ambetter. FROM superior healthplan

2023 Major Medical Expense Policy

Ambetter + Adult Vision

Ambetter.SuperiorHealthPlan.com

29418TX016-2023

Notice: Premium may be increased upon the renewal date.

CELTIC INSURANCE COMPANY FOR AMBETTER FROM SUPERIOR HEALTHPLAN

Major Medical Expense Policy

THIS MAJOR MEDICAL EXPENSE POLICY (*CONTRACT*) IS ISSUED TO YOU, WHO HAVE ENROLLED IN

CELTIC INSURANCE COMPANY FOR 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.

Celtic Insurance Company
200 East Randolph Street
Suite 3600
Chicago, IL 60601
1-877-687-1196

IMPORTANT NOTICES:

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 POLICY 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: at 1-877-687-1196

Toll-free: 1-877-687-1196

Online: Ambetter.SuperiorHealthPlan.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 CO-CP, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Ambetter from Superior HealthPlan

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

HMO:

Llame a: al 1-877-687-1196

Teléfono gratuito: 1-877-687-1196
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 CO-CP, P.O. Box 12030, Austin, TX 78711-2030

Celtic Insurance Company

Major Medical Expense Policy

In this Major Medical Expense Policy (*contract*), the terms "you" or "your" will refer to the *enrollee* or any *dependent enrollees* enrolled in this *contract*. The terms "we," "our," or "us" will refer to Celtic Insurance Company 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 enrollment application and the timely payment of premiums, we will provide benefits to you, the *enrollee*, for covered health care services as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

Annually, we must file this product, the *cost share* and the rates associated with it for approval. Guaranteed renewable means that your *contract* 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; (2) we withdraw from the *service area*; or (3) there is fraud or an intentional material misrepresentation made by or with the knowledge of an *enrollee* in filing a claim for *covered services*.

Annually, we may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The *policy* plan, and age of *enrollees,* type and level of benefits, and place of *residence* on the premium due date are some of the factors used in determining your premium rates. We have the right to change premiums however, all premium rates charged will be guaranteed for a calendar year.

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 *contract* contains *prior authorization* requirements. 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.

Celtic Insurance Company

Kevin J. Counihan, President

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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 health care services we cover.
- The portion of your health care costs you will be required to pay.

This *contract*, with the enrollment application, the *Schedule of Benefits*, 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 health care 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.

Throughout this *contract,* you will also see references for Celtic Insurance Company and Ambetter from Superior HealthPlan. Both references are correct, as Ambetter from Superior HealthPlan operates under its legal entity, Celtic Insurance Company.

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 hard of hearing (Relay Texas/TTY 1-800-735-2989).

Your Provider Directory
A listing of *network providers* is available online at Ambetter.SuperiorHealthPlan.com. We have *network providers and hospitals* who have agreed to provide you with your health care 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 Identification Card
We will mail you an *enrollee* identification 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 *enrollee* identification card shows your name, *enrollee* identification 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 *enrollee* identification card. A temporary *enrollee* identification card can be downloaded from our secure member portal at Ambetter.SuperiorHealthPlan.com

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

Quality Improvement
We are committed to providing quality health care 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 health care, 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 health care services.
3. Providing programs and educational items about general health care and specific diseases.
4. Sending reminders to *enrollees* to get annual tests such as a physical examination, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the health care 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 ten 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 ten 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* are prohibited from *balance billing* health plan *enrollees* for:

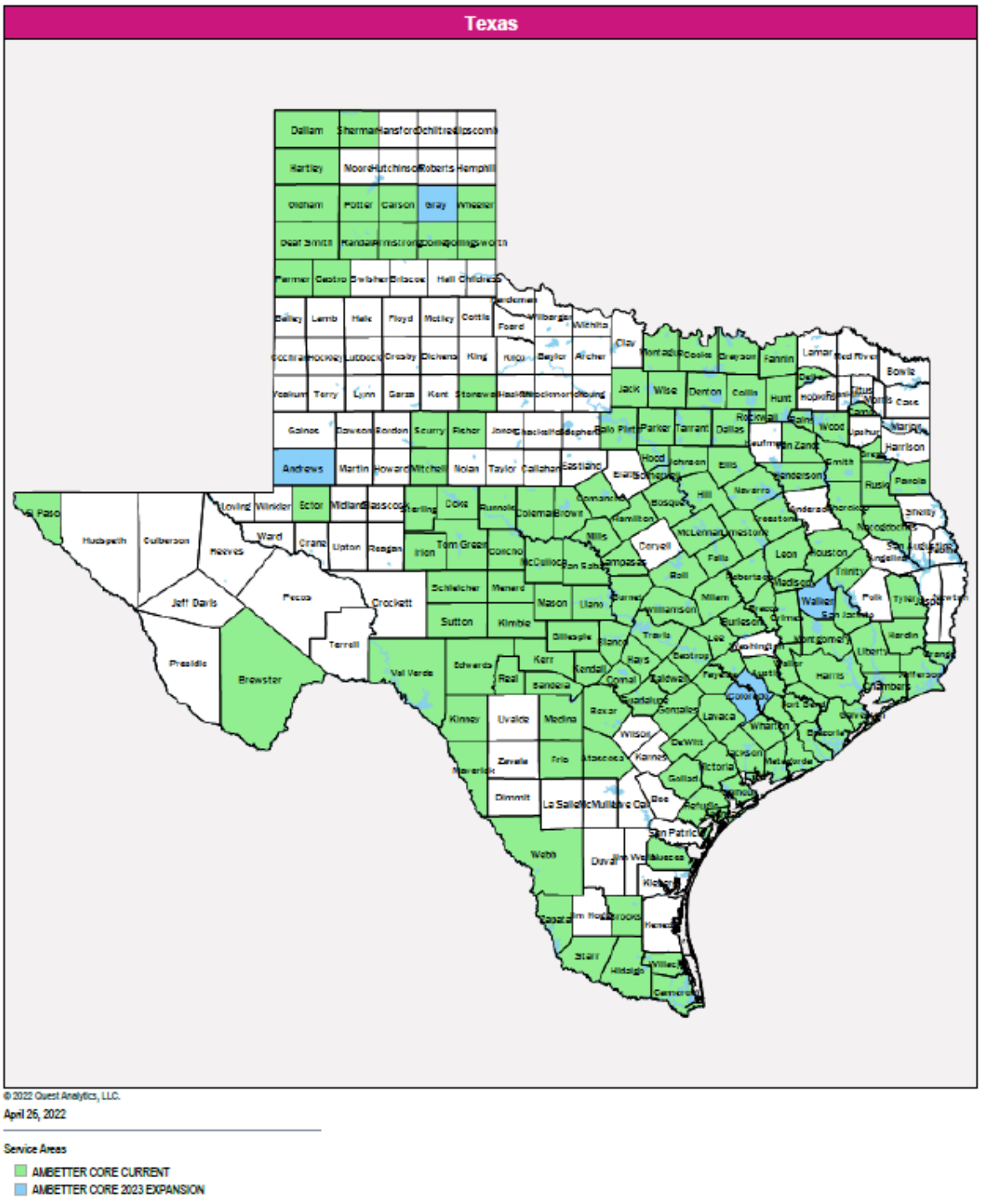
1. Emergency Services provided to an *enrollee*, regardless of plan participation; or
2. Non-emergency health care services provided to an *enrollee* at a *network hospital* or at a *network* health care *facility* if the *enrollee* did not give informed consent or *prior authorization* to be seen by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

Please review the Access to Care and Covered Healthcare Services and Supplies sections of this *contract* for detailed information.

SERVICE AREA MAP

Superior HealthPlan, Inc.

AMBETTER CORE EPO



April 26, 2022

Service Areas

- AMBETTER CORE CURRENT
- AMBETTER CORE 2023 EXPANSION

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.

Advance 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. *Advance premium tax credits* can be used right away to lower your monthly premium costs. If you qualify, you may choose how much *advance premium tax credit* to apply to your premiums each month, up to the maximum amount. If the amount of *advance premium tax credits* you receive for the year is less than the total premium tax credit you *are* due, you *will* get the difference as refundable credit when you file your federal income tax return. If the amount of *advance premium tax credits* for the year are more than the total tax credit that you *are* due, you must repay the excess *advance premium tax credit* with your tax return.

