *your PCP* is not required for urgent care services. Benefits for *eligible service 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 *provider's* office. The necessary medical care is for a condition that is not life-threatening.

Emergency Room Services

In an emergency situation (anything that could endanger *your* life (or *your* fetus's life), *you* should call 911 or head straight to the nearest emergency room. *We* cover emergency medical *and behavioral health* services both in and out of *our* service area. *We* cover these services 24 hours a day, 7 days a week.

Please note some providers that treat *you* within the ER may not be contracted with Ambetter. If that is that case, they may not balance bill *you* for the difference between *our* allowed amount and the *provider's billed charge*.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

Rehabilitation services and *habilitation* services, including coverage for chiropractic services, are available from a *network provider* when *preauthorized* or prescribed by *your PCP*. *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 be determined *medically necessary*.
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 *provider*, filled by a licensed pharmacist, and 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 licensed practitioners*.
5. Outpatient physical therapy, occupational therapy, and speech therapy.

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*.

Home Health Care Service Expense Benefits

Services must be provided or arranged by *your PCP*. *Covered service expenses* and supplies for *home health care* are covered when your physician provides an order indicating you are not able to travel for appointments to a medical office. Coverage is provided for *medically necessary* in-network care provided at the *enrollee's* home and are limited to the following charges:

1. *Home health aide services* only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*.
3. *Home infusion therapy*.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment*.
8. Sleep studies.

Charges under (3) 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.
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

Hospice care benefits are allowable for a *terminally ill enrollee* receiving *medically necessary* care under a *hospice care program*. *Covered services* and supplies include:

1. Room and board in a *hospice* while the *enrollee* is an *inpatient*.
2. Occupational therapy.
3. Speech-language therapy.
4. Respiratory therapy.
5. 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*.
6. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
7. Counseling the *enrollee* regarding his or her terminal *illness*.
8. *Terminal illness counseling* of the *enrollee's immediate family*.
9. *Bereavement counseling*.

Exclusions and Limitations:
Hospice care benefits do not include the following:

1. Services received from a *provider* who is related to an *enrollee* or *dependent enrollees* by blood, marriage or adoption or who is normally a member of the *enrollee's* or *dependent enrollee's* household;
2. Services or procedures to cure or prolong life;
3. Services for which any other benefits are payable under this *contract*;
4. Services or supplies that are used primarily to aid the *enrollee* or *dependent enrollee* in daily living;
5. Services for *custodial care*; and
6. Nutritional supplements, non-*prescription drugs* or substances, medical supplies, vitamins or minerals.

Respite Care Expense Benefits
Respite care is only for home and inpatient locations, and is subject to all forms of *cost sharing*.

Hospital Benefits

Services, except for *emergency care*, required *inpatient* stay for maternity care and treatment of breast cancer, must be arranged by *your PCP* and requires *prior authorization*. Services provided through a participating *hospital* outpatient department or a free-standing *facility* must be prescribed by *your PCP*.

Covered service expenses and supplies are limited to charges made by a *hospital* for:

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.

2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *Inpatient* use of an operating, treatment, or recovery room.
4. Outpatient use of an operating, treatment, or recovery room for *surgery.*
5. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatient.*
6. Emergency treatment of an *injury* or *illness*, even if confinement is not required. See *your Schedule of Benefits* for limitations.
7. Administration of whole blood and blood plasma. (Note: Whole blood, including the cost of blood, blood plasma, and blood expanders that are not replaced by or for the *enrollee*).
8. Meals and special diets when *medically necessary*.
9. Private Duty Nursing when *medically necessary*.
10. Short term rehabilitation therapy services when in an acute *hospital* setting.

Infertility

Infertility treatment requires *prior authorization*. Infertility treatment is a *covered service expense* when medical services are provided to the *enrollee* which are *medically necessary* for the diagnosis of infertility. This does not cover treatment or *surgical procedures* for infertility including artificial insemination, in vitro fertilization, and other types of artificial or surgical means of contraception including drugs administered in connection with these procedures.

Medical and Surgical Benefits

1. *Surgery* in a *provider's* office or at an *outpatient surgical facility*, including services and supplies.
2. *Physician* professional services, including *surgery*.
3. Assistant surgeon.
4. Professional services of a non-*physician* medical practitioner, including surgery.
5. Medical supplies that are *medically necessary*, including dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies*.
6. Diagnostic testing using radiologic, ultrasonographic, or laboratory services.
7. Chemotherapy, radiation therapy or treatment (*inpatient* or outpatient), and inhalation therapy.
8. Hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components.
9. Anesthetic cost and administration.
10. Oxygen and its administration.
11. For accidental *Dental service* expenses incurred by an *enrollee* will be provided on the same basis as for treatment of any other *illness* or *injury*, as shown within this *contract*, that results in:
    a. Damage to his or her natural teeth;
    b. Expenses are of a treatment plan that was prescribed by a *provider*; and
    c. Injury to the natural teeth will not include any injury as a result of chewing.
12. *Dental services* necessary for the treatment or correction of accidental *injuries*, congenital defects and oral *surgery*, which is defined as maxillofacial *surgical procedures*, are limited to:
    a. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and pre-malignant lesions and growths;
    b. Incision and drainage of facial abscess;
    c. *Surgical procedures* involving salivary glands and ducts and non-dental related procedures of the accessory sinuses;

d. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the plan; and
e. Removal of complete bony impacted teeth.

13. *Surgery* to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint, to include necessary tooth extractions.
14. Cosmetic or plastic *surgery* for the correction of congenital deformities or for conditions resulting from accidental *injuries*, scars, tumors or diseases will be the same as for treatment of any other sickness as shown on *your Schedule of Benefits*.
15. *Reconstructive surgery* - The following *eligible service expenses* described below for *reconstructive surgery* will be the same as for treatment of any other sickness as shown on *your Schedule of Benefits*:
    a. Treatment provided for the correction of defects incurred in an accidental *injury* sustained by the *enrollee*;
    b. Treatment provided for *reconstructive surgery* following cancer *surgery*;
    c. *Surgery* performed for the treatment or correction of a congenital defect;
    d. For the treatment or correction of a congenital defect other than conditions of the breast; or
    e. Reconstructive breast *surgery* charges as a result of a partial or total mastectomy. 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.
16. Mastectomy or Lymph Node Dissection

    Minimum *inpatient* stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for *inpatient* care for a minimum of:
    a. 48 hours following a mastectomy, and
    b. 24 hours following a lymph node dissection.

    The minimum number of *inpatient* hours is not required if the covered *enrollee* receiving the treatment and the attending *provider* determine that a shorter period of *inpatient* care is appropriate.
17. Diabetic equipment and supplies that are *medically necessary* and prescribed by a *provider*.
18. Tissue transplants.
19. 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.
20. Genetic blood tests that are *medically necessary*.
21. Immunizations to prevent Respiratory Syncytial Virus (RSV) that are *medically necessary*.
22. Rental of Continuous Passive Motion (CPM) machine; one per *enrollee* following a covered joint *surgery*.
23. One pair of eyeglasses or contact lenses per *enrollee* following a covered cataract *surgery*.
24. Benefits for speech and hearing services are available for the services of a *physician* or other professional *provider* to restore loss of or correct an impaired speech or hearing function, including coverage of hearing aids for *enrollees* and *dependent enrollees*. See the *Schedule of Benefits* for benefit levels or additional limits.

25. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.
26. *Medically necessary* telehealth services subject to the same clinical and utilization review criteria, plan requirements and limitations as the same health care services when delivered to an insured in person. Telehealth Services provided by Ambetter Telehealth are subject to $0 copay. Telehealth Services not provided by Ambetter Telehealth would be subject to the same *cost sharing* as the same health care services when delivered to an *enrollee* in-person. Pursuant to federal regulation, the $0 cost share does not apply to *enrollees* enrolled in an HSA-eligible plan. Please review *your* Schedule of Benefits to determine if your plan is HSA-eligible.

Diabetic Care

Coverage for diabetic care includes the following:

1. *Diabetes self-management training*;
2. Blood glucose monitors, including noninvasive glucose monitors designed to be used by or adapted for the legally blind;
3. Test strips specified for use with a corresponding glucose monitor;
4. Lancets and lancet devices;
5. Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
6. Insulin and insulin analog preparations;
7. Injection aids, including devices used to assist with insulin injection and needleless systems;
8. Insulin syringes;
9. Biohazard disposal containers;
10. 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;
11. 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;
12. Prescription medications and medications available without a prescription for controlling the blood sugar level;
13. Podiatric appliances, including up to two pairs of therapeutic footwear per calendar year, for the prevention of complications associated with diabetes;
14. Routine foot care such as trimming of nails and corns;
15. Glucagon emergency kits;
16. 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 *provider* or other healthcare practitioner;
17. Eye Exam and one retinopathy examination screening per year;
18. Glucometers; and
19. Nutritional counseling.

