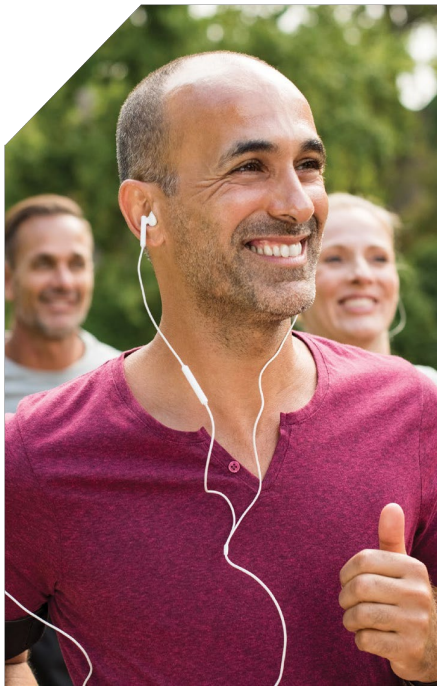
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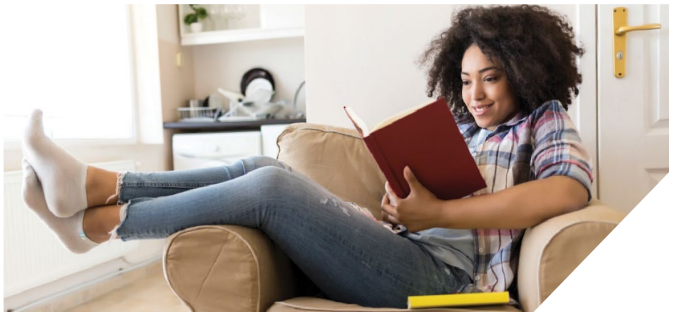




2027 EVIDENCE OF COVERAGE

Ambetter + Adult Dental + Adult Vision





ambetterhealth.com/en/tx

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

AMBETTER FROM SUPERIOR HEALTHPLAN

Evidence of Coverage

HEALTH MAINTENANCE ORGANIZATION

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

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

Superior HealthPlan, Inc.
5900 E. Ben White Blvd.
Austin, Texas 78741
1-877-687-1196

Insert Total Premium Payable. Please note that premiums are subject to change.

IMPORTANT NOTICES:

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in EVIDENCE of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

THIS IS NOT A *CONTRACT* OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A *SUBSCRIBER* TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS *CONTRACT*, 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-*SUBSCRIBER*S AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

THIS EVIDENCE OF COVERAGE IS NOT A MEDICARE SUPPLEMENT *CONTRACT* OR CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Have a *complaint* or need help?

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

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

Ambetter from Superior HealthPlan
To get information or file a *complaint* with your insurance company or HMO:
Call: Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)
Online: ambetterhealth.com/en/tx
Mail: 5900 E. Ben White Blvd.
Austin, Texas 78741

For general inquiries you may also contact Ambetter via the email and mailing addresses below.

Email: HPMSCONTACTUS@CENTENE.COM
Mail: 5900 E. Ben White Blvd.
Attn: Ambetter
Austin, Texas 78741

To file a *complaint* in writing you can send your *complaint* to the address below or by using the online *complaint* form located on the Ambetter website.

5900 E. Ben White Blvd.
Attn: Complaints
Austin, Texas 78741
Online: ambetterhealth.com/en/tx

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

Ambetter from Superior HealthPlan para obtener información o presentar una queja con su compañía de seguros o HMO: Llame: Servicios para Miembros al 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) En línea: Ambetterhealth.com/es/tx

Para consultas generales, también puede comunicarse con Ambetter a través del correo electrónico y las direcciones postales a continuación. Email: HPMSCONTACTUS@CENTENE.COM Correo: 5900 E. Ben White Blvd. Attention: Ambetter Austin, Texas 78741

Para presentar una queja por escrito, puede enviar su queja a la siguiente dirección o mediante el formulario de queja en línea que se encuentra en el sitio web de Ambetter. 5900 E. Ben White Blvd. Attention: Complaints 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

Superior HealthPlan, Inc.