Adverse determination means any decision by us which results in:

1. A denial of a request for service.
2. A denial, reduction or failure to provide or make payment in whole or in part for a *covered service*.
3. A determination that an admission, continued stay, or other health care service does not meet our requirements for *medical necessity*, appropriateness, health care setting, or level of care or effectiveness.
4. A determination that a service is *experimental, investigational, cosmetic treatment,* not *medically necessary* or inappropriate.
5. Our decision to deny coverage based upon an eligibility determination.
6. A *rescission* of coverage determination as described in the General Provisions section of this *contract.*
7. A prospective review or retrospective review determination that denies, reduces or fails to provide or make payment, in whole or in part, for a *covered service*.

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

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 non-network care that is otherwise covered under your *contract* and that is provided by a *non-network provider* at a *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 *enrollee* identification 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 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 insurer 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 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 is a neurological and developmental disorder that begins early in childhood and lasts throughout a person's life. It is a condition related to brain development that impacts how a person perceives and socializes with others, causing problems in social interaction and communication. It may include intellectual impairment but not always. The disorder may include problems with the ability to recognize or share interests or emotional experiences, problems expressing or understanding verbal or non-verbal communication, and/or developing or maintaining relationships. Repetitive patterns of behavior or an inability to tolerate change is often seen.

Balance billing means a *non-network provider* billing you for the difference between the *provider's* charge for a service and the *eligible 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 *enrollee* identification card.

Behavioral health means both mental health and *substance use disorders*, 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 health care services included on a claim submitted by a *physician* or *provider*.

Care management means 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 health care 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 means a *hospital* that*:*

1. Specializes in a specific type or types of *medically necessary* 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 means the involvement of 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 amount means the percentage of *covered services* that you may be required to pay when you receive a *covered 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 Section 1301.055, 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 complications 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 means this *contract*, as issued and delivered to you. It includes the attached pages, the enrollment application, the *Schedule of Benefits*, and any amendments or riders.

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. Members of a federally recognized American Indian tribe and/or an Alaskan Native may qualify for additional cost sharing reductions.

Covered service or ***covered service expenses*** means health care 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, 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 their *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 primary *subscriber's* lawful *spouse,* domestic partner and/or an *eligible child*. Each *dependent enrollee* must either be named in the enrollment application or we must agree in writing to add them as a *dependent enrollee*.

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 primary *subscriber*, 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 foster child placed in your custody;
6. A child for whom legal guardianship has been awarded to you, your *spouse,* or domestic partner;
7. 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;
8. A child of an on-exchange *enrollee* who is not eligible for coverage under Medicare;
9. 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 enrollment application; or
10. A child whose coverage is required by a medical support order.

It is your responsibility to notify the entity with which you enrolled (either the Health Insurance 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*.

Eligible 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 expense* is the contracted fee with that *provider*.

2. For *non-network providers*, unless otherwise required by Federal or State law, the *eligible expense* is as follows:
    a. When a *covered emergency service* is received from a *non-network provider* within Texas, the *eligible 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 services* 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 *emergency* service is received from a non-*network provider* outside of Texas, the *eligible 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. *Enrollee* cost share will be calculated from the recognized amount based upon federal law. You should 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 *enrollee* identification card.
    c. When a *covered service* is received from a *non-network* professional *provider* who renders non-*emergency* services at a *network facility,* including but not limited to *diagnostic imaging* or laboratory testing services, the *eligible 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 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 should 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. *Enrollee 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 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 should 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 member identification card.
    e. 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 ten days prior to receiving care, you are responsible for the balance billed amount.

f. For all other *covered services* received from a *non-network provider* for which any needed *authorization* is received from us, the *eligible 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 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 services (medical and behavioral health) means health care 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 unborn child) 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 enrollment application; or
2. Whom we agree in writing to add as an *enrollee*.

Exclusive provider (network provider) is a health care *provider* or an organization of health care *providers* who contract or subcontract to provide health care services to covered *enrollees* under your *exclusive provider benefit plan*.

Exclusive provider benefit plan (EPO) is a type of health care plan offered by an issuer that arranges for or provides benefits to covered *enrollees* through a *network* of *exclusive providers*, and that limits or excludes benefits for services provided by out of *network providers*, except in cases of emergency or *approved* referral. Ambetter is an EPO.

Experimental or ***investigational*** is a health care 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* or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *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 disabled.

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

Generally accepted standards of medical practice means 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 health care 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 be performed in an inpatient or outpatient setting and include: physical therapy, occupational therapy, and speech therapy.

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 a *network physician*. We work 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 *PCP*. When an *enrollee* is admitted to an inpatient facility, a *physician* other than the *enrollee's PCP* 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*, domestic partner, *eligible child*, or siblings of an *enrollee*, 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 unit or area of a *hospital* that meets the required standards of the Joint Commission on Accreditation of Hospitals for special care units.

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

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 means the sum of the *deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount* and *coinsurance* of *covered services*, 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.

Mediation means a process in which an impartial mediator facilitates and promotes agreement between the insurer offering an *exclusive provider benefit plan* or the administrator and a *facility*-based *provider* or *emergency services provider* or the *provider's* representative to settle a health benefit claim of an *enrollee*.

Medically necessary means health care 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 provision under the Covered Health Care Services and Supplies section.

Mental health disorder means a condition that causes disturbance in behavior, emotion and cognition. These disorders can vary in impact, ranging from no impairment to mild, moderate or severe impairment. Depending on the severity, they may be accompanied by significant distress that affects an individual's work, school and social relationships. *Mental health disorder* benefits are defined as benefits for items or services for mental health conditions listed in ICD-10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79).

Minimum essential coverage means any health insurance plan that meets the Affordable Care Act (ACA) requirement(s) for health insurance coverage. Examples include, job-based plans, Health Insurance Marketplace ("Marketplace") plans, most individual plans sold outside of the Marketplace, Medicare, Medicaid, Children Health Insurance Program (CHIP), TRICARE, COBRA and plans sold through the Small Business Health Insurance Program (SHOP) Marketplace.

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 health care 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 health care services to our *enrollees* for an agreed upon fee. *Enrollees* will receive most, if not all, of their health care services by accessing the *network*.

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

Network provider means any licensed person or entity that has entered into a contract with Ambetter from Superior HealthPlan 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 means a medical practitioner, *provider facility*, or other *provider* that does not have a contract with us to provide medical care or health care to the *enrollee* through this *contract*. 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 health care services received at a *network facility*, as described in the Managing Your Health Care 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 means *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 us. 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.

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily *injury* or *illness* 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 FDA approved 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 physician 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 us. A *PCP* supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Prior authorization means a determination by us that the health care services proposed to be provided to an *enrollee* are *medically necessary* and appropriate. *Prior Authorization* process will conducted in accordance with Texas Insurance Code, Chapter 1301 and 4201, 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 health care *facility*.

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.

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,* cardiac 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 disabled.

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 therapy to help a person regain abilities that have been lost or impaired as a result of disease, injury or treatment. It is provided to optimize functioning and reduce disability in individuals. Types of rehabilitation therapy include: physical therapy, occupational therapy, speech therapy, cardiac therapy, respiratory therapy. It may occur in either an outpatient or inpatient setting.

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

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

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

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

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

Routine patient care costs means the costs of any *medically necessary* health care 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 health care 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 health care service that is specifically excluded from coverage under a health benefit plan.

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

Self-injectable drugs means *prescription drugs* that are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-injectable drugs* safely and effectively.