Durable Medical Equipment

The supplies, equipment and appliances described below are *covered services* under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is *medically necessary* in *your* situation or needed to treat *your* condition, reimbursement will be based on the maximum allowable amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowable amount for the standard item which is a *covered service* is *your* responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates *your* condition. Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as *approved* by *us*. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

1. The equipment, supply or appliance is a *covered service*;
2. The continued use of the item is *medically necessary*; and
3. There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by *our* habilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

1. Repair and replacement due to misuse, malicious breakage or gross neglect.
2. Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Durable Medical Equipment

The rental (or, at *our* option, the purchase) of *durable medical equipment* prescribed by a *physician* or other *provider*. *Durable medical equipment* is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of *illness* or *injury*; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, *hospital* beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are *covered services*. Payment for related supplies is a *covered service* only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the *enrollee*; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered services and supplies may include, but are not limited to:

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.

4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when *we approve* based on the *enrollee's* condition.
9. Home INR testing machines.

Exclusions:
Non-*covered services* and supplies may include, but are not limited to:

1. Air conditioners.
2. Ice bags/coldpack pump.
3. Raised toilet seats.
4. Rental of equipment if the *enrollee* is in a *facility* that is expected to provide such equipment.
5. Translift chairs.
6. Treadmill exerciser.
7. Tub chair used in shower.
8. Vehicle installations or modifications which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.

<u>Medical and Surgical Supplies</u>
Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.
Covered services and supplies may include, but are not limited to:

1. Allergy serum extracts.
2. Chem strips, Glucometer, Lancets.
3. Clinitest.
4. Needles/syringes.
5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not *covered services*.

Exclusions:
Non-*covered services* and supplies may include, but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators.
2. Arch supports.
3. Doughnut cushions.
4. Hot packs, ice bags.
5. Vitamins (except as provided for under Preventive benefits).
6. Med-injectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Orthotic and Prosthetic Devices

Orthotic and *prosthetic devices* must be provided and arranged by *your PCP* and will require *prior authorization*. *We* will cover the most appropriate model of *orthotic* and *prosthetic devices* that are determined *medically necessary* by *your* treating *physician*, podiatrist, prosthetist, or orthotist.

Prosthetics

Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. *Covered services* include purchase, fitting, needed adjustment, repairs, and replacements of *prosthetic devices* and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be *medically necessary*. Applicable taxes, shipping and handling are also covered.

Covered services and supplies may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD).
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per benefit period, as required by the Women's Health and Cancer Rights Act. Maximums for *prosthetic devices*, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are *covered services*. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract *surgery* or *injury*; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of *surgery* are not considered contact lenses, and are not considered the first lens following *surgery*. If the *injury* is to one eye or if cataracts are removed from only one eye and the *enrollee* selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs (the first one following cancer treatment, not to exceed one per benefit period), when purchased through a *participating provider*.

Exclusions:

Non-covered prosthetic appliances may include, but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances (oral appliances, oral sprints, oral orthotics, devices or prosthetics).
3. Devices that prevent or correct defects to the teeth and supporting tissues.

4. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
5. Wigs (except as described above following cancer treatment).

Orthotic Devices
Covered services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered *orthotic devices* may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts. Coverage is limited to diabetes care only.

Orthotic appliances may be replaced or repaired, unless the repair or replacement is due to misuse or loss by the *enrollee*.

Exclusions:
Non-*covered services* and supplies may include, but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.
5. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.

Maternity Care

An *inpatient* stay is covered for the mother and newborn for at least 48 hours following an uncomplicated vaginal delivery, and for at least 96 hours following an uncomplicated caesarean delivery. Coverage will include post-delivery care for a mother and newborn who are discharged before the expiration of the minimum hours of coverage. *We* do not require that a *physician* or other healthcare *provider* obtain *prior authorization* for delivery. However, an *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to the Health Plan.

Other maternity benefits which may require *prior authorization* include:

1. 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, and childbirth classes.

2. *Physician* home visits and office services.
3. Parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
4. *Complications of pregnancy*.
5. *Hospital* stays for other *medically necessary* reasons associated with maternity care.
6. For medical services or supplies for maternity deliveries at home, required for medical professional or medically necessary treatment.

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. This provision also does not require an *enrollee* who is eligible for coverage under a health benefit plan to:

1. give birth to a child in a *hospital* or other healthcare *facility*; or
2. remain under *inpatient* care in a *hospital* or other healthcare *facility* for any fixed term following the birth of a child.

Duty to Cooperate. We do not cover services or supplies related to *enrollees* pregnancy when an *enrollee* is acting as a *surrogate* and has entered into a *surrogacy arrangement*. For more information on excluded services, please see the General Non Covered Services and Exclusions section. *Enrollees* who are a Surrogate at the time of enrollment or *enrollees* who agree to a *Surrogacy Arrangement* during the plan year must, within 30 days of enrollment or agreement to participate in a *Surrogacy Arrangement*, send *us* written notice of the *Surrogacy Arrangement* to Superior Health Plan at Member Services, 5900 E. Ben White Blvd., Austin, Texas 78741. In the event that an *enrollee* fails to comply with this provision, *we* reserve *our* right to enforce this EOC on the bases of fraud, misrepresentation or false information, up to and including recoupment of all benefits that *we* paid on behalf of the Surrogate during the time that the Surrogate was insured under *our contract*, plus interest, attorneys' fees, costs and all other remedies available to *us*.

Note: This provision does not amend the *contract* to restrict any terms, limits, or conditions that may otherwise apply to Surrogates and children born from Surrogates. Please see General Non-Covered Services and Exclusions.
In the event *we* cancel or do not renew this *contract*, there will be an extension of *pregnancy* benefits for a *pregnancy* commencing while the *contract* is in force and for which benefits would have been payable had the *contract* remained in force.

Newborn Charges
Medically necessary services, including *hospital* services, are provided for a covered newborn child immediately after birth. Each type of *covered service* incurred by the newborn child will be subject to his/her own *cost sharing* (*copayment*, *coinsurance* percentage, *deductible* and maximum out-of-pocket amount), as listed in the Schedule of Benefits. Please refer to the Dependent Enrollee Coverage section of this document for details regarding Coverage for a Newborn Child/Coverage for an Adopted Child.

Newborns' and Mothers' Health Protection Act Statement of Rights
Health Insurance Issuers generally may not, under federal law, restrict benefits 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 cesarean section. However, federal law generally does

not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain *authorization* from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Second Medical Opinion

Enrollees are entitled to a second medical opinion under the following conditions:

1. Whenever a minor *surgical procedure* is recommended to confirm the need for the procedure;
2. Whenever a serious *injury* or *illness* exists; or
3. Whenever *you* find that *you* are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a *physician* of the *enrollee's* choice. The *enrollee* may select a *network provider* listed in the Healthcare Provider Directory. If an *enrollee* chooses a *network provider*, he or she will only be responsible for the applicable *cost sharing* for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional *cost sharing*. If a second medical opinion is obtained by a *non-network provider*, *prior authorization* must be obtained before services are considered an *eligible service expense*. If *prior authorization* is not obtained for a second medical opinion from a *non-network provider*, *you* will be responsible for the related expenses.

Clinical Trial Coverage

Services must be provided or arranged by *your PCP*. Clinical Trial Coverage includes *routine patient care costs* incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. Coverage will include *routine patient care costs* incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a *qualified individual* that are provided in the clinical trial except:

1. The *investigational* item or service itself;
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
3. Items and services customarily provided by the research sponsors free of charge for any *enrollee* in the trial.

Phase I and II clinical trials must meet the following requirements:

1. Phase I and II of a clinical trial is approved or funded by one or more of the following:
    a. The National Institutes of Health;
    b. The Centers for Disease Control and Prevention;
    c. The Agency for Health Care Research and Quality;
    d. The Centers for Medicare & Medicaid Services;
    e. Cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs;
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

g. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration;
h. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
i. 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; and

2. The *enrollee* is enrolled in the clinical trial. This section shall not apply to *enrollees* who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

Phase III and IV clinical trials must be approved or funded by one of the following entities:

1. One of the National Institutes of Health (NIH);
2. The Centers for Disease Control and Prevention;
3. The Agency for Health Care Research and Quality;
4. The Centers for Medicare & Medicaid Services;
5. An NIH Cooperative Group or Center;
6. The FDA in the form of an *investigational* new drug application;
7. The federal Departments of Veterans' Affairs, Defense, or Energy;
8. 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; or
9. A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating *facility* and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-*investigational treatment* alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-*investigational* alternatives.

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to *us* upon request.

Prescription Drug Benefits

Covered service expenses and supplies 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 medical practitioner.

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*.

Maximum Insulin Medication Cost Share:
Insulin medications are covered with a maximum *cost share* of $25 per prescription for a 30-day supply. If *your cost share* per 30-day supply of insulin medications is less than $25, *you* will be responsible for the

lower amount. Please refer to *our formulary* for tier placement of insulin medications and *your Schedule of Benefits* for *your cost share* responsibility for the associated drug tier.

Emergency refills of insulin and insulin-related equipment will be covered in the same manner as non-emergency refills.

Formulary or Preferred Drug List
The formulary or preferred drug list is a guide to available generic and brand name drugs and some over-the-counter medications when ordered by a *physician* that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 of the Drug List to help identify brand name drugs that are clinically appropriate, safe and cost effective treatment options, if a generic medication on the formulary is not suitable for your condition.