Evidence of Coverage

In this Evidence of Coverage (*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 Superior or Ambetter from Superior HealthPlan.

AGREEMENT AND CONSIDERATION

This document along with the corresponding *Schedule of Benefits* is your *contract* and it is a legal document. It is the agreement under which benefits will be provided and paid. In consideration of your application and the timely payment of premiums, we will provide benefits to you, the *enrollee*, for covered 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 *contract*s 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*. If your *contract* is terminated for any of these reasons, we will notify you in writing and via electronic communication.

Annually, we will change the rate table used for this *contract* form. Each premium will be based on the rate table in effect on that premium's due date. The *contract* 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 *referral* requirements, outlined below, and *prior authorization* requirements, outlined in the **Prior Authorization** and **Access to Care** sections, and your *Schedule of Benefits*. You are required to obtain a *referral* from your *primary care physician*

(*PCP*) in order to obtain all services outside of a *PCP* visit, including, but not limited to, receiving care from a specialist provider. If your *PCP* refers you to a specialist provider in the same *medical group* as your *PCP*, a *referral* will not be required. *Referral*s will be required for care received outside of your *medical group*. You may seek services from an obstetrician/gynecologist, physical therapist, a *behavioral health* provider without a *referral*. You may seek emergency care and *urgent care* services without a *referral*. If you do not obtain a *referral* from your *PCP*, then the services are not *covered services* and will not be paid for under this *contract*. In addition, any amounts you are required to pay for such services will not count towards your maximum out of pocket amount.

Superior HealthPlan, Inc.



Jared A. Wolfe
Plan Chief Product 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, and 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.

This is an Ambetter Value *contract*. Ambetter Value is a product that features in-person care from a provider *network* centered around *primary care physician*s (*PCP*) from a designated *medical group* who will coordinate *referral*s to see specialists. *Enrollees* must select a *primary care physician* (*PCP*) from a designated *medical group* who will coordinate *referral*s to see specialists.

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. local time, Monday through Friday
Member Services 1-877-687-1196
Relay Texas/TTY 1-800-735-2989
Fax 1-877-941-8077
Emergency 911
Suicide and Crisis Lifeline: 988 (call or text)
24/7 Nurse Advice Line 1-877-687-1196
Website: ambetterhealth.com/en/tx

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.

Your Provider Directory

A listing of *network provider*s is available online at ambetterhealth.com/en/tx. We have plan providers and *hospital*s who have agreed to provide you with your health care services. You may find any of our *network provider*s 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.

You may also contact us at Member Services to request information about whether a *physician*, *hospital*, or other medical practitioner is a *network provider*. We will respond to any such requests within one business day.

If you receive services from a *non-network provider* because of inaccurate information in the Provider Directory or in response to an inquiry about *network* status, please contact Member Services. If the services you received are otherwise *covered services*, you will only be responsible for paying the *cost sharing* that applies to *network provider*s and should not be balance billed by the *non-network provider*. See *balance billing*, *balance billing protections*, 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 member identification card.

Your Member Identification Card

We will mail you a member 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 member identification card shows your name, member identification number, helpful phone numbers, and *copayment amount*s you will have to pay at the time of service. Any applicable *deductibles*, and any applicable out-of-pocket maximum limitations will also be accessible through the member identification card. If you lose your card, please call Member Services. We will send you another member identification card. A temporary member identification card can be downloaded your secure consumer dashboard at member.ambetterhealth.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 ambetterhealth.com/en/tx. It also gives you information on your benefits and services such as:

1. Finding a *network provider*, including *hospital*s 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 member identification card.

4. *Enrollee*'s Rights and Responsibilities.
5. Notice of Privacy Practices.
6. Current events and news.
7. Our formulary or *prescription 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 preventative care such as assessments, 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 provider*s to help us develop and monitor our program activities.
7. Investigating any *enrollee* concerns regarding care received.