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: Andrews, Aransas, Armstrong, Atascosa, Austin, Bandera, Bastrop, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Brewster, Brooks, Brown, Burleson, Burnet, Caldwell, Calhoun, Cameron, Camp, Carson, Castro, Chambers, Cherokee, Coke, Coleman, Collin, Collingsworth, Colorado, Comal, Comanche, Concho, Cooke, Dallam, Dallas, Deaf Smith, Delta, Denton, DeWitt, Donley, Ector, Edwards, El Paso, Ellis, Falls, Fannin, Fayette, Fisher, Fort Bend, Freestone, Frio, Galveston, Gillespie, Goliad, Gonzales, Gray Grayson, Gregg, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hartley, Hays, Henderson, Hidalgo, Hill, Hood, Houston, Hunt, Irion, Jack, Jackson, Jefferson, Johnson, Kendall, Kerr, Kimble, Kinney, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Llano, Madison, Mason, Matagorda, Maverick. McCulloch, McLennan, Medina, Menard, Milam, Mills, Mitchell, Montague, Montgomery, Nacogdoches, Navarro, Nueces, Oldham, Orange, Palo Pinto, Panola, Parker, Parmer, Potter, Rains, Randall, Real, Refugio, Robertson, Rockwall, Runnels, Rusk, San Jacinto, San Saba, Schleicher, Scurry, Sherman, Smith, Somervell, Starr, Sterling, Stonewall, Sutton, Tarrant, Tom Green, Travis, Trinity, Tyler, Val Verde, Van Zandt, Victoria, Walker, Waller, Webb, Wharton, Wheeler, Willacy, Williamson, Wise, Wood, and Zapata. 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*.

Subscriber means the primary individual who applied for this insurance policy.

Substance use disorder means a disorder that affects a person's brain and behavior, leading to an inability to control his/her use of substances (e.g., alcohol, medications and legal or illegal drugs). Symptoms can range from moderate to severe, with addiction being the most severe form of a substance use disorder. *Substance use disorder* benefits are defined as benefits for items or services for substance use disorder conditions listed in ICD 10 Chapter 5 (F), except for subchapter 1 (F01-09) and subchapter 8 (F70-79).

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.

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 health care 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 health care service delivered by a dentist, or a health care 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 enrollment 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, health care services, procedures, or settings. Areas of review may include ambulatory review, *prior authorization*, 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;
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;
5. 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 last day of the month we receive a request from you to terminate this contract, or any later date stated in your request will be effective the last day of the requested month but no further than 60 days in advance;
6. The date a foster child is placed in your custody; or
7. The date a domestic partnership is established, pursuant to state law.

Effective Date for Initial Dependent Enrollees

Dependent enrollees included in the initial enrollment application for this *contract* will be covered on your *effective date*.

Coverage for a Newborn Child

An *eligible child* born to you or a covered 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 Health Insurance 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, we 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 policy and apply in writing, or directly at enroll.ambetterhealth.com, 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 *enrollee* identification card for the added *dependent enrollee*.

ONGOING ELIGIBILITY

For All Enrollees

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

1. The date that an *enrollee* 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 primary *enrollee* residing outside the *service area* or moving permanently outside the *service area* of this *contract*;
3. The date the *enrollee* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact;
4. 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;
5. The date we decline to renew this *contract*, as stated in the Discontinuance provision; or
6. The date of an *enrollee's* death.

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 health insurance 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 *contract*, and prior coverage terminating immediately before the *effective date* of this *contract* furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this *contract* 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 services* related to the *Inpatient* coverage after your *Effective Date*. Ambetter coverage requires you notify Ambetter within two 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, 2022 and extends through January 15, 2023. *Qualified individuals* who enroll on or before December 15, 2022 will have an *effective date* of coverage on January 1, 2023.

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

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

In general, a *qualified individual* has 60 days to report certain life changes, known as "qualifying events" to the Health Insurance Marketplace or by using Ambetter's *Enhanced Direct Enrollment* tool. *Qualified Individuals* may be granted a Special Enrollment Period where they may enroll in or change to a different Health Insurance Marketplace plan during the current plan year if they have a qualifying event. Qualifying events include:

1. A *qualified individual* or *dependent* experiences a loss of *minimum essential coverage*, non-calendar year group or individual health insurance coverage, *pregnancy*-related coverage, access to health care 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. 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 one or more days during the 60 days preceding the date of marriage;
3. A *qualified individual* or *dependent*, who was not previously a citizen, national, or lawfully present individual gains such status; or who is no longer incarcerated or whose incarceration is pending the disposition of charges;
4. A *qualified individual's* enrollment or non-enrollment in a plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or its instrumentalities as evaluated and are determined by the Health Insurance Marketplace;
5. An *enrollee* or *dependent* adequately demonstrates to the Health Insurance Marketplace that the plan in which he or she is enrolled substantially violated a material provision of its *contract* in relation to the *enrollee*;
6. A *qualified individual*, *enrollee*, or *dependent*, adequately demonstrates to the Health Insurance Marketplace that a material error related to plan benefits, *service area*, or premium influenced the *qualified individual's* or *enrollee's* decision to purchase the *QHP*;
7. An *enrollee* or *dependent* enrolled in the same plan is determined newly eligible or newly ineligible for *advance premium tax credits* or has a change in *eligibility* for *cost sharing reductions*;
8. A *qualified individual* or *dependent* who is enrolled in an eligible employer-sponsored plan is determined newly eligible for *advance premium tax credits* based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR §1.36B-2(c)(3);

9. A *qualified individual*, *enrollee*, or *dependent* gains access to new *QHPs* as a result of a permanent move, and had *minimum essential coverage* as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 days preceding the date of the permanent move;
10. A *qualified individual* or *dependent* who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a plan or change from one 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 Health and Human Services (HHS), that the individual meets other exceptional circumstances as the Health Insurance Marketplace may provide;
12. A *qualified individual*, *enrollee*, or *dependent* is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2, 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 applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;
14. A *qualified individual* newly gains access to an employer sponsored Individual Coverage Health Reimbursement Arrangement (ICHRA) (as defined in 45 CFR 146.123(b)) or a Qualified Small Employer Health Reimbursement Arrangement (QSHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code);
15. 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 plan through the Health Insurance Marketplace following termination of enrollment due to a failure to verify such status within the time period specified in 45 C.F.R. § 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; or
16. A *qualified individual* or dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions or government subsidies completely cease.
17. Subject to the availability of enhanced tax subsidies, a *qualified individual* or *enrollee*, or their *dependent* who is eligible for advance payments of the premium tax credit, and whose household income is expected to be no greater than 150 percent of the Federal poverty level.

To determine if you are eligible and apply for a Special Enrollment Period, please visit Healthcare.gov and search for "special enrollment period." The Health Insurance Marketplace is responsible for all health care eligibility and enrollment decisions for *enrollees* who enrolled via the Marketplace.

If you are currently enrolled in Ambetter from Superior HealthPlan, please contact Member Services at 1-877-687-1196 with any questions related to your health insurance coverage

Coverage Effective Dates for Special Enrollment Periods

Regular effective dates. Except as specified below, coverage will be effective on the first of the month following plan selection.

Special effective dates. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective for a *qualified individual* or *enrollee* on the date of birth, adoption, placement for adoption, or placement in foster care. In the case of marriage, or in the case where a *qualified individual* loses *minimum essential coverage*, coverage is effective on the first day of the following month.

In the case of erroneous enrollment, contract violation, or exceptional circumstances, coverage is effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by the Department of Health and Human Services. Such date must be either (i) the date of the event that triggered the special enrollment period or (ii) in accordance with the regular *effective dates*.

If a *qualified individual*, *enrollee*, or *dependent* loses coverage, gains access to a new *QHP*, becomes newly eligible for enrollment in a *QHP*, becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move, or is enrolled in COBRA continuation coverage and employer contributions to or government subsidies completely cease, and if the plan selection is made on or before the day of the triggering event the Health Insurance Marketplace must ensure that the coverage *effective date* is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, coverage is effective on the first day of the following month.

If a *qualified individual*, *enrollee*, or *dependent* newly gains access to an ICHRA or is newly provided a QSEHRA, and if the plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following plan selection.

1. If a *qualified individual*, *enrollee*, or *dependent* did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a qualifying event occurred, the Health Insurance Marketplace must allow the *qualified individual*, *enrollee*, or *dependent* to select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. And at the option of a *qualified individual*, *enrollee* or *dependent,* the Health Insurance Marketplace must provide the earliest effective that would have been available, based on the applicable qualifying event.

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 *advance 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 Health and Human Services (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 *advance premium tax credits* on behalf of the *enrollee* from the Department of the Treasury, and will return the *advance 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 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
We require each *enrollee* to pay his or her premiums and this is communicated on your monthly billing statements. Our 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 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;
5. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan; or
6. 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 premium remains due.

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 Special Enrollment Periods provision for more information.