Please note, the formulary is not meant to be a complete list of the drugs covered under *your* prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated and may be subject to change. Drugs may be added or removed or additional requirements may be added in order to approve continued usage of a specific drug. If *we* negatively modify the formulary *we* will perform such modifications at the time of coverage renewal. *We* will notify *you* at least 60 days in advance of such modification if *you* are affected by the change in drug coverage. Negative changes are defined as removing the drug from the formulary, adding quantity limit, adding *prior authorization* requirements, and adding step therapy requirements of moving drug to higher tier.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. For the most current Ambetter Formulary or Preferred Drug List or for more information about our pharmacy program, visit Ambetter.SuperiorHealthPlan.com (under “For Member”, “Drug Coverage”) or call Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

Formulary means *our* list of covered drugs available on *our* website at Ambetter.SuperiorHealthPlan.com or by calling Member Services. The drug formulary (approved drug list) is a list of *prescription drugs* that are covered by this *contract*. The formulary includes drugs for a variety of disease states and conditions. Periodically, the formulary is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. Sometimes it is *medically necessary* for an *enrollee* to use a drug that is not on the formulary, or has been removed from the formulary. When this occurs, the prescribing *provider* may request an exception for coverage through Member Services. For a list of covered drugs please visit Ambetter.SuperiorHealthPlan.com or contact Member Services. In addition, some covered drugs on the formulary may require *prior authorization* to ensure it is clinically appropriate for an *enrollee*.

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

Coverage is provided for any *prescription drug* that was *approved* or covered under the plan formulary for a medical condition or mental *illness*, regardless of whether the drug has been removed from the plan's drug formulary, at the contracted benefit level until the plan renewal date.

Certain specialty and non-specialty generic medications may be covered at a higher *cost share* than other generic products. Please reference the formulary and *Schedule of Benefits* for additional information. For purposes of this section, the tier status as indicated by the formulary will be applicable.

You will not be required to pay more than the applicable *copayment*, allowable claim amount, or amount required without insurance or discounts at the time of purchase.

Your total drug cost will always be either *your copayment* amount for the specific tier (after the *deductible*, if applicable) or the total cost of the drug, whichever is less. *We* do not charge a penalty for use of formulary brand drugs when a generic is available.

For prescription eye drops to treat a chronic eye disease or condition, refills are dispensed on or before the last day of the prescribed dosage period, but not earlier than the following:

1. 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;
2. 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
3. 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

Please note: *We* will provide a 30-day notice prior to the discontinuance of concurrent prescription drugs and intravenous infusions.

Over-the-Counter (OTC) Prescriptions
We cover a variety of over-the-counter (OTC) medications when ordered by a *physician*. *You* can find a list of covered over-the-counter medications in *our* formulary – they will be marked as "OTC". *Your* prescription must meet all legal requirements.

How to Fill a Prescription
Prescriptions can be filled at an *in-network* retail pharmacy or through *our* mail-order pharmacy.

If *you* decide to have *your* prescription filled at an *in-network* pharmacy, *you* can use the Provider Directory to find a pharmacy near *you*. *You* can access the Provider Directory at Ambetter.SuperiorHealthPlan.com on the Find a Provider page. *You* can also call Member Services to help you find a pharmacy. At the pharmacy, *you* will need to provide the pharmacist with *your* prescription and *your* member ID card.
We also offer a three-month (90-day) supply of maintenance medications by mail or from in-network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high blood pressure, asthma and diabetes. *You* can find a list of covered medications on Ambetter.SuperiorHealthPlan.com. *You* can also request to have a copy mailed directly to *you*.

Mail Order Pharmacy
If *you* have more than one prescription *you* take regularly, *you* may select to enroll in *our* mail order delivery program. *Your* prescriptions will be safely delivered right to *your* door at no extra charge to *you*. *You* will still be responsible for your regular *copayment/coinsurance*. To enroll for mail order delivery or for any additional questions, call *our* mail order pharmacy at 1-888-624-1139. Alternatively, *you* can find instructions on how to enroll on *our* Ambetter website. Once on *our* website, click on the section, "For Member," "Drug Coverage." The enrollment form will be located under "Forms."

Step Therapy
The step-therapy does not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Non-Formulary and Tiered Formulary Contraceptives:
Under Affordable Care Act, *you* have the right to obtain contraceptives that are not listed on the formulary (otherwise known as "non-formulary drugs") and tiered contraceptives (those found on a formulary tier other than "Tier 0 – no *cost share*") at no cost to *you* on *you* or *your* medical practitioner's request. To exercise this right, please get in touch with *your* medical practitioner. *Your* medical practitioner can utilize the usual *prior authorization* request process. See "Prior Authorization" below for additional details.

Non-Formulary Prescription Drugs:
Under Affordable Care Act, *you* have the right to request coverage of *prescription drugs* that are not listed on the plan formulary (otherwise known as "non-formulary drugs"). To exercise this right, please get in touch with *your* medical practitioner. *Your* medical practitioner can utilize the usual *prior authorization* request process. See "Prior Authorization" below for additional details.

Prescription Drug Synchronization
Under Texas law, *you* have the right to request synchronization of *your* medications. Synchronization is alignment of *your* fill dates so that all of *your* medication-refill dates are on the same day. For example, if *you* fill medication A on the 5th of each month and *your* prescriber prescribes *you* a new prescription B on the 20th of the month, *you* have the right to request a refill for prescription B that is shorter or longer than 30 days. This may help *you* adjust your fill dates for medication B and synchronize the fill dates with medication A. *We* will adjust *copays* to reflect shorter or longer coverage. If *you* would like to exercise this right, please call Member Services.

Prescription Drug Exception Process
Standard exception request
An *enrollee*, an *enrollee's* designee or an *enrollee's* prescribing *provider* may request a standard review of a decision that a drug is not covered by the plan. The request can be made in writing or by telephone. Within 72 hours of the request being received, *we* will provide the *enrollee*, the *enrollee's* designee or the *enrollee's* prescribing *provider* with *our* coverage determination. If *we* do not deny a standard exception request within 72 hours, the request is considered granted. Should the standard exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited exception request
An *enrollee*, an *enrollee's* designee or an *enrollee's* prescribing *provider* may request an expedited review based on exigent circumstances. Exigent circumstances exist when an *enrollee* is suffering from a health condition that may seriously jeopardize the *enrollee's* life, health, or ability to regain maximum function or when an *enrollee* is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, *we* will provide the *enrollee*, the *enrollee's* designee or the *enrollee's* prescribing *provider* with *our* coverage determination. If *we* do not deny an expedited exception request within 24 hours, the request is considered granted. Should the expedited exception request be granted, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review
If *we* deny a request for a standard exception or for an expedited exception, the *enrollee* or the *enrollee's* designee may request that the denial of such request be reviewed by an external review organization. The external review organization will make the determination on the denied exception request and notify the *enrollee* or the *enrollee's* designee of the coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

If *we* or the external review organization grants an exception for a standard or expedited exception request, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

Exception to step therapy or fail first protocol:
We will grant an exception to step therapy or fail first protocol when:

a. The drug required under the step therapy protocol:
    1. Is contraindicated;
    2. Will likely cause an adverse reaction in or physical or mental harm to the patient;
    3. Is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
    4. The patient previously discontinued taking the drug required under the step therapy protocol, or another prescription drug in the same pharmacologic class or with the same mechanism of action as the required drug, while under the health benefit plan currently in force or while covered under another health benefit plan because the drug was not effective or had a diminished effect or because of an adverse event;
    5. The drug required under the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the drug is expected to:
        1) Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
        2) Worsen a comorbid condition of the patient; or
        3) Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.
    6. The drug that is subject to the step therapy protocol was prescribed for the patient's condition and:
        1) The patient received benefits for the drug under the health benefit plan currently in force or a previous health benefit plan;
        2) The patient is stable on the drug; and
        3) The change in the patient's prescription drug regimen required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known clinical characteristics of the patient and the known characteristics of the required prescription drug regimen.

For product approved under this section we will issue an approval letter outlining coverage under this *contract*. For any product denied under this section, *you* have the right to appeal *our* decision. Any product requested under this section will be reviewed within 72 hours of receipt of the request for standard requests and within 24 hours of receipt of urgent or exigent request. If we fail to respond to a step therapy request with 24 hours for urgent and 72 hour for standard requests, such requests will be automatically approved.

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

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss prescription drugs unless otherwise listed on the formulary.
3. For immunization agents, blood, except when used for preventative care and listed on the formulary.
4. For medication that is to be taken by the *enrollee*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *enrollee* is a patient at an institution that has a facility for dispensing pharmaceuticals.

6. For a refill dispensed more than 12 months from the date of a *physician's* order.
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. This exclusion does not apply to prescribed FDA approved contraceptive methods.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90 day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. Foreign Prescription Medications, except those associated with an Emergency Medical Condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
13. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *enrollee's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
14. For medications used for cosmetic purposes.
15. For infertility drugs unless otherwise listed on the formulary.
16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
17. For drugs or dosage amounts determined by Ambetter to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
18. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
19. For any drug dispensed from a non-lock-in pharmacy while *enrollee* is in a lock-in program.
20. For any drug related to surrogate pregnancy.
21. For any injectable medication or biological product that is not expected to be self-administered by the *enrollee* at *enrollee's* place of residence unless listed on the formulary.
22. For any claim submitted by non lock-in pharmacy while *enrollee* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *enrollee's* participation in lock-in status will be determined by review of pharmacy claims.
23. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
24. Medication refills where an *enrollee* has more than 15 days' supply of medication on hand.