Ten-Day Right to Examine this Contract

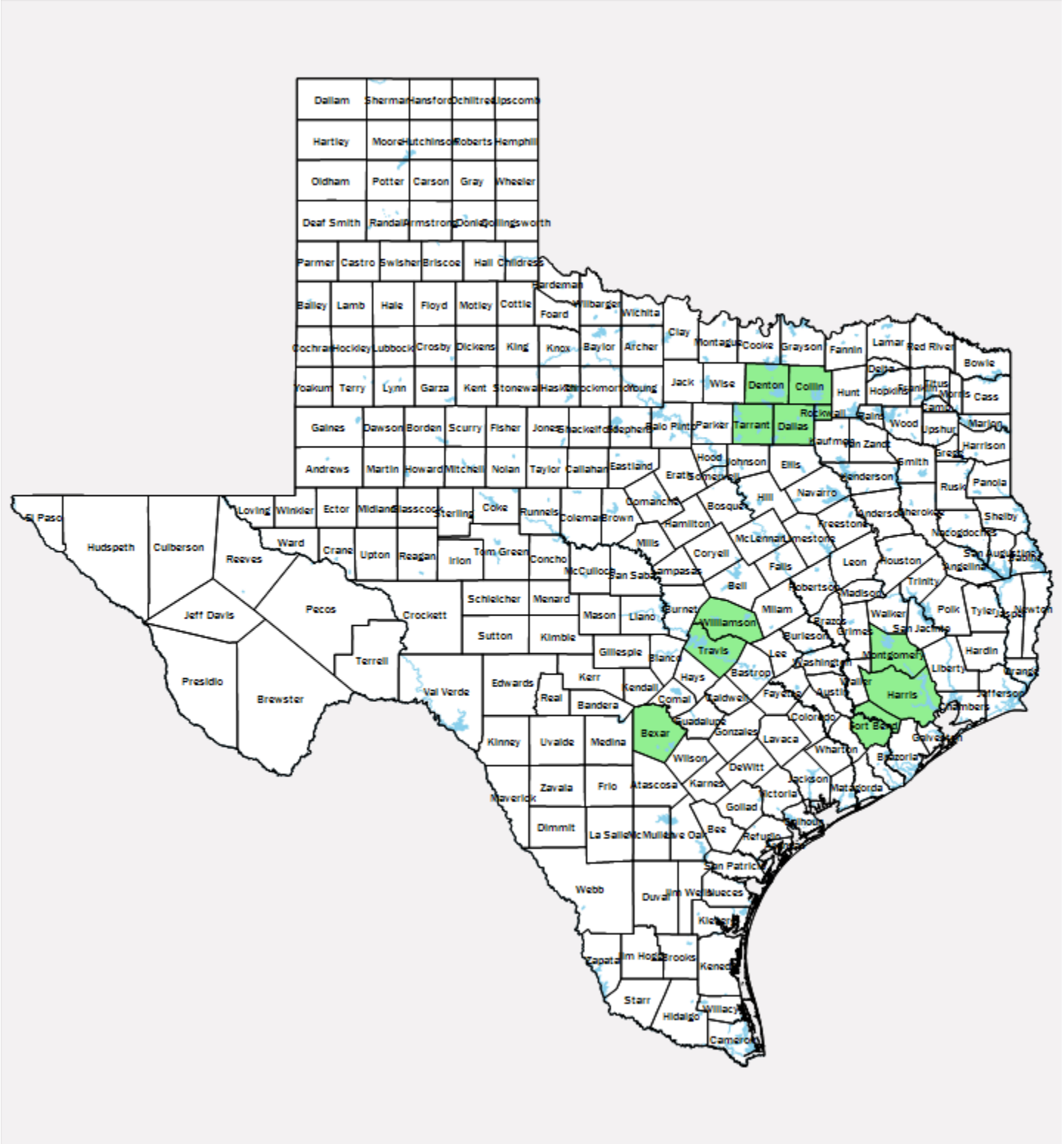
You shall be permitted to return this *contract* within 10 calendar days of receiving it and to have any premium you paid refunded back to the original method of payment and/or payor if, after examination of the *contract*, you are not satisfied with it for any reason. If you return the *contract* to us, the *contract* will be considered void from the beginning and the parties are in the same position as if no *contract* had been issued. If any services were rendered or claims paid by us during the 10 calendar 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 provider*s or facilities are prohibited from *balance billing* health plan *enrollees* for services that are subject to *balance billing protections* as described in the **Definitions** section of this *contract*. You will only be responsible for paying your member cost share for these services, which is calculated as if you had received the services from a *network provider* and based on the recognized amount as

defined in applicable law. Please note that military treatment facilities are not subject to this regulation and may balance bill.