Misstatement of Tobacco or Nicotine Use

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

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 health care 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 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*.

Deductibles
The benefits of this *contract* 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 expenses* before benefits are available under the *contract*.

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 in 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*.

Copayments
A *copayment* is typically a fixed dollar 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,* as shown in the *Schedule of Benefits,* are due at the time of service. 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*.

Coinsurance Stop-Loss Amount
Most of your *eligible expense* payment obligations, including *copayment amounts*, are considered *coinsurance* amounts and are applied to the *coinsurance* stop-loss amount maximum.
Your *coinsurance* stop-loss amount will **not** include:

1. Services, supplies, or charges limited or excluded by the *contract*;

2. Expenses not covered because a benefit maximum has been reached;
3. Any *eligible expenses* paid by the primary plan when Ambetter from Superior HealthPlan is the secondary plan for purposes of coordination of benefits;
4. Any *deductibles*;
5. Penalties applied for failure to receive *authorization*;
6. Any *copayment amounts* paid under the Pharmacy Benefits; or
7. Any remaining unpaid Medical/ Surgical Expense in excess of the benefits provided for covered drugs.

Individual Coinsurance Stop-Loss Amount
When the *coinsurance* amount for the *network* or *non-network* benefits level for an *enrollee* in a calendar year equals the "individual" "*coinsurance* stop-loss amount" shown on your *Schedule of Benefits* for that level, the benefit percentages automatically increase to 100 percent for purposes of determining the benefits available for additional *eligible expenses* incurred by that *enrollee* for the remainder of that calendar year for that level.

Family Coinsurance Stop-Loss Amount
When the *coinsurance* amount for the *network* or *non-network* benefits level for all *enrollees* under your coverage in a calendar year equals the "family" "*coinsurance* stop-loss amount" shown on your *Schedule of Benefits* for that level, the benefit percentages automatically increase to 100 percent for purposes of determining the benefits available for additional *eligible expenses* incurred by all family *enrollees* for the remainder of that calendar year for that level. No *enrollee* will be required to contribute more than the individual *coinsurance* amount to the family *coinsurance* stop-loss 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* insurance is in force under the *contract* if the charge for the service or supply qualifies as an *eligible expense*.

When the annual *maximum out-of-pocket amount* has been met, additional *covered service expenses* will be provided or payable at 100 percent 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 expenses*;
3. Any reduction for expenses incurred at a non-network provider.

Please refer to the applicable *deductible amount(s)*, *coinsurance amounts*, and *copayment amounts* on your *Schedule of Benefits*.

Non-Network Liability and Balance Billing
If you receive services from a *non-network provider*, you may have to pay more for services you receive. *Non-network providers* may be permitted to bill you for the difference between what we agreed to pay and the full amount charged for a service. This is known as balance billing. This amount is likely more than *network* costs for the same service and might not count toward your annual *maximum out-of-pocket amount* limit.

When receiving care at a *network* facility, it is possible that some hospital-based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with us as *network providers*. We encourage you to inquire about the providers who will be treating you before you begin your treatment, so that you can understand their network participation status with us.

As an *enrollee*, *non-network providers* should not bill you for *covered services* for any amount greater than your applicable *network cost sharing* responsibilities when:

1. You receive a covered *emergency service* or air ambulance service from a *non-network provider*. This includes services you may get after you are in stable condition, unless the *non-network provider* obtains your written consent.
2. You receive non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory services)) from a *non-network provider* at a *network hospital* or *network* ambulatory surgical facility.
3. You receive other non-emergency services from a *non-network provider* at a *network hospital* or *network* ambulatory surgical facility, unless the *non-network provider* obtains your written consent.

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 15th day of the month will become effective on the first day of the following month. Requests between the 16th 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*.

Health Savings Account (HSA)
A Health Savings Account (HSA) is a special tax-exempt custodial account or trust owned by a member where contributions to the account may be used to pay for current and future qualified medical expenses. Please refer to your Schedule of Benefits to see if the plan you are enrolled in has a HSA. For members enrolled in an HSA compatible plan, the following terms apply.

Individual members must satisfy federal HSA eligibility criteria in order to open and contribute to an HSA.

This *contract* is administered by and underwritten by Celtic Insurance Company for Ambetter from Superior Health Plan. Neither entity is an HSA trustee, HSA custodian or a designated administrator for HSAs. Celtic Insurance Company its designee and its affiliates, including Celtic Insurance Company for Ambetter from Superior Health Plan., do not provide tax, investment or legal advice to members.

MEMBERS ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERING HSA MAXIMUM ALLOWABLE AMOUNT, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, EACH MEMBER WITH AN HSA IS RESPONSIBLE FOR NOTIFYING HIS/HER HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THEIR HSA PLAN HAS BEEN CANCELED OR TERMINATED.

THE TERMS OF THIS CONTRACT ARE CONFINED TO THE BENEFITS PROVIDED HEREIN AND DO NOT ENCOMPASS ANY INDIVIDIUAL HSA FEE ARRANGEMENTS, ACCOUNT MAINTENANCE OR CONTRIBUTION

REQUIREMENTS, APPLICATION PROCEDURES, TERMS, CONDITIONS, WARRANTIES OR LIMITATIONS THERETO, GRIEVANCES OR CIVIL DISPUTES WITH ANY HSA CUSTODIAN OR TRUSTEE.

PLEASE CONSULT A PROFESSIONAL TAX ADVISOR FOR MORE INFORMATION ABOUT THE TAX IMPLICATIONS OF A HSA OR HSA PROGRAM.

MANAGING YOUR HEALTH CARE

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 *enrollee* 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 us 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 Ambetter state for non-emergency services. Contact Member Services at the phone number on your *enrollee* identification card for further information.

Emergency Services Outside of Service Area

We cover *emergency* 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. You do not need *prior authorization* for *emergency 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.

Preferred Partnership

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 Physician (PCP)

You may, but are not required to, select any *network PCP* who is accepting new patients from any of the following provider types:

1. Family practitioners
2. General practitioners
3. Internal medicine
4. Nurse practitioners*
5. Physician assistants
6. Obstetricians/gynecologists
7. Pediatricians (for children)

*If you choose a nurse practitioner as your *PCP*, your benefit coverage and *copayment amounts* are the same as they would be for services from other *network providers*. See your *Schedule of Benefits* for more information.

You may obtain a list of *network PCPs* at our website by using the "Find a Provider" function or by contacting our Member Services department. You should get to know your *PCP* and establish a healthy relationship with them. Your *PCP* will:

1. Provide preventive care and screenings
2. Conduct regular physical examinations as needed
3. Conduct regular immunizations as needed
4. Deliver timely service
5. Work with other doctors when you receive care somewhere else
6. Coordinate specialty care with *network specialists*
7. Provide any ongoing care you need
8. Update your medical record, which includes keeping track of all the care that you get from all of your *providers*
9. Treat all patients the same way with dignity and respect
10. Make sure you can contact him/her or another *provider* at all times
11. Discuss what advance directive are and file directives appropriately in your medical record

Your *network PCP* will be responsible for coordinating all covered health services with other *network providers*.

Contacting Your Primary Care Physician (PCP)

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 *enrollee* identification card and photo identification.

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 PCP* will assist you in coordinating all covered health services with other *network providers,* if necessary. Should *medically necessary* covered health care services not be available through *network providers*, upon the request of a *network PCP*, within the time appropriate to the circumstances relating to the delivery of the health care services and your condition, but in no event to exceed five business days after receipt of reasonably requested documentation, we shall allow a referral to a *non-network provider* and shall fully reimburse the *non-network provider* at the usual and customary rate or agreed rate.

Changing Your Primary Care Physician (PCP)
You may change your *network PCP* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at ambetter.superiorhealthplan.com, or by contacting Member Services at the number shown on your *enrollee* identification card. The change to your *network PCP* of record will be effective no later than 30 days from the date we receive your request.

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 *prior authorization* 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 five days prior to an elective admission as an *inpatient* in a *hospital*, *extended care* or *rehabilitation facility*, *hospice facility*, or residential treatment 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 five 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 three 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.

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 *enrollee* 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.

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 health care services, or has substantially failed to perform the proposed medical or health care 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*.