Lock-in program

To help decrease overutilization and abuse, certain *enrollees* identified through our Lock-in Program, may be locked into a specific pharmacy for the duration of their participation in the lock-in program. *Enrollees* locked into a specific pharmacy will be able to obtain their medication(s) only at specified location. Ambetter pharmacy, together with Medical Management will review *enrollee* profiles and using specific criteria, will recommend *enrollees* for participation in lock-in program. *Enrollees* identified for

participation in lock-in program and associated providers will be notified of *enrollee* participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which *enrollee* is locked-in, and any appeals rights.

Medication Balance-On-Hand
Medication refills are prohibited until an *enrollee's* cumulative balance-on-hand is equal to or fewer than 15 days' supply of medication. This program operates in addition to any applicable medication quantity limit or refill guidelines.

Split-Fill Dispensing Program
Enrollees are limited to 15-day supplies for the first 90 days when starting new therapy using certain medications (like oral oncology). *Enrollees* pay half the 30-day cost-share for a 15-day supply, and would be responsible for the other half of the 30-day cost share for each additional 15-day supply. After 90 days, *enrollees* will fill their medications for 30-day supplies.

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

1. immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
2. severe food protein-induced enterocolitis syndrome;
3. eosinophilic disorders, as evidenced by the results of a biopsy; and
4. impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Note: Benefits will be provided on a basis no less favorable than the basis on which prescription drugs and other medications and related services are covered by the plan, and to the same extent that the plan provides coverage for drugs that are available only on the orders of a *physician*.

Exclusions: any other non-medical dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

Preventive Care Services

Preventive care expenses will not be limited based on an individual's sex assigned at birth, gender identity or recorded gender. Coverage and claims will not be denied or limited or subject to additional *cost sharing* or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.

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:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. These recommendations include but not limited to:
    a. Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked;

b. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 40 to 70 years who are overweight or obese;
c. Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a ≥10% 10-year cvd risk;
d. Asymptomatic Bacteriuria in Adults: Screening: pregnant persons;
e. BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation;
f. Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer;
g. Breast Cancer: Screening: women aged 50 to 74 years;
h. Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children;
i. Cervical Cancer: Screening: women aged 21 to 65 years;
j. Colorectal Cancer: Screening: adults aged 45 to 75 years;
k. Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years;
l. Depression in Adults: Screening: general adult population, including pregnant and postpartum women;
m. Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years;
n. Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older;
o. Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy;
p. Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation;
q. Chlamydia and Gonorrhea: Screening: sexually active women;
r. Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Intervention (offer or refer adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity);
s. Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women;
t. Hepatitis B Virus Infection: Screening, 2014: persons at high risk for infection;
u. Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years;
v. Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons;
w. Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years;
x. High Blood Pressure in Adults: Screening: adults aged 18 years or older;
y. Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age;
z. Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection;
aa. Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication : pregnant women who are at high risk for preeclampsia;
bb. Lung Cancer: Screening: adults aged 50-80, with a history of smoking;

cc. Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older;
dd. Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns;
ee. Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis;
ff. Osteoporosis to Prevent Fractures: Screening: women 65 years and older;
gg. Perinatal Depression: Preventive Interventions: pregnant and postpartum persons;
hh. Preeclampsia: Screening: pregnant woman;
ii. Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of hiv acquisition;
jj. Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco;
kk. Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women;
ll. Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit;
mm. Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults;
nn. Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children;
oo. Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10% or greater;
pp. Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection;
qq. Syphilis Infection in Pregnant Women: Screening: pregnant women;
rr. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: adults who are not pregnant;
ss. Tobacco Smoking Cessation in Adults, Including Pregnant Women: Behavioral and Pharmacotherapy Interventions: pregnant women;
tt. Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women;
uu. Unhealthy Drug Use: Screening: adults age 18 years or older;
vv. Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years;
ww. Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults.
xx. Offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.

Note: The full list of recommendations and descriptions are available at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.

Please be advised that these recommendations are subject to change. *Enrollees* are encouraged to visit the website provided for the most up-to-date listing of recommendations.

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Covers without *cost sharing*:
    a. Screening for *tobacco or nicotine use*; and
    b. For those who *use tobacco or nicotine* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) *nicotine* or *tobacco* cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without *prior authorization*; and
        ii. All Food and Drug Administration (FDA) approved *nicotine* or *tobacco* cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a healthcare *provider* without *prior authorization*.

If a service is considered diagnostic or non-preventive, *your* plan *copayment*, *coinsurance* and *deductible* will apply. It is important to know what type of service *you* are getting. If a diagnostic or non-preventive service is performed during the same healthcare visit as a preventive service, *you* may have *copayment* and *coinsurance* charges. Whether something is preventive is determined by the claim service data submitted by the *provider*.

As new recommendations and guidelines are issued, those services will be considered *covered services* when required by the United States Secretary of Health and Human Services, but not later than one year after the recommendation or guideline is issued.

Covered Preventive Care Services for Children including:

1. Autism screening;
2. Behavioral assessments for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years;
3. Developmental screening for children under age 3, and surveillance throughout childhood;
4. Fluoride Chemoprevention supplements for children without fluoride in their water source;
5. Lead screening for children at risk of exposure;
6. Tuberculin testing;
7. Obesity screening and counseling; and
8. Oral Health risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.

Covered Preventive Care Services for Women, Including Pregnant Women:

1. Anemia screening on a routine basis for pregnant women;
2. BRCA counseling about genetic testing for women at higher risk;
3. Breastfeeding comprehensive support and counseling from trained *providers*, as well as access to breastfeeding supplies, for pregnant and nursing women;
4. Contraceptive care;
5. Domestic and interpersonal violence screening and counseling for all women;

6. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
7. Gonorrhea screening for all women at higher risk;
8. Hepatitis B screening for pregnant women at their first prenatal visit;
9. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
10. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
11. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
12. Sexually Transmitted Infections (STI) counseling for sexually active women; and
13. Well-woman visits.
14. *Tobacco or nicotine use* screening and interventions for all *enrollees*, and expanded counseling for pregnant tobacco users.

Covered Preventive Services for Adults including:

1. Alcohol Misuse screening and counseling;
2. Blood Pressure screening for all adults;
3. Depression screening for adults;
4. Type 2 Diabetes screening for adults with high blood pressure;
5. HIV screening for all adults at higher risk;
6. Obesity screening and counseling for all adults;
7. *Tobacco or nicotine use* screening for all adults and cessation interventions for *tobacco* or *nicotine* users;
8. Syphilis screening for all adults at higher risk; and
9. Screenings for colorectal cancer when billed as preventive starting at age 45 to 75 and the follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure were abnormal. Frequency of colorectal cancer screenings as follows:
    a. Annual fecal occult blood tests (FOBTs);
    b. Flexible sigmoidoscopy every 5 years;
    c. Cologuard tests every 3 years;
    d. Screening colonoscopy for persons at average risk for colorectal cancer every 10 years;
    e. or for persons at high risk for colorectal cancer every 2 years;
    f. Barium enema every 5 years as an alternative to flexible sigmoidoscopy;
    g. or every 2 years as an alternative to colonoscopy for persons at high risk for colorectal cancer; and
    h. Other procedures the provider finds appropriate based on consultation with appropriate experts and organizations are based on *medical necessity* outside of frequency mentioned above. Any services billed as non-preventive or on and above these frequency limits as mentioned above are subject to member *cost sharing*.

Benefits for Routine Exams and Immunizations

Benefits for routine exams are available for the following Preventive Care Services:

1. Well-baby care (after newborn's initial examination and discharge from the *hospital*);
2. Routine annual physical examination;
3. Annual vision examination;
4. 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*; and

5. 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, rotovirus, 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 *contract* provisions.
6. Newborn coverage includes all newborn test screenings and testing screening kits.

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, Ovarian and Cervical Cancer
Benefits are available for certain tests for the detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer, for each *enrollee* who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage includes, at a minimum, a CA 125 blood test, a conventional Pap smear screening or a screening using liquid–based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus, any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

Benefits for Mammography Screening and Diagnostic Imaging
Benefits are available for a diagnostic or screening for the presence of occult breast cancer for an *enrollee.* Benefits for mammogram screenings are limited to one test per year for enrollees 35 years of age and older. Benefits for *diagnostic imaging* are allowed for *enrollees* regardless of age.

A mammogram is an x-ray of the breast. While screening mammograms are routinely administered to detect breast cancer in women who have no apparent symptoms, *diagnostic imaging* are used after suspicious results on a screening mammogram or after some signs of breast cancer alert the physician to check the tissue.

Such signs may include:

- A lump
- Breast pain
- Nipple discharge
- Thickening of skin on the breast
- Changes in the size or shape of the breast

Diagnostic imaging can help determine if these symptoms are indicative of the presence of cancer.

As compared to screening mammograms, *diagnostic imaging* provides a more detailed x-ray of the breast using specialized techniques. They are also used in special circumstances, such as for patients with breast implants.