SERVICE AREA MAP



DEFINITIONS

In this *contract*, italicized words are defined. Words that are 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 *physician*s. *Rehabilitation services* must be performed by one or more *rehabilitation licensed practitioner*s 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 credit*s 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 credit*s 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 credit*s 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

1. A determination by a *utilization review* agent made on behalf of any payor that the health care services provided or proposed to be provided to an *enrollee* are not *medically necessary* or appropriate or are *experimental or investigational*.
2. As it relates to the *balance billing protections* under the federal No Surprises Act, *adverse determination* means:
    a. A determination that *balance billing protections* do not apply to a service.
    b. An incorrectly calculated amount of *cost sharing* a *enrollee* owes when *balance billing protections* apply.

We will notify you of an *adverse determination* as follows:

1. For *enrollees* who are hospitalized at the time of *adverse determination*, within one working day, followed by written communication to you and your provider within three working days;
2. For *enrollees* who are not hospitalized, within three working days;
3. For post-stabilization subsequent to emergency treatment, within the time appropriate to the circumstances, not to exceed one hour after the time of the request.

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.

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 non-*network* care that is subject to *balance billing protections* and otherwise covered under your *contract*. See *Balance billing*, *Balance billing protections*, and *Non-network provider* definitions for additional information. If you are balanced billed in these situations, please contact Member Services immediately at the number listed on the back of your member identification card.

Ambetter-designated Telehealth Provider means the vendor selected by Ambetter to *contract* with providers to render *telehealth services*, including *Virtual 24/7 Care* benefits, to *enrollees*. All services provided through the *Ambetter-designated Telehealth Provider* shall be deemed independent from Ambetter to ensure that an *enrollee*'s care and treatment plan are rendered via a practicing *physician*, or other medical professional with appropriate licensure.

Ambulatory surgical center 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.

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 determination*, service or claim.

Applicable laws means laws of the state in which your *contract* was issued and/or federal laws.

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 provider*s 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 member identification card.

Behavioral health means both mental health and *substance use disorders*, encompassing a continuum of prevention, intervention, treatment and recovery support services.

Balance billing protections means the protections against *balance billing* under the federal No Surprises Act and Texas law. These protections apply to *covered services* that are:

1. *Emergency services* provided to an *enrollee*, as well as services provided after the *enrollee* is *stabilize*d;
2. Non-emergency health care services provided by a *non-network provider* to an *enrollee* at a *network hospital* or at a *network* ambulatory surgical center unless the *enrollee* gave *notice and consent* pursuant to the federal No Surprises Act and there is *Texas waiver* to be balance billed by the *non-network provider*; or
3. Air ambulance services provided to an *enrollee* by a *non-network provider*.

Under Texas law, there are additional protections than exist under the federal No Surprises Act. The additional Texas protections apply to *covered services* that are:

1. Non-emergency laboratory and *Diagnostic imaging* services provided by a *non-network provider* in connection with services by *network provider* unless there is *Texas waiver* to be balance billed by the *non-network provider*; or
2. Non-emergency health care services provided by a *non-network provider* to an *enrollee* at a *network facility* other than a *hospital* or ambulatory surgical center unless there is *Texas waiver* to be balance billed by the *non-network provider*, or
3. Ground ambulance services provided to an *enrollee* by a *non-network provider.*

You will only be responsible for paying your *enrollee* cost share for these services, which is calculated as if you had received the services from a *network provider* and is based on the recognized amount as defined in applicable law. If you are balance billed for any of the above services, contact Member Services immediately at the number listed on the back of your member identification card.