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 at a *network hospital* or other *facility*, it is possible that some *hospital* based providers (for example, assistant surgeons, hospitalists, and intensivists) may not be under contract with us as *network providers*. If appropriate notice is provided to and acknowledged by you before rendering services, you may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by us – this is known as "*balance billing*". 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 us. Any amount you are obligated to pay to the *non-network provider* in excess of the *eligible expense* will not apply to your *deductible amount* or *maximum out-of-pocket* .

You may not be *balance billed* for non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, 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*.

COVERED HEALTH CARE SERVICES AND SUPPLIES

We provide coverage for health care services for you and your covered dependents when received from *network providers*. Some services require *prior authorization*.

Essential health benefits are defined by federal and state law and refer to benefits in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and *substance use disorder* services, including *behavioral health* treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Essential health benefits provided within this *contract* are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime or annual dollar maximum.

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

The benefit percentages of your total eligible health care services shown on the *Schedule of Benefits* in excess of your *copayment amounts*, *coinsurance amounts*, and any applicable *deductibles* shown are our obligation. The remaining unpaid Medical/ Surgical Expense in excess of the *copayment amounts*, *coinsurance* amounts, and any *deductibles* is your obligation to pay.

To calculate your benefits, subtract any applicable *copayment amounts* and *deductibles* from your total eligible Medical/ Surgical Expense and then multiply the difference by the benefit percentage shown on your *Schedule of Benefits*. Most remaining unpaid health care services in excess of the *copayment amounts* and *deductible* is your *coinsurance* amount.

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, a skilled nursing 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;
3. Is medically stable; and
4. 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 with the expectation that with the provision of these services and support, the person can return to a community-based setting, rather than reside in a facility setting.

Ambulance Services

Covered service expenses will include ambulance services for ground and water 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*. Unless otherwise required by Federal or State law, if you receive services from non-network ambulance providers, you may be responsible for costs above the *allowed amount*.

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.
4. When an *enrollee* is required by us to move from a non-network provider to a network provider.

Air Ambulance Service Benefits

Covered services will include ambulance services for transportation by fixed wing and rotary wing ambulance from home, scene of accident, or medical emergency:

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 a skilled nursing, *rehabilitation facility,* and *enrollee's* home 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:** 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 *enrollee* 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.

Note: Non-emergency ambulance transportation requires *prior authorization*.

Exclusions:
No benefits will be paid for:
1. Expenses incurred for air ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-emergency 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. Air ambulance services provided for an *enrollee's* comfort or convenience.
5. Non-emergency transportation excluding ambulances.

Autism Spectrum Disorder Benefits

Generally recognized services prescribed in relation to *autism spectrum disorder* by the *enrollee's physician* or *Behavioral Health* Practitioner in a treatment plan recommended by that *physician* or *Behavioral Health* Practitioner.

Individuals providing treatment prescribed under that plan must be a health care practitioner:
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; or
3. who is certified as a *provider* under the TRICARE military health system.

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

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*.

No limitation exists within the benefits for *applied behavior analysis* services. These services are subject to *prior authorization* to determine *medical necessity*. **If multiple services are provided on the same day by different *providers*, a separate *copayment* and/or *coinsurance* will apply to each *provider***.

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

Mental Health and Substance Use Disorder Benefits

The coverage described below is designed 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.

Mental health services will be provided on an *inpatient* and outpatient basis and include 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 *behavioral health network provider*. *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* treatment of mental, emotional, or *substance use disorders* as defined in this *contract*.

When making coverage determinations, our mental health and *substance use* 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 Change Healthcare InterQual criteria for mental health and *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered *inpatient* and outpatient *mental health* and/or *substance use disorder* services are as follows:

Inpatient

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

Outpatient

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

In addition, Integrated Care Management is available for all of your health care needs, including *behavioral health* and substance use disorders. 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 your *Schedule of Benefits* for more information regarding services that require *prior authorization* and specific benefit limits, if any.

Chiropractic Services

Chiropractic services are covered when a network chiropractor finds that the services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered service expenses* are subject to all other terms and conditions of the *contract*, including the *deductible amount* and *cost sharing* provisions.

Dialysis Services

Medically necessary acute and chronic dialysis services are *covered services* 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 a *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 *network 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 a *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, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT) scan, Positron Emission Tomography (PET)/Single Photon Emission Computerized Tomography (SPECT), mammogram, ultrasound). *Prior authorization* may be required, see your *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 Room Services and Treatment of Accidental Injury

In an emergency situation (anything that could endanger your life (or your unborn child'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, seven days a week. 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 services* or treatment of an accidental *injury* and recommend that care. If not reasonably possible, go to the nearest emergency *facility*, whether or not the *facility* is in the *network*.

Whether you require hospitalization or not, you should notify your *network provider* 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*.

Please note some *providers* that treat you within the emergency room may not be contracted with us. If that is that case, they may not balance bill you for the difference between our *allowed amount* and their *billed amount*.

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*.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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

1. *Covered service expenses* available to an *enrollee* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision.
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must 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 United States 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 your *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

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 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*.

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*, personal attendant services or educational care.

Hospice Care Benefits

This provision only applies to a *terminally ill enrollee* receiving *medically necessary* care under a *hospice care program* or in a home setting. *Respite care* is only for services related to *hospice* care in home and *inpatient* locations, and is subject to all forms of *cost sharing*. *Respite care* allows temporary relief to family members from the duties of caring for an *enrollee* who is undergoing *hospice care*. Respite days that are applied toward the *enrollee's cost share* obligations are considered benefits provided and shall apply against any maximum benefit limit for these services.
Covered service expenses 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. In home dialysis (except when End State Renal Disease (ESRD) is the terminal condition.)
8. Counseling the *enrollee* regarding his or her terminal *illness*.
9. *Terminal illness counseling* of the *enrollee's immediate family*.
10. 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.

Hospital Benefits

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. A private hospital room when needed for isolation.
3. Daily room and board and nursing services while confined in an *intensive care unit*.
4. *Inpatient* use of an operating, treatment, or recovery room.
5. Outpatient use of an operating, treatment, or recovery room for *surgery.*
6. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatient.*
7. Emergency treatment of an *injury* or *illness*, even if confinement is not required. See your *Schedule of Benefits* for limitations.

Long Term Acute Care

Long-term acute care hospitals (LTACHs) furnish extended medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods.

Common conditions/services that may be considered medically necessary for LTACH level of care included, but are not limited to:

- Complex wound care:
  - Daily physician monitoring of wound
  - Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue
  - Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
  - Lower extremity wound with severe ischemia
  - Skin flaps and grafts requiring frequent monitoring
- Infectious disease:
  - Parenteral anti-infective agent(s) with adjustments in dose
  - Intensive sepsis management
  - Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis,
  - peritonitis, meningitis/encephalitis, abscess and wound infections
- Medical complexity:
  - Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
  - Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease

• Rehabilitation:
    - Care needs cannot be met in a rehabilitation or skilled nursing facility
    - Patient has a comorbidity requiring acute care
    - Patient is able to participate in a goal-oriented rehabilitation plan of care
    - Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic surgery
    - Mechanical ventilator support:
    - Failed weaning attempts at an acute care facility
    - Patient has received mechanical ventilation for 21 consecutive days for 6 hours or more/day
    - Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
    - Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
    - Patient is hemodynamically stable and not dependent on vasopressors
    - Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60% or less with O2 saturation at least 90%
    - Common conditions include complications of acute lung injury, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders

Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

Infertility

Infertility treatment is a *covered service expense* when medical services are provided to the *enrollee* which are *medically necessary* for the diagnosis of infertility such as diagnostic laparoscopy, endometrial biopsy and semen analysis. Benefits are included to treat the underlying medical conditions that cause infertility (such as endometriosis, obstructed fallopian tubes and hormone deficiency). 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.

Lymphedema

Treatment of lymphedema is covered when rendered or prescribed by a licensed *physician* or received in a *hospital* or other public or private facility authorized to provide lymphedema treatment. Coverage includes multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

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. 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 *illness* as shown on your *Schedule of Benefits*.
12. *Reconstructive surgery* - The following *eligible expenses* described below for *reconstructive surgery* will be the same as for treatment of any other *illness* 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.
13. Mastectomy or Lymph Node Dissection
    Minimum *inpatient* stay: If due to treatment of breast cancer, any person covered by this *contract* has either a mastectomy or a lymph node dissection, this *contract* will provide coverage for *inpatient* care for a minimum of:
    a. 48 hours following a mastectomy, and
    b. 24 hours following a lymph node dissection.