Benefits for Detection and Prevention of Osteoporosis

If an *enrollee* is a *qualified individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

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

Benefits for Certain Tests for Detection of Prostate Cancer
Covered service expenses includes an annual physical examination for the detection of prostate cancer and "prostate specific antigen tests" performed to determine the level of prostate specific antigen in the blood for a covered *enrollee* who is at least fifty (50) years of age; and at least once annually for a covered *enrollee* who is at least 40 years of age and has 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 must be performed or authorized by *your PCP* and are available for *eligible service 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.

Covered services include the cost of *medically necessary* hearing aid or cochlear implant and related services and supplies:

1. Fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids;

2. Any treatment related to hearing aids and cochlear implants, including coverage for *habilitation* and *rehabilitation* as necessary for educational gain; and
3. For a cochlear implant, and external speech processor and controller with necessary components replacement every three years.

Limitations:

1. One hearing aid in each ear every three years; and
2. One cochlear implant in each ear with internal replacement as medically or audiologically necessary.

Contraceptive Care

All FDA-approved contraception methods (identified on www.fda.gov) are *approved* for *enrollees* without *cost sharing* as required under the Affordable Care Act. *Enrollees* have access to the methods available and outlined on *our* drug formulary or Preferred Drug List without *cost share*. Some contraception methods are available through an *enrollee's* medical benefit, including the insertion and removal of the contraceptive device at no *cost share* to the *enrollee*. Emergency contraception is available to *enrollees* without a prescription and at no *cost share* to the *enrollee*.

Benefits for Medically Necessary Vision Services

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed or authorized by *your PCP*. *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 for adults is excluded.
2. Vision Therapy Development Testing for children, except when *authorized* by *us*.
3. Any vision services, treatment or material not specifically listed as a *covered service*.
4. Low vision services and hardware for adults.
5. Non-network care, only as defined within this document.
6. Reading glasses for children may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior *approval* basis.

Sleep Studies

Sleep studies are covered when determined to be *medically necessary*; *prior authorization* may be required.

Note: A sleep study can be performed either at home or in a facility.

Transplant Services

Covered services for transplant service expenses:
Transplants are a covered benefit when an *enrollee* is accepted as a transplant candidate and pre-*authorized* in accordance with this *contract*. *Prior authorization* must be obtained through the *Center of Excellence*, a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy, before an evaluation for a transplant. *We* may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

Cost share benefit coverage related to transplant services is available to both the recipient and donor of a covered transplant as follows:

1. If both the donor and recipient have coverage provided by the same contractholder each will have their benefits paid by their own coverage program.
2. If *you* are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this *contract* will be provided for both *you* and the donor. In this case, payments made for the donor will be charged against enrollees benefits.
3. If *you* are the donor for the transplant and no coverage is available to *you* from any other source, the benefits under this *contract* will be provided for *you*. However, no benefits will be provided for the recipient.

If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

If *we* determine that an *enrollee* and donor are appropriate candidates for a *medically necessary* transplant or live donation, *covered service expenses* will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting of the organ from the donor.
3. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
4. *Outpatient covered services* related to the transplant *surgery*, pre-transplant laboratory testing and treatment; such as high dose chemotherapy, peripheral stem cell collection, and other immunosuppressive drug therapy, etc.
5. Pre-transplant stabilization, meaning an *inpatient* stay to *medically stabilize* to prepare for a later transplant, whether or not the transplant occurs.
6. The transplant itself, including the acquisition cost for the organ or bone marrow when authorized through the *Center of Excellence, a network facility,* or in *our* approved *non-network facility* when there is no network adequacy and services are performed at a participating facility..
7. Post-transplant follow-up visits and treatments.
8. Transplant benefit expenses include services related to donor search and acceptability testing of potential live donors.
9. All costs incurred and medical expenses by the donor; shall be paid under the transplant recipient policy, this excludes travel, lodging, food, mileage. Please see transplant travel expense policy for outlined details on reimbursement limitations. (*www*.Ambetter.com).

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* when donor has no coverage available to them from any other source.

Ancillary "Center Of Excellence" Service Benefits:
An *enrollee* may obtain services in connection with a transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence, a network facility,* or in *our* approved *non-network facility* when there is no network adequacy:

1. *We* will pay for the following services when the *enrollee* is required to travel more than 75 miles from the *residence* to the *Center of Excellence*:
2. *We* will pay a maximum of $10,000 per transplant service 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,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy, in the United States.
b. When enrollee and/or donor is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
c. Maximum reimbursement for mileage is limited to travel to and from the *enrollee's* home to the transplant facility, and to and from the donor's home to the transplant facility, and will be reimbursed at the current IRS mileage standard for miles driven for medical purposes.
d. Lodging at or near the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy for any live donor and the *immediate family* accompanying the *enrollee* while the *enrollee* is confined in the *Center of Excellence* in the United States. *We* will reimburse *enrollees* for the proof of costs directly related for transportation, lodging and any of the following approved items listed in the member transplant reimbursement guidelines. However, *you* must make the arrangements and provide the necessary paid receipts for reimbursement within 6 months of the date of service in order to be reimbursed.
e. Incurred costs related to a certified/registered service animal for the transplant enrollee and/or donor.
f. Please refer to the member resources page for member reimbursement transplant travel forms and information at *www*.Ambetter.com.

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

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision through the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy.
4. To keep a donor alive for the transplant operation, except when authorized through the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants unauthorized through the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy and is not included under this provision as a transplant.
7. For a 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.
8. The acquisition cost for the organ or bone marrow, when provided at an un*authorized* facility or not obtained through the *Center of Excellence,* a *network facility,* or in *our* approved *non-network facility* when there is no network adequacy.
9. For any transplant services and/or travel related expenses for enrollee and donor, when preformed outside of the United States.
10. The following ancillary items listed below, will not be subject to member reimbursement under this *contract*:
    a. Alcohol/tobacco

b. Car Rental (unless pre-approved by Case Management)
c. Vehicle Maintenance for motorized and hybrid, and electric car (includes: any repairs/parts, labor, general maintenance, towing, roadside assistance, etc.)
d. Parking, such as but not limited to hotel, valet or any offsite parking other than hospital.
e. Storage rental units, temporary housing incurring rent/mortgage payments.
f. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
g. Speeding tickets
h. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
i. For any services related to pet care, boarding, lodging, food, and/or travel expenses; other than those related to certified/registered service animal(s).
j. Expenses for persons other than the patient and his/her covered companion
k. Expenses for lodging when *enrollee* is staying with a relative
l. Any expense not supported by a receipt
m. Upgrades to first class travel (air, bus, and train)
n. Personal care items (e.g., shampoo, deodorant, clothes)
o. Luggage or travel related items including passport/passport card, REAL ID travel ids, travel insurance, TSA pre-check, and early check-in boarding fees, extra baggage fees.
p. Souvenirs (e.g., t-shirts, sweatshirts, toys)
q. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.
r. All other items not described in the *contract* as eligible expenses
s. Any fuel costs/charging station fees for electric cars, not related to travel to and from the *Center of Excellence* or *our* approved *facility,* when there is no network adequacy.

Organ Transplant Medication Notification
Enrollees will not be subject to any formulary change that alters the terms of coverage for a patient receiving immunosuppressant drugs or discontinues coverage for a prescribed immunosuppressant drug that a patient is receiving during the enrollment year. *We* must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or legal guardian if the *enrollee* is a child, or the *spouse*/caretaker of an *enrollee* who is *authorized* to consent to the treatment of the patient 60 days prior to renewal or enrollment. The notification will be in writing and will disclose the formulary change, indicate that the prescribing *physician* may initiate an *appeal*, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s *appeal* process.

As an alternative to providing written notice, *we* may provide the notice electronically if, and only if, the patient affirmatively elects to receive such notice electronically. The notification shall disclose the formulary change, indicate that the prescribing *physician* may initiate an appeal, and include information regarding the procedure for the prescribing *physician* to initiate the *contract*'s appeal process.

At the time a patient requests a refill of the immunosuppressant drug, *we* may provide the patient with the written notification required above along with a 60-day supply of the immunosuppressant drug under the same terms as previously allowed.

Pediatric Vision Expense Benefits

Covered service expenses in this benefit subsection include the following services performed by an optometrist, therapeutic optometrist, or ophthalmologist 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) in glass or plastic, or initial supply of *medically necessary* contacts every calendar year;
    a. Other lens options included are: Fashion and Gradient Tinting, Ultraviolet Protective Coating, Oversized and Glass-Grey #3 Prescription Sunglass lenses, Polycarbonate lenses, Blended Segment lenses, Intermediate Vision lenses, Standard Progressives, Premium Progressives (Varilux®, etc.), Photochromic Glass Lenses, Plastic Photosensitive Lenses (Transitions®), Polarized Lenses, Standard Anti-Reflective (AR) Coating, Premium AR Coating, Ultra AR Coating, and Hi-Index Lenses
3. One pair of prescription frames per calendar year;
4. Scratch-resistant coating; and
5. Low vision aids as *medically necessary*.

Covered service expenses and supplies 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*;
5. *Non-network providers*;
6. Discount for laser vision correction;
7. Lasik surgery.

Pediatric Services will extend through the end of the plan year in which they turn 19 years of age.