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 specializes in a specific type or types of *medically necessary* transplants or other medical services and is a *network provider* who meets quality of care criteria established by us and/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 amount*s 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 means any dissatisfaction expressed orally or in writing by a complainant to a health maintenance organization regarding any aspect of the health maintenance organization's operation. The term includes dissatisfaction relating to plan administration, procedures related to review or *appeal* of an *adverse determination* under Section 843.261, 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 or was 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 amount*s 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* for air or ground ambulance services from *non-network provider*s, *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(s) 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, *respite 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 amount*s are shown in the *Schedule of Benefits*.

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 a primary *subscriber*, if that child is less than 26 years of age. If an *eligible child* turns 26 during the plan year, they will remain an *eligible child* through the end of the plan year. 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 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 provider*s: When a *covered service* is received from a *network provider*, the *eligible expense* is the *contract*ed fee with that provider.
2. For *non-network provider*s, unless otherwise required by federal or state law, the *eligible expense* is as follows:
    a. When *balance billing protections* apply to a *covered service* received from a *non-network provider*, 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.
    b. 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 reimbursement as determined by us and as required by applicable law. In addition to applicable *cost sharing*, you may be balanced billed for these services.

Emergency condition means a medical condition or a *behavioral health* condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the *enrollee* (or, with respect to a pregnant woman, the health of the woman or her fetus) in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Emergency services means *covered services* needed to evaluate and *stabilize* an *emergency condition*. This includes a medical screening examination in a *hospital* emergency department or independent freestanding emergency department to evaluate the *emergency condition*, as well as services needed to *stabilize* the *emergency condition*. Services to *stabilize* an *emergency condition* can be provided in any department of a *hospital*.

Follow-up care is not considered emergency care. Benefits are provided for *emergency services* without *prior authorization*. Benefits for *emergency services* include *facility* costs and *physician* services and supplies and *prescription drugs* charged by that *facility*. If you are admitted to a *hospital* as a result of an *emergency condition*, you must notify us or verify that your *physician* has notified us of your admission within 48 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the *inpatient* setting is appropriate, and if appropriate, the number of days considered *medically necessary*. By contacting us, you may avoid financial responsibility for any *inpatient* care that is determined to be not *medically necessary* under your *contract*. If your provider does not *contract* with us, you may be financially responsible for any care we determine is not a *covered service* because it is not *medically necessary*. Care and treatment provided once you are *stabilize*d is no longer considered *emergency services* under your *contract*. Continuation of care beyond what is needed to evaluate or *stabilize* your condition in an emergency will not be a *covered service* unless we authorize the continuation of care and it is *medically necessary*.

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*.

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

1. 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.
2. An *unproven service*.
3. Subject to FDA approval, and:
    a. It does not have FDA approval;
    b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
    c. It has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of an FDA-approved drug is a use that is determined by us to be:

i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or

iii. Not an *unproven service*;

d. It has FDA approval, but is being used to treat a condition, or for a use that is not listed on the Premarket Approval issued by the FDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *enrollee*.

4. *Experimental or investigational* according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV FDA clinical trials. Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise *covered services* under this *contract*.

***Extended care facility* (*ECF*)** is primarily engaged in providing comprehensive post-acute *hospital* and *inpatient* rehabilitative care, and is licensed by the designated government agency to provide such services. The definition of an *ECF* does not include institutions that provide only minimal, custodial, assisted living (except for services related to an *acquired brain injury*) independent living communities, extended nursing homes, residential care homes, ambulatory or part-time care services, or institutions that primarily provide for the care and treatment of *behavioral health*, or pulmonary tuberculosis.

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.

Fertility preservation means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue. This does not include the storage of such unfertilized genetic materials.

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. We may use the World Health Organization’s International Classification of Diseases (ICD) and the American Psychiatric Association’s Diagnostic and Statistical Manual for Mental Disorders (DSM) to inform *generally accepted standards of medical practice*.
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 provided by a *home health care agency* and prescribed and supervised by a provider.