    The minimum number of *inpatient* hours is not required if the covered *enrollee* receiving the treatment and the attending *provider* determine that a shorter period of *inpatient* care is appropriate.
14. Diabetic equipment and supplies that are *medically necessary* and prescribed by a *provider*.
15. Tissue transplants.
16. 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.
17. Genetic blood tests that are *medically necessary*.
18. Immunizations to prevent Respiratory Syncytial Virus (RSV) that are *medically necessary*.
19. Rental of Continuous Passive Motion (CPM) machine; one per *enrollee* following a covered joint *surgery*.
20. One pair of eyeglasses or contact lenses per *enrollee* following a covered cataract *surgery*.
21. 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 your *Schedule of Benefits* for benefit levels or additional limits.
22. Coverage for *medically necessary* bone mass measurement and for diagnosis and treatment of osteoporosis.
23. *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 *enrollee* in

person. *Telehealth Services* provided by *Ambetter Telehealth* Vendors are subject to $0 *copay*. *Telehealth Services* not provided by *Ambetter Telehealth* Vendors would be subject to the same *cost sharing* as the same health care services when delivered to an insured 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 *contract* is HSA-eligible.

24. For respiratory and pulmonary therapy.
25. Family planning for certain professional provider contraceptive services and supplies, including but not limited to vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.
26. Testing of pregnant women and other *enrollees* for lead poisoning.
27. For pulse oximetry screening on a newborn.
28. Allergy testing, injections and serum.
29. For children's early intervention therapy for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age with an identified developmental disability and/or delay;
30. *Medically necessary* routine footcare; *prior authorization* may be required.
31. *Medically necessary* nutritional counseling; *prior authorization* may be required.

Diabetic Care

Benefits are available for *medically necessary* services and supplies used in the treatment of persons with gestational, type I or type II diabetes.

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 health care practitioner;
17. Eye examination and one retinopathy examination screening per year;
18. Glucometers; and
19. Nutritional counseling.

Durable Medical Equipment, Prosthetics, and Orthotic Devices

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 allowed amount for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the maximum allowed 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. We 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.

Medical and Surgical Supplies

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*.
6. Disposable medical supplies, which have a primary medical purpose, are covered and are subject to reasonable quantity limits as determined by us. Examples include, but are not limited to: bandages & wraps, gloves, suction catheters, surgical sponges, hypodermic needles, syringes, and applicators. The supplies are subject to the *enrollee's deductible, copayment,* and/or *coinsurance amounts*.

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 Care Expense Benefits provision).
6. Med-injectors.
7. Items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Orthotic and Prosthetic Devices

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 Assist 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 (not to exceed one per benefit period), when purchased through a *network provider*. This coverage is only provided for *enrollees* who suffer from hair loss as a result of an underlying medical condition, treatment or *injury*. Coverage shall be subject to a written recommendation by the treating *physician* stating that the wig is *medically necessary*.

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).

<u>Orthotic Devices</u>
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. We cover *medically necessary* corrective footwear. *Prior authorization* may be required.

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.

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. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.
2. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under the Medical Supplies provision above).
3. Garter belts or similar devices.
4. 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 cesarean delivery. We do not require that a *physician* or other health care *provider* obtain *prior authorization* for the delivery. However, an *inpatient* stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require notification to us.

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

1. Outpatient and *inpatient* pre- and post-partum care including examinations, 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. 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* to:

1. give birth to a child in a *hospital* or other health care *facility*; or
2. remain under *inpatient* care in a *hospital* or other health care *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 *contract* 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 section, as limitations may exist.

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*, *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).

Other Dental Services

Anesthesia and *hospital* charges for dental care, for an *enrollee* less than 19 years of age or an *enrollee* who is physically or mentally disabled, are covered if the *enrollee* requires dental treatment to be given in a *hospital* or outpatient ambulatory surgical facility. The indications for general anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the *enrollee's* condition under general anesthesia.

Coverage is also provided for:
1. For medically necessary oral surgery, including the following:
    a. Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
    b. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw bone and is medically necessary to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental injuries.
    d. Treatment for Temporomandibular Joint Disorder (TMJ), including removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services.

e. Treatment of non-dental lesions, such as removal of tumors and biopsies.
f. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
g. Surgical procedures that are medically necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
h. Reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance.

2. Dental anesthesia charges include coverage for the administration of general anesthesia and hospital or office charges for dental care, rendered by a dentist, regardless of whether the services are provided in a participating hospital, surgical center or office, provided to the following *enrollees*:
   a. An *enrollee* under the age of 19;
   b. a person who is severely disabled; or
   c. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
3. For dental service expenses when an *enrollee* suffers an injury, that results in:
   a. Damage to his or her natural teeth;
   b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a health care professional and began within 12 months of the accident to be considered as a covered service; and
   c. Injury to the natural teeth will not include any injury as a result of chewing.
4. For surgery, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.

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 Provider Directory. If an *enrollee* chooses a *network provider*, he or she will only be responsible for the applicable copayment amount 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 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

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 United States 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 United States Food and Drug Administration; and
    h. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
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 in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; 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.
3. For any other use of a drug approved by the FDA when the drug has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided such drug is recognized for treatment of such indication in one of the standard reference compendia or in the medical literature as recommended by current American Medical Association (AMA) policies. Any coverage of a drug required shall also include medically necessary services associated with the administration of the drug. This benefit shall not be construed to require:
    a. Coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
    b. Coverage for experimental or investigational drugs not approved for any indication by the FDA; and
    c. Reimbursement or coverage for any drug not included on the drug formulary or list of covered drugs specified in this policy.
4. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) standard reference compendium; or
    b. Recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
5. Prescribed, oral anticancer medication.

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. The total amount you will be required to pay for a covered insulin drug will not exceed any state and/or federally mandated limits.

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 United States 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.

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 Members", "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 our formulary for a medical condition or mental *illness*, regardless of whether the drug has been removed from our drug formulary, at the contracted benefit level until the *contract* 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.

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 order* must meet all legal requirements.

How to Fill a Prescription
*Prescription order*s can be filled at a *network* retail pharmacy or through our mail order pharmacy.

If you decide to have your *prescription order* filled at a *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 order* and your *enrollee* identification card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from *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 or 1-800-552-6694. 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."

Self-injectable Drugs
Self-injectable drugs are delivered into a muscle or under the skin with a syringe and needle. Although medical supervision or instruction may be needed in the beginning, the patient or caregiver can administer *self-injectable drugs* safely and effectively. *Self-injectable drugs* are covered under the prescription drug benefits; prescription drug cost share applies.

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 the 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 " Prescription Drug Exception Process" below for additional details.

Non-Formulary Prescription Drugs:
Under the Affordable Care Act, you have the right to request coverage of *prescription drugs* that are not listed on our 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 fifth 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 authorized representative* or an *enrollee's* prescribing *provider* may request a standard review of a decision that a drug is not covered by this *contract*. 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 authorized representative* 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 authorized representative* 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 authorized representative* 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 authorized representative* 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 authorized representative* 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 provision 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 otherwise not required by the Affordable Care Act.
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 listed on the formulary.
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*. Ambetter permits pharmacies to dispense at mail order discounted *cost sharing* should they request to join our mail order network and accept all terms and conditions. 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's Pharmacy and Therapy committee 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 related to *surrogate pregnancy*.
20. 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.
21. 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.
22. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
23. Medication refills where an *enrollee* has more than 15 days' supply of medication on hand.
24. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.

Lock-in program
To help improve *enrollee* safety, 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 provision 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. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein. Such coverage shall be provided when the prescribing *physician* has issued a written order stating that the enteral formula or food product is *medically necessary*.

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 services are covered as required by the Affordable Care Act (ACA). According to the ACA, preventive care services must include the following:

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 (USPSTF).
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA.

Preventive care benefits obtained from a network provider are covered without *enrollee* cost share (i.e., covered in full without deductible, coinsurance or copayment). For current information regarding available preventive care benefits, please access the Federal Government's website at: www.healthcare.gov/coverage/preventive-care-benefits/ .