Vision Services - Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are managed through Envolve Vision. 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 Envolve Vision 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 Envolve Vision'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 the *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 standard contact lenses. 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 Envolve Vision *providers*, call

Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

Wellness and Other Program Benefits

Benefits may be available to *enrollees* for participating in certain programs that *we* may make available in connection with this *contract*. Such programs may include wellness programs, disease or *care management* programs, and other programs as found under the Health Management Programs Offered provision. These programs may include a reward or an incentive, which *you* may earn by completing different activities.

If *you* have a medical condition that may prohibit *you* from participating in these programs, *we* may require *you* to provide verification, such as an affirming statement from *your physician*, that your medical condition makes it unreasonably difficult or inadvisable to participate in the wellness or health improvement program, in order for *you* to receive the reward or incentive.

You may obtain information regarding the particular programs available at any given time by visiting *our* website at Ambetter.SuperiorHealthPlan.com or by contacting Member Services by telephone at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989). The benefits are available as long as coverage remains active, unless changed by *us* as described in the programs' terms and conditions. Upon termination of coverage, program benefits are no longer available.

All *enrollees* are automatically eligible for the program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the *enrollees*. The programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change by *us* through updates available on *our* website or by contacting *us*.

Enrollees will be able to earn rewards for focusing on their total health. The "My Health Pays" member rewards program may offer rewards when members participate in activities focused on eating right, moving more, saving smart and living well. *Enrollees* may have the opportunity to earn rewards for completing activities in the categories below:

Behavior/Action	Notes
Program Activation and Onboarding	Rewards for activating and onboarding onto the program
Online Activities (Power ups and Challenges)	Frequent online activities providing educational content and calls to action focused on targeted wellness behaviors and healthy living
Clinical Activities	Clinical activities focused on health management, including recommended preventive screenings and disease management participation

Earned rewards may be used to shop for items at the online My Health Pays Rewards Store or may be converted into dollars and spent on healthcare-related items. The rewards may be applied towards social determinants.

Rewards for participating in a wellness program are available to all *enrollees*. If *you* think *you* might be unable to meet a standard for a reward under this wellness program, *you* might qualify for an opportunity

to earn the same reward through an alternative means. *Enrollees* should contact Member Services by telephone at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) so they can work with *you* (and, if *you* wish, with your doctor) to find a wellness program that offers the same reward and is right for *you* in light of your health.

Care Management Programs

We understand special health needs and are prepared to help you manage any that you may have. *Our* Care Management services can help with complex medical or *behavioral health* needs. If *you* qualify for Care Management, *we* will partner *you* with a care manager. Care managers are registered nurses or social workers that are specially trained to help *you*:

- Better understand and manage *your* health conditions
- Coordinate services
- Locate community resources

Your care manager will work with *you* and *your* doctor to help *you* get the care *you* need. If *you* have a severe medical condition, *your* care manager will work with *you*, *your* primary care provider (PCP) and other providers to develop a care plan that meets *your* needs and *your* caregiver's needs. If *you* think *you* could benefit from *our* Care Management program, please call Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

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, fees, taxes, or 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 for an *enrollee* by an *enrollee's immediate family*, including someone who is related to an *enrollee* by blood, marriage or adoption or who is normally a member of the *enrollee's* household. This exclusion does not apply to *eligible service expenses* rendered from a dental *provider* for dental benefits.
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*.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.
6. For any non-*medically necessary* court ordered care for a medical/surgical or mental health/substance use disorder diagnosis, unless required by state law.

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 *provider*; and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness*, or covered under the Preventive Care Services 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 *contract'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 cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of Gender Dysphoria.
5. The reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term or delivered).
7. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses*.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations, except those meeting the definition of *telehealth services* or *telemedicine medical services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a medical practitioner when no treatment is rendered.

12. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the Medical and Surgical Benefits provision.
13. For *cosmetic treatment*, except for *reconstructive surgery* for mastectomy or 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.
14. For mental health exams and services involving:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Marriage counseling;
    c. Pre-marital counseling;
    d. Court ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise covered under this *contract*;
    e. Testing of aptitude, ability, intelligence or interest;
    f. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *contract*.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Services provision.
16. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
19. 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.
20. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
21. 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.
22. 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 an *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* workers' 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.
23. As a result of:
    a. 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 administer or prescribed by a physician, except as

expressly provided under the Mental Health and Substance Abuse Expense Benefit and excluding presence of mental health and substance abuse disorders.

24. For fetal reduction *surgery*.
25. 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.
26. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any non-motorized vehicle or conveyance (if the *enrollee* is paid to participate or to instruct); 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).
27. 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.
28. As a result of any *injury* sustained while at a *residential treatment facility*.
29. For the following miscellaneous items (except where required by federal or state law): in vitro fertilization, artificial insemination, biofeedback; 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 when not rendered in an *inpatient* setting; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *contract*.
30. Services of a private duty registered nurse rendered on an outpatient basis.
31. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
32. For any medicinal and recreational use of cannabis or marijuana.
33. *Surrogacy Arrangement*. Health care services, including supplies and medication relating to a *Surrogacy Agreement*, to a *Surrogate*, including an *enrollee* acting as a *Surrogate* or utilizing the services of a *Surrogate* who may or may not be an *enrollee*, and any child born as a result of a *Surrogacy Arrangement*. This exclusion applies to all health care services, supplies and medication relating to a *Surrogacy Agreement*, to a *Surrogate* including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the Surrogate following childbirth);
    d. Mental Health Services related to the *Surrogacy Arrangement*;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a *Surrogacy Arrangement*;
    g. Use of frozen gamete or embryos to achieve future conception in a *Surrogacy Arrangement*;
    h. Preimplantation genetic diagnosis relating to a *Surrogacy Arrangement*;
    i. Any complications of the child or Surrogate resulting from the pregnancy; or
    j. Any other health care services, supplies and medication relating to a *Surrogacy Arrangement*.

k. Any and all health care services, supplies or medication provided to any child birthed by a *Surrogate* as a result of a *Surrogacy Arrangement* are also excluded, except where the child is the adoptive child of *enrollee* possessing an active *contract* with us and/ or the child possesses an active *contract* with us at the time of birth.

34. Vehicle installations (modifications) which may include but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
35. For all health care services obtained at an Urgent Care Facility that is a *non-network provider*.

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. For any reason or event of non-renewal or cancellation as outlined in the Guaranteed Renewable provision.
    a. The last day of coverage is the last day of the month following the month in which the notice is sent by *us* unless *you* request an earlier termination effective date.
3. For an *eligible child* reaching the limiting age of 26, coverage under this *contract*, for an *eligible child*, will terminate at 11:59 p.m. CST on the last day of the year in which the *eligible child* reaches the limiting age of 26.
    a. Coverage may be extended beyond the limiting age for a *dependent eligible child* who is not capable of self-sustaining employment due to mental retardation or physical disability and is mainly dependent on *you* for support and maintenance.
4. *You* obtain other minimum essential coverage.

Refund upon Cancellation

We will refund any premium paid and not earned due to *contract* termination. *You* may cancel the *contract* at any time by written notice, delivered or mailed to the Health Insurance Marketplace or by visiting www.healthcare.gov at https://www.healthcare.gov/keep-or-change-plan/, or if an off-exchange *enrollee* by written notice, delivered or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

Discontinuance

90-Day Notice: If *we* discontinue offering and decide not 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 decide not 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 plan. The premium rate applicable to the new *contract* will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new *contract*, 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 e*nrollees* combined, only those expenses incurred by the e*nrollee* continuing coverage under the new contract will be applied toward the satisfaction of the *deductible amount* under the new contract.)

If an *enrollee's* coverage terminates due to a change in marital status, *you* may be issued coverage that most nearly approximates the coverage of the *contract* which was in effect prior to the change in marital status.

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.

Reinstatement

For coverage purchased outside of the Health Insurance Marketplace, 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.

For coverage purchased through the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement.

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, benefits are not 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. The period of extended loss must begin before coverage of the *enrollee* ceases under this *contract*. Benefits are not 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.

THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

As used herein, the term "*third party*" means any party that is, or may be, or is claimed to be responsible for *illness* or *injuries* to an *enrollee*. Such *injuries* or *illness* are referred to as "*third party injuries*." *Third party* includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of *third party injuries*, to the extent permitted by Texas law.

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*.

If this plan provides benefits under this *contract* to a *enrollee* for expenses incurred due to *third party injuries*, then Superior retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *enrollee* that are associated with the *third party injuries*. Superior's rights of recovery apply to any recoveries made by or on behalf of the *enrollee* from any sources, including but not limited to:

1. Payments made by a *third party* or any insurance company on behalf of the *third party*;
2. Any payments or awards under an uninsured or underinsured motorist coverage policy if the *enrollee* or *enrollee's immediate family* did not pay the premiums for the coverage;
3. Any Workers' Compensation or disability award or settlement;
4. Medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and
5. Any other payments from a source intended to compensate an *enrollee* for *third party injuries*.

By accepting benefits under this plan, the *enrollee* specifically acknowledges Superior's right of subrogation. When this plan provides health care benefits for expenses incurred due to *third party injuries*, the plan shall be subrogated to the *enrollee's* rights of recovery against any party to the extent of the full cost of all benefits provided by this plan, to the extent permitted by Texas law. Superior may proceed against any party with or without the *enrollee's* consent.