Preventive care refers to services or measures taken to promote health and early detection or prevention of diseases and injuries, rather than treating or curing them. Preventive care includes, but is not limited to, immunizations, medications, tobacco cessation treatment, examinations and screening tests tailored to an individual's age, health and family history.

Certain services can be performed for preventive or diagnostic reasons (e.g., mammograms). If a service is deemed preventive care and is appropriately reported/billed, it will be covered under the preventive care services benefit. However, when a service is performed for diagnostic purposes and reported/billed accordingly, it will be considered a non-preventive medical benefit and appropriate cost share will apply. Note: If preventive and diagnostic services are performed during the same visit, applicable cost share will be taken for the latter.

As new preventive care recommendations and guidelines are issued (by the USPSTF, CDC or HRSA), those services will become covered preventive care benefits. According to the ACA, coverage of new recommendations and guidelines become effective upon a plan's start or anniversary date that is one year after the date the recommendation or guideline is issued.

Note: In addition to providing coverage in accordance with the ACA, we also provide preventive care benefits in accordance with applicable State law.

Notification

As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 days advance notice to you before any material modification will become effective, including any changes to preventive benefits covered under this contract. You may access our website or the Member Services Department at 1-877-687-1196 to get the answers to many of your frequently asked questions regarding preventive services. Our website has resources and features that make it easy to get quality care. Our website can be accessed at ambetter.superiorhealthplan.com.

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;
13. Well-woman visits; and
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. Colorectal cancer tests for any non-symptomatic covered person, in accordance with the current American Cancer Society guidelines. Covered services include tests for covered persons, starting at age 45 (note: screening should start before age 45 for high risk).

Benefits for Routine Examinations and Immunizations
Benefits for routine examinations 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, 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.

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* is 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 digital rectal examination 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 50 years of age; and at least once annually for a covered *enrollee* who is less than 50 years of age and who is at high risk for prostate cancer according to the most recently published guidelines of the American Cancer Society.

Benefits for Early Detection Tests for Cardiovascular Disease

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

1. Computed tomography (CT) scanning measuring coronary artery calcifications; or

2. Ultrasonography measuring carotid intima-media thickness and plaque.

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

Benefits for Screening Tests for Hearing Impairment
Benefits are available for *eligible expenses* incurred by a covered Dependent child:

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

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

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*.

Medical Vision Services

Covered services include:

- Vision screenings to diagnose and treat a suspected disease or *injury* of the eye.
- Vision screenings to determine the presence of refractive error.
- *Enrollees* who have been diagnosed with diabetes may self-refer once each year to an eye care *specialist*, for the purpose of receiving an eye examination for the detection of eye disease. Continued, or follow-up care from the eye care *specialist* may require a referral through your *PCP*.

Vision Services under the medical portion of your *health plan* do not include:

- Referrals to a *specialist* for evaluation and diagnosis of refractive error, including presbyopia, for *enrollees* over the age of 19 years.
- Eye examinations required by an employer or as a condition of employment.
- Radial keratotomy, LASIK, and other refractive eye surgery.
- Services or materials provided as a result of any workers' compensation law or required by any governmental agency.
- Orthoptics, vision training, or subnormal vision aids.

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 Benefits

Covered services for transplant service expenses:

Transplants are a *covered service* when an *enrollee* is accepted as a transplant candidate and obtain *prior authorization* 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 insurer 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.
4. If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a *covered service*.

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 Assist 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. Also included is the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for

utilization in bone marrow transplantation. Coverage is limited to a maximum cost of $75 per transplant.

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 *network 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, and mileage. Please refer to the Member Transplant Travel Reimbursement Policy for outlined details on reimbursement limitations at https://ambetter.superiorhealthplan.com/resources/handbooks-forms.html.

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 six 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 https://ambetter.superiorhealthplan.com/resources/handbooks-forms.html.

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 (FDA) regulation, regardless of whether the trial is subject to FDA 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*

11. 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

At least 60 days prior to making 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, *we* must, to the extent possible, notify the prescribing *physician* and the patient, or the parent or guardian if the patient is a child, or the *spouse* of a patient who is *authorized* to consent to the treatment of the patient. 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.

Urgent Care

Benefits for *eligible expenses* for urgent care will be determined as shown on your *Schedule of Benefits*. A *copayment amount*, in the amount indicated on your *Schedule of Benefits*, will be required for each urgent care visit. Urgent care means the delivery of medical care in a *facility* dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a *hospital* emergency room/treatment room department or *provider's* office. The necessary medical care is for a condition that is not life-threatening.

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

Coverage for vision services is provided for adults, age 19 and older.

1. Routine ophthalmological examination
    a. Refraction;
    b. Dilation;
    c. Contact lens fitting.
2. Frames
3. Prescription lenses
    a. Single;
    b. Bifocal;
    c. Trifocal;
    d. Lenticular; or
    e. Contact lenses (in lieu of glasses).

Please refer to *your Schedule of Benefits* for a detailed list of *enrollee cost sharing*, annual maximum and appropriate service limitations. To see which vision *providers* are part of the network, please visit ambetter.superiorhealthplan.com or call Member Services.

Services not covered:

1. Visual therapy;
2. Low vision services and hardware for adults; and
3. LASIK surgery.

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. 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 can earn rewards for focusing on their total health. The "My Health Pays" *enrollee* rewards program may offer rewards when *enrollees* 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 health care 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 *PCP (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 by a member of the 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 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*.
2. For any portion of the charges that are in excess of the *eligible 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 between providers, 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.*
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 examinations 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 would otherwise be 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 are *medically necessary* and 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 eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
20. 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.
21. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.
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. For fetal reduction *surgery*.
24. 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.

25. 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).
26. 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.
27. As a result of any *injury* sustained while at a *residential treatment facility*.
28. For the following miscellaneous items (except where required by federal or state law): in vitro fertilization, Artificial Insemination (except when required by federal or state law), 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; *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*.
29. Services of a private duty registered nurse rendered on an outpatient basis.
30. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
31. For any medicinal and recreational use of cannabis or marijuana.
32. 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.
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 insureds possessing an active *contract* with us and/ or the child possesses an active *contract* with us at the time of birth.

34. For all health care services obtained at an *urgent care center* that is a *non-network provider*.
35. For expenses, services, and treatments from a naprapathic specialists for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
36. For expenses, services, and treatments from a naturopathic specialists for treatment of prevention, self-healing and use of natural therapies.
37. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a hospice care program.
38. Dry needling.

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 dependent *enrollee* reaching the limiting age of 26, coverage under this *contract* will terminate at 11:59 p.m. on the last day of the year in which the dependent *enrollee* reaches the limiting age of turns 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 disabilities 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 providing written notice to the entity in which you enrolled. 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 *contract*. 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.

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 Celtic 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*. Celtic'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 Celtic'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. Celtic may proceed against any party with or without the *enrollee's* consent.

By accepting benefits under this plan, the *enrollee* also specifically acknowledges Celtic'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, Celtic 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. Celtic's right of reimbursement is cumulative with and not exclusive of the plan's subrogation right and Celtic 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 health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. 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 health care benefits to which the COB provision applies and which may be reduced because of the benefits of *other plans*. Any other part of the *contract* providing health care benefits is separate from this plan. A *contract* may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any *other plan* without considering any *other plan's* benefits. When this plan is secondary, it determines its benefits after those of another plan and

may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(b) "Allowable expense" is a health care expense, including *deductibles*, *coinsurance*, and *copayments,* that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care *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 health care *provider* or *physician* has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care *provider's* or *physician's* contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a 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 health care *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-network 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 health care benefits to covered *enrollees* primarily in the form of services through a panel of health care *providers* and *physicians* that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care *providers* and *physicians*, except in cases of emergency or referral by a panel member.

(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 non-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 health care *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 health care expenses or health care 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 health care expenses or health care 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 health care expenses or health care 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 health care expenses or health care coverage, the order of benefits for the child are as follows:

(I) the plan covering the custodial parent;

(II) the plan covering the *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 health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, 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 health care 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 health care 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.