By accepting benefits under this plan, the *enrollee* also specifically acknowledges Superior's right of reimbursement. This right of reimbursement attaches, to the extent permitted by Texas law, when this plan has provided health care benefits for expenses incurred due to *third party injuries* and the *enrollee* or the *enrollee's* representative has recovered any amounts from any source, to the fullest extent permitted by law. By providing any benefit under this plan, Superior is granted an assignment of the proceeds of any settlement, judgment or other payment received by *you* to the extent of the full cost of all benefits provided by this plan. Superior's right of reimbursement is cumulative with and not exclusive of the plan's subrogation right and Superior may choose to exercise either or both rights of recovery.

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 we* have provided or paid to the extent permitted by Texas law.

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 permitted by Texas law 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. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan to the extent permitted by Texas law.
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 within 30 days prior to the settlement.
8. To reimburse *us* from any money received from any *third party*, to the extent permitted by Texas law for benefits *we* paid for the *third party 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*.

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.

In the event of a recovery from a *third party*, *we* will pay attorney fees or costs associated with the *enrollee's* claim or lawsuit only to the extent required by Texas law unless otherwise agreed.

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.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

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

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

DEFINITIONS

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

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization

evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and *exclusive provider benefit plans*; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

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

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

“This plan" means, in a COB provision, the part of the *contract* providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of *other plans*. Any other part of the *contract* providing healthcare benefits is separate from this plan. A *contract* may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has healthcare coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any *other plan* without considering any *other plan's* benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(b) "Allowable expense" is a healthcare expense, including *deductibles*, *coinsurance*, and *copayments,* that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a healthcare *provider* or *physician* by law or in accord with a contractual agreement is prohibited from charging a covered *enrollee* is not an allowable expense.

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

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

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

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

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

(5) The amount of any benefit reduction by the primary plan because a covered *enrollee* has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, *prior authorization* of admissions, and preferred healthcare *provider* and *physician* arrangements.

(6) When an *enrollee* is also a Medicare beneficiary, and Medicare is primary, the allowable expense is Medicare's *allowable amount*.

(c) "*Billed amount*" is the amount of a *billed charge* that a carrier determines to be covered for services provided by a non-participating healthcare *provider* or *physician*. The *allowed amount* includes both the carrier's payment and any applicable *deductible*, *copayment*, or *coinsurance* amounts for which the *enrollee* is responsible.

(d) "Closed panel plan" is a plan that provides healthcare benefits to covered *enrollees* primarily in the form of services through a panel of healthcare *providers* and *physicians* that have contracted with or are employed by the plan, and that excludes coverage for services provided by other healthcare *providers* and *physicians*, except in cases of emergency or referral by a panel member.

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered *enrollee* uses a non-contracted healthcare *provider* or *physician*, except for emergency services or *authorized* referrals that are paid or provided by the primary plan.

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

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

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

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

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

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

(i) if a court order states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, and that parent's *spouse* does, then the *spouse's* plan is the primary plan. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

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

(I) the plan covering the custodial parent;

(II) the plan covering the *spouse* of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the *spouse* of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

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

(E) In the event the dependent child's coverage under the *spouse's* plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's *spouse*.

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

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, *enrollee*, subscriber, or retiree or covering the person as a dependent of an employee, *enrollee*, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the *other plan* does not have

this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

(b) When an *enrollee* is also a Medicare beneficiary, this plan is secondary. In that case, the allowable expense is reduced to reflect Medicare's *allowable amount*. At no point should this plan's *allowable amount* exceed what the plan would pay if the plan was primary. *Enrollees* may no longer be eligible to receive a premium subsidy for the Health Insurance Marketplace plan once Medicare coverage becomes effective.

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

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by this plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered

enrollee. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ENROLLEE CLAIM REIMBURSEMENT

Notice of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible. *We* must receive a request for reimbursement through receipt of a claim within 90 days of the date of service.

Claim Submission
Providers will typically submit claims on your behalf, but sometimes you may have to pay for a *covered service* and file a claim for reimbursement. This may happen if:
1. Your provider is not contracted with us.
2. You have an out-of-area emergency.

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid, less any deductible, copayment or cost sharing that is your financial responsibility.

To request reimbursement for a *covered service*, you need a copy of the detailed claim from the provider. You also need to submit an explanation of why you paid for the *covered services*. Send this to us at the following address:

Ambetter from Superior HealthPlan
Attn: Claims Department- Member Reimbursement
P.O. Box 5010
Farmington, MO 63640-3800

After getting your claim, we will let you know we have received it, begin an investigation and request all items necessary to resolve the claim. We will do this in 15 days or less.

We will notify you, in writing, that we have either accepted or rejected your claim for processing within 15 days after receiving all items necessary to resolve your claim. If we accept your claim, we will make payment within 5 business days after notifying you of the payment of your claim. If we reject your claim, we will give you the reason your claim is rejected. If we are unable to come to a decision about your claim within 15 days, we will let you know and explain why we need additional time, and will make our decision to accept or reject your claim no later than the 45th day after our notice about the delay for paper claims or no later than the 30th day after our notice about the delay for electronic claims.

Claim Forms
The contractholder, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the contractholder for filing *proof of loss*. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to *proof of loss* on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

Non-Assignment
The coverage, rights, privileges and benefits provided for under this *contract* are not assignable by *you* or anyone acting on *your* behalf, except to a *physician* or other healthcare *provider*. Any assignment or purported assignment of coverage, rights, privileges and benefits provided for under this *contract* that *you* may provide or execute in favor of any *hospital* or any other person or entity other than a *physician* or other healthcare *provider* shall be null and void and shall not impose any obligation on *us.*

No Third Party Beneficiaries
This *contract* is not intended to, nor does it, create or grant any rights in favor of any *third party*, including but not limited to any *hospital, provider* or medical practitioner providing services to *you*, and this *contract* shall not be construed to create any *third party* beneficiary rights.

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 180 calendar days from the date of the incident to file a *complaint*. *Complaints* are considered standard unless they concern an emergency or denial of continued stay for hospitalization, in which case they will be considered expedited.

If *you* notify *us* orally or in writing of a *complaint*, *we* will, not later than the fifth (5th) 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 to be completed and returned to *us* for prompt resolution of the *complaint*.

You should send *your* written *complaint* to:
Ambetter from Superior HealthPlan Complaint Department
5900 E. Ben White Blvd.
Austin, TX 78741
Fax: 1-866-683-5369

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

For oral *complaints* received and not confirmed in writing, *we* will research the issue as best practice and communicate findings to *you* verbally.

An expedited *complaint* concerning an emergency or denial of continued stay for hospitalization will be resolved in one (1) business day of receipt of *your complaint*. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case and *we* will send *you* a letter with *our* resolution within three (3) business days.

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

Complaint Appeals to the 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 healthcare 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*, except with respect to *appeals* relating to ongoing emergencies or denial of continued stays for hospitalization which shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one (1) business day after *your* request for *appeal*.
2. *We* shall send an acknowledgment letter to *you* not later the fifth (5th) business day after the date of receipt of the request of the *appeal*.
3. *We* shall appoint members 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, *providers*,

and *enrollees*. A member of the appeal panel may not have been previously involved in the disputed decision.

4. Not later than the fifth (5th) 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 *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 (1) 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 *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.

Appeal of Adverse Determination

An "*adverse determination*" is a decision that is made by *us* or *our* Utilization Review Agent that the healthcare services furnished or proposed to be furnished to *you* are not *medically necessary* or appropriate.

If *you*, *your* designated representative, or *your provider* of record disagree with the *adverse determination*, *you*, *your* designated representative, or *your provider* may *appeal* the *adverse determination* orally or in writing. An enrollee has 180 calendar days following receipt of a notification of an *adverse determination* to file an *appeal*.

For a standard *appeal*, *we* will acknowledge *your appeal* within five (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 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 provider* should send to *us* or to *our* Utilization Review Agent for the *appeal*. The *appeal* will be resolved no later than thirty (30) calendar days after the date *we* or *our* Utilization Review Agent receives the *appeal*.

If *you*, *your* designated representative, or *your provider* orally *appeal* the *adverse determination*, *we* or *our* Utilization Review Agent will send *you*, *your* designated representative, or *your 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*.

Expedited *appeals* of *adverse determinations* involving ongoing emergencies or denials of continued stays in a *hospital,* denials of *prescription drugs*, intravenous infusions, or a denied step therapy protocol exception will be resolved no later than one (1) business day after the request is received.

With respect to retrospective utilization review, if additional time is needed due to matters beyond our

control, *you* or *your* designated representative will be notified before the thirtieth (30th) calendar day with specific reasons why the additional time is needed and the additional time will be no greater than fifteen (15) calendar days.

You can also request an expedited *appeal* for an urgent care denial. *We* will answer *your appeal* for urgent care within one (1) business day of *your* request. *You* can request an expedited *appeal* for urgent care if:

1. *You* think the denial could seriously hurt *your* life or health.
2. *Your provider* thinks that *you* will experience severe pain without the denied care or treatment.

External Review

If the *appeal* of the *adverse determination* is denied, *you* or *your* designated representative have the right to request an external review of that decision. The external review organization is not affiliated with *us* or *our* Utilization Review Agent. You may also request an external review without first completing an internal appeal if your internal appeal rights have already been exhausted.

In circumstances involving a life-threatening condition, *emergency care*, hospitalized *enrollees*, denials of *prescription drugs*, intravenous infusions, or a denied step therapy protocol exception, *you*, *your* designated representative, or *your provider* is entitled to an immediate external review without having to comply with the procedures for internal *appeals* of *adverse determinations*.

You or *your* designated representative can ask for a standard external review within four (4) months after the date *you* receive the final internal *appeal* determination notice. *Your* request should be submitted directly to the external review organization, and *you* must provide the following information: name and address, phone number, email address, whether the request is urgent or standard, a completed Appointment of Representative Form if someone is filing on *your* behalf, and a brief description of the reason *you* disagree with *our* decision. When the external review organization completes its review and issues its decision, *we* will abide by the decision.

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* health in serious jeopardy.

Simultaneous Expedited Appeal and Expedited Internal Review

In the case of an appeal involving urgent care, *you* or *your* authorized representative may also request an expedited internal review. A request for expedited internal appeal may be submitted orally or in writing by the *enrollee* or their authorized representative; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the *enrollee* or their authorized representative by telephone, facsimile, or other expeditious method. *You* may also request an expedited external review without first completing an internal appeal if *your* internal appeal rights have already been exhausted.

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 electronically at www.tdi.texas.gov or by phone at 1-800-252-3439.

You may also send a printed copy of *your complaint* to the Texas Department of Insurance:

1. **By mail:** Texas Department of Insurance, Consumer Protection (111-1A), P.O. Box 149104, Austin, Texas 78714-9091
2. **In person or by delivery service:** Texas Department of Insurance, Consumer Protection (111-1A), 333 Guadalupe St., Austin, Texas 78701
3. **By fax:** (512) 490-1007
4. **By email:** ConsumerProtection@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; or
3. *We*, the *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 *you* because *you* or person acting on *your* behalf 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 *provider*, because the *provider* has, on *your* behalf, 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 provider* and medical practitioners.
3. Providing information to help *you* become an informed healthcare consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as an *enrollee*.
6. Providing coverage regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.

You have the right to:

1. Participate with *your provider* and medical practitioners in decisions about *your* healthcare. 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 representative. *You* should be informed of *your* care options.
2. Know who is approving and 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 *providers* and medical practitioners, and *your* rights and responsibilities.
7. Candidly discuss with *your provider* 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 provider* about what might be wrong (to the level known), treatment and any known likely results. *Your primary care provider* 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 provider* 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 the rights and responsibilities policy.
9. Voice *complaints* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. File an *appeal* if *you* disagree with certain decisions *we* have made.
11. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your provider*(s) of the medical consequences.
12. See *your* medical records.
13. Be kept informed of *covered* and non-*covered services*, program changes, how to access services, *providers*, advance directive information, *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; and
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 provider*'s instructions are not followed. *You* should discuss all concerns about treatment with *your primary care provider*. *Your primary care provider* 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 provider* within the *network*. *You* also have the right to change *your primary care provider* 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 *provider* is *your primary care provider*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network provider*, if *you* want more information about *your* treatment or would like to explore additional treatment options.
24. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help *your primary care provider* 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; or
    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 entire *contract*.
2. Treat all healthcare 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 provider* 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* ID card and keep scheduled appointments with *your provider*, and call the *provider*'s office during office hours whenever possible if *you* have a delay or cancellation.

6. Know the name of *your primary care provider*. *You* should establish a relationship with *your provider*. *You* may change *your primary care provider* verbally or in writing by contacting Member Services.
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* healthcare professionals and *providers* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* healthcare professionals and *providers* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* healthcare professionals and *provider*.
11. Tell *your* healthcare professional and *provider* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with *your primary care provider* 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 provider*.
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 the entity with which *you* enrolled.
15. Pay *your* monthly premiums on time and pay all *deductible amounts*, *copayment amounts*, or *coinsurance* at the time of service.
16. Inform the entity in which *you* enrolled for this *contract* if *you* have any changes to *your* name, address, or family members covered under this *contract* within 60 days from the date of the event.

Texas Department of Insurance Notice

1. A health maintenance organization (HMO) plan provides for services *you* receive from out-of-network *physicians* or *providers*, with specific exceptions as described in *your* evidence of coverage and below.
2. *You* have the right to an adequate *network* of *participating physicians* and *providers* (known as "*network physicians* and *providers*").
    a. If *you* believe that the *network* is inadequate, *you* may file a *complaint* with the Texas Department of Insurance at www.tdi.texas.gov/consumer.complfrm.html.
3. If *your* HMO *approves* a referral for out-of-network services because no *preferred provider* is available, or if *you* have received out-of-network *emergency care*, *your* HMO must, in most cases, resolve the *non-participating provider's* bill so that *you* only have to pay any applicable *coinsurance*, *copay*, and *deductible amounts*.
4. *You* may obtain a current directory of *participating providers* at the following website: Ambetter.SuperiorHealthPlan.com or by calling 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) for assistance in finding available *participating providers*. If *you* relied on materially inaccurate directory information, *you* may be entitled to have an out-of-network claim paid at the in-network level of benefits, if *you* present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before *you* received the service.

GENERAL PROVISIONS

Entire Contract
This *contract*, with the *Schedule of Benefits*, application, riders or amendments are the entire *contract* between *you* and *us*. No agent may:

1. Change this *contract* unless approved by an officer of Ambetter from Superior HealthPlan;
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, intentional misrepresentation of a material fact 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 Texas on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of Texas state law.

Conditions Prior To Legal Action
Legal Actions: An action at law or in equity may not be brought to recover on this *contract* before the 61st day after the date written *proof of loss* has been provided in accordance with the requirements of this *contract*. An action at law or in equity may not be brought after the expiration of three years after the time written *proof of loss* is required to be provided.

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.

Personal Health Information (PHI)
Your health information is personal. *We* are committed to do everything *we* can to protect it. *Your* privacy is also important to *us*. *We* have policies and procedures in place to protect *your* health records.

We protect all oral, written and electronic PHI. *We* follow Health Insurance Portability and Accountability Act (HIPAA) requirements and have a Notice of Privacy Practices. *We* are required to notify *you* about these practices every year. This notice describes how *your* medical information may be used and disclosed and how *you* can get access to this information. Please review it carefully. If *you* need more information or would like the complete notice, please visit https://Ambetter.SuperiorHealthPlan.com/privacy-practices.html or call Member Services at 1-877-687-1196 (Texas/TTY 1-800-735-2989).

We protect all of *your* PHI. *We* follow HIPAA to keep *your* healthcare information private.

Language
If *you* don't speak or understand the language in *your* area, *you* have the right to an interpreter. For language assistance, please visit: https://ambetter.SuperiorHealthPlan.com/language-assistance.html.

Time Limit on Certain Defenses:

(a) After the second anniversary of the date this *contract* is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the plan may not be used to void the *contract* or to deny a claim for loss incurred or disability (as defined in the *contract*) beginning after that anniversary.

(b) A claim for loss incurred or disability (as defined in the *contract*) beginning after the second anniversary of the date this *contract* is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the *effective date* of coverage of this *contract*.

Statement of Non-Discrimination

Ambetter from Superior HealthPlan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Superior HealthPlan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Superior HealthPlan:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- **Provides free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from Superior HealthPlan at 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989).

If you believe that Ambetter from Superior HealthPlan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint with:

Superior HealthPlan Complaints Department
5900 E Ben White Blvd., Austin, TX 78741
1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989)
Fax 1-866-683-5369

You can file a complaint by mail, fax, or email. If you need help filing a complaint, Ambetter from Superior HealthPlan is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Declaración de no discriminación

Ambetter de Superior HealthPlan cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. Ambetter de Superior HealthPlan no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Ambetter de Superior HealthPlan:

- **Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:**
  - Intérpretes calificados de lenguaje por señas
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- **Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:**
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Ambetter de Superior HealthPlan a 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989).

Si considera que Ambetter de Superior HealthPlan no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante:

Superior HealthPlan Complaints Department
5900 E Ben White Blvd., Austin, TX 78741
1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989)
Fax 1-866-683-5369

Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Ambetter de Superior HealthPlan está disponible para brindarle ayuda.

También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de queja están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

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Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Superior HealthPlan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Superior HealthPlan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Superior HealthPlan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Superior HealthPlan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) 로 전화하십시오.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Superior HealthPlan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Urdu:	اگر Ambetter from Superior HealthPlan کے بارے میں آپ، یا جن کی آپ مدد کررہے ہیں ان کے سوالات ہوں تو، آپ کو بلامعاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) پر کال کریں۔
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Superior HealthPlan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Superior HealthPlan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Superior HealthPlan के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) पर कॉल करें।
Persian:	اگر شما، یا کسي که به او کمک مي کنيد سؤالي در مورد Ambetter from Superior HealthPlan داريد، از اين حق برخورداريد که کمک و اطلاعات را بصورت رايگان به زبان خود دريافت کنيد. براي صحبت کردن با مترجم با شماره 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) تماس بگيريد.
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Superior HealthPlan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) an.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Superior HealthPlan વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) ઉપર કોલ કરો.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Superior HealthPlan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Japanese:	Ambetter from Superior HealthPlan について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) までお電話ください。
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Superior HealthPlan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

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