Proof of Loss
We must receive written *proof of loss* within 90 days of the *loss* or as soon as reasonably possible. *Proof of loss* furnished more than one year late will not be accepted, unless you or your *covered dependent enrollee* had no legal capacity to submit such *proof* during that year.

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 a copy of the member reimbursement claim form posted at Ambetter.SuperiorHealthPlan.com under "Member Resources". Send all the documentation 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 five 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 insurer, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the insurer 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 *contract* as to *proof of loss* on submitting, within the time fixed in the *contract* for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

Proof of Loss
For a claim for loss for which this *contract* provides any periodic payment contingent on continuing loss, a written *proof of loss* must be provided to the insurer at the insurer's designated office before the 91st day after the termination of the period for which the insurer is liable. For a claim for any other loss, a written *proof of loss* must be provided to the insurer at the insurer's designated office before the 91st day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the date *proof of loss* is otherwise required, except in the event of a legal incapacity.

Time of Payment of Claims
Indemnities payable under this *contract* for any loss, other than a loss for which this *contract* provides any periodic payment, will be paid immediately on receipt of due written proof of the loss. Subject to due written *proof of loss*, all accrued indemnities for a loss for which this *contract* provides periodic payment will be paid monthly and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written *proof of loss*.

Payment of Claims
Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this *contract* and effective at the time of payment. If such a designation or provision is not then effective, the indemnity will be payable to the *enrollee's* estate. Any other accrued indemnities unpaid at the *enrollee's* death may, at the option of the insurer, be paid either in accordance with the beneficiary designation or to the *enrollee's* estate. All other indemnities will be payable to the *enrollee*.

All benefits payable under this *contract* on behalf of a *dependent enrollee* who is insured by this *contract* for which benefits for financial and medical assistance are being provided by Texas Health and Human Services, shall be paid to said department whenever:

1. Texas Health and Human Services is paying benefits under the Human Resources Code, Chapter 31 or Chapter 32, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code;
2. The parent who purchased the individual *contract* has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
3. The insurer or group nonprofit *hospital* service company must receive at its home office, written notice affixed to the insurance claim when the claim is first submitted, and the notice must state that all benefits paid pursuant to this section must be paid directly to Texas Health and Human

Services.

Foreign Claims Incurred for Emergency Care
Medical *emergency services* is a *covered service* while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no benefit coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.

Claims incurred outside of the United States for *emergency services* and treatment of an *enrollee* must be submitted in English or with an English translation, at the *enrollee's* expense within 180 calendar days from the date of service. Foreign claims must also include the applicable medical records in English or with an English translation, at the *enrollee's* expense to show proper *proof of loss* and evidence of payment(s) to the *provider*.

Foreign claims must be submitted with the Member Reimbursement Medical Claim Form, along with all requested documents as detailed on the claim form. All forms and member resources are available at Ambetter.SuperiorHealthPlan.com.

The amount of reimbursement will be based on the following:

- Member's benefit plan and member eligibility on date of service
- Member's responsibility/share of cost based on date of service.
- Currency rate at the time of completed transaction, Foreign Country currency to United States currency.

Once we have reviewed all the necessary documentation and the *emergency* claim has been processed, an *enrollee's* Explanation of Benefits (EOB) will be mailed. The EOB will identify member responsibility according to the member benefit plan at the time of travel. If services are deemed as a true medical *emergency*, *enrollee* will be issued reimbursement payment for any eligible incurred costs, minus member cost share obligation.

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 health care *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 health care *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 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 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 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 business days.

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

Complaint Appeals

1. If the *complaint* is not resolved to your satisfaction, you have the right either to appear in person before a complaint appeal panel where you normally receive health care services, unless another site is agreed to by you, or to address a written *appeal* to the complaint appeal panel. We shall complete the *appeals* process not later than the 30th calendar day after the date of the receipt of the request for *appeal*.
2. We shall send an acknowledgment letter to you not later the fifth 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 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 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 health care 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 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 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*. If additional time is needed due to matters beyond our control, you or your designated representative will be notified before the 30th calendar day with specific reasons why the additional time is needed and the additional time will be no greater than 15 calendar days.

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 working day after the request is received.

You can also request an expedited *appeal* for an urgent care denial. We will answer your *appeal* for urgent care within one working day or 72 hours, whichever is lesser, upon receipt 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 services*, 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 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 our benefit determination on review, shall be transmitted between us 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 MC CO-CP, P.O. Box 12030, Austin, TX 78711-2030
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 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.

Appeal and Grievance Filing and Key Communication Timelines

	Timely Filing	Acknowledgment	Resolution	Allowable Extension
Standard Grievance	180 Calendar Days	5 Business Days	30 Calendar Days	30 Calendar Days
Expedited Grievance	180 Calendar Days	N/A	72 Hours	N/A
Standard Pre-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	N/A
Expedited Pre-Service Appeal	180 Calendar Days	N/A	72 Hours	N/A
Standard Post-Service Appeal	180 Calendar Days	5 Business Days	30 Calendar Days	30 Calendar Days
External Review	4 Months	N/A	15 Calendar Days	N/A
Expedited External Review	4 Months	N/A	72 Hours	N/A

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 health care 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 health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized 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 *physicians*, medical practitioners, *hospitals*, other facilities 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 *PCP* about what might be wrong (to the level known), treatment and any known likely results. Your *PCP* can tell you about treatments that may or may not be covered by this *contract*, 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 representative*. Your *provider* will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
8. Voice *complaints* about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
9. File an *appeal* if you disagree with certain decisions we have made.
10. See your medical records.
11. 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.

12. A current list of *network providers*. You can also get information on your *network providers*' education, training, and practice.
13. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
14. Adequate access to qualified medical practitioners and treatment or services regardless of age, ethnicity, race, religion, gender, sexual orientation, national origin, physical or mental disability, or expected health or genetic status.
15. Access *medically necessary* urgent and emergency services 24 hours a day and seven days a week.
16. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.
17. Refuse treatment to the extent the law allows without jeopardizing future treatment, and be informed by your provider(s) of the medical consequences. You are responsible for your actions if treatment is refused or if the *PCP's* instructions are not followed. You should discuss all concerns about treatment with your *primary care physician*. Your *PCP* can discuss different treatment plans with you, if there is more than one option that may help you. You will make the final decision.
18. Select your *primary care physician* within the *network*. You also have the right to change your *PCP* or request information on *network providers* close to your home or work.
19. Know the name and job title of people giving you care. You also have the right to know which *provider* is your *PCP*.
20. An interpreter when you do not speak or understand the language of the area.
21. A second opinion by a *network provider*, if you want more information about your treatment or would like to explore additional treatment options.
22. Make advance directives for health care 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 *PCP* 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. *Enrollees* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. "Do Not Resuscitate" Orders.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illnesses*, hospitalizations, medications, and other matters about your health that we or your medical practitioners need in order to provide care. 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 *enrollee* identification 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 *PCP*. You should establish a relationship with your *provider*. You may change your *PCP* 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. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and *provider*.
10. Tell your health care professional and *provider* if you do not understand your treatment plan or what is expected of you. You should work with your *PCP* 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.
11. Follow all *contract* guidelines, provisions, policies and procedures.
12. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your *PCP*.
13. 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.
14. Pay your monthly premium, *deductible amount*, *copayment amounts*, and *coinsurance amounts* on time.
15. 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. An *exclusive provider benefit plan* provides no benefits for services you receive from *non-network providers*, with specific exceptions as described in your *contract* and below.
2. You have the right to an adequate *network* of *network providers*.
    a. If you believe that the *network* is inadequate, you may file a *complaint* with the Texas Department of Insurance.
3. If your insurer *approves* a referral for *non-network* services because no *network provider* is available, or if you have received *non-network emergency services*, your insurer must, in most cases, resolve the *non-network 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 *network 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 *network providers*. If you relied on materially inaccurate directory information, you may be entitled to have a *non-network* claim paid at the *network* level of benefits.

GENERAL PROVISIONS

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

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

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

Rescissions
No misrepresentation of fact made regarding an *enrollee* during the enrollment 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 enrollment application, including amendments, signed by an *enrollee*;
2. A copy of the enrollment 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 (Relay Texas/TTY 1-800-735-2989).

We protect all of your PHI. We follow HIPAA to keep your health care 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 enrollment application for the *contract* 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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