Home health care agency means a business that provides home health services and 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 diagnosed with a terminal condition and are in a *hospice inpatient* program or in a home setting, as certified by a *network physician*

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 *contract*ual 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 *contract*ual 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 *hospital*s; 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 *illness*es 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, biologicals, or treatment, for a medical condition 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. *Covered services* include anesthesia and oxygen services, inhalation therapy, laboratory and other diagnostic tests, radiation therapy, use of intensive care unit and services, and x-ray services.

Intensive care unit means a unit or area of a *hospital* that meets the required standards of the Joint Commission on Accreditation of *Hospital*s for special care units.

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation licensed practitioner*s 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 maximum amount a *enrollee* must pay towards *covered services* in the form of *cost sharing* in a given plan year. A *enrollee's deductible amount*, *prescription drug deductible amount* (if applicable), *copayment amount*s and *coinsurance amount*s all contribute towards the *maximum out-of-pocket amount*. The individual and family *maximum out-of-pocket amount*s are shown in your *Schedule of Benefits*.

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

Medical group means a group of *physician*s who are organized as a legal entity that has an agreement in effect with the plan to provide medical care to its *enrollees*.

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.

Mental health disorder means a condition - excluding those mental or behavioral disorders due to psychoactive substance use (or equivalent category) - that falls under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter of the most current version of the International Classification of Diseases or that is listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

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 mean medical supplies that are necessary for the care or treatment of an *injury* or *illness*.

They do not include reusable or *durable medical equipment* and 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 *hospital*s, *inpatient* mental health care facilities, medical clinics, *behavioral health* clinics, acupuncturists, chiropractors, massage therapists, nurse practitioners, addiction medicine practitioners, etc.) who have *contract*s with us, or our *contract*or or sub*contract*or, 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* directly or indirectly with Ambetter from Superior HealthPlan under the Ambetter Value TX *network* to provide *covered services* to *enrollees* under this *contract*, including but not limited to, *hospital*s, specialty *hospital*s, *urgent care* facilities, *physician*s, pharmacies, laboratories and other health professionals.

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 *stabilize*d 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 who is not a *network provider*. 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. Air or ground ambulance services; as described in the **Covered Healthcare Services and Supplies** section of this contract; and
4. Situations otherwise specifically described in this contract.

Non-quantitative treatment limitation (NQTL) means a limit on the scope or duration of treatment that is not expressed numerically. The term includes:

1. A medical management standard limiting or excluding benefits based on *medical necessity* or medical appropriateness or based on whether a treatment is *experimental or investigational*;
2. Formulary design for prescription drugs;
3. Network tier design;
4. A standard for provider participation in a network, including reimbursement rates;
5. A method used by a health benefit plan to determine usual, customary and reasonable charges;
6. A step therapy protocol;
7. An exclusion based on failure to complete a course of treatment; and
8. A restriction based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefit.

Notice and consent means the conditions that must be met in order for a *enrollee* to waive *balance billing protections* under the federal No Surprises Act. *Notice and consent* occurs only when each of the following conditions is met:

1. The *non-network provider* provides the *enrollee* a written notice in the format required by applicable law that states the provider is a *non-network provider*, includes a good faith estimate of the *non-network provider*'s charges for the services, identifies any *prior authorization* or other limitations that may be required in advance of receiving the services, and clearly states that consent is optional and the *enrollee* may seek care from a *network provider*.
2. The *non-network provider* provides the notice described above to the *enrollee* at least 72 hours before the services are furnished, except that for services scheduled within 72 hours, the notice must be provided at least 3 hours before the services are furnished.
3. The *enrollee* provides written consent to be treated by the *non-network provider* that includes the following:

a. The *enrollee*'s acknowledgement that they have been provided written notice as described above and informed that payment of the *non-network provider*'s billed amount may not accrue toward the *enrollee*'s *deductible* or *maximum out-of-pocket amount*;

b. The *enrollee's* statement that by signing the consent, they agree to be treated by the *non-network provider* and understand they may be balance billed and subject to cost-sharing that applies to *non-network provider*s; and

c. The time and date on which the *enrollee* received the written notice and signed the consent to receive services from the *non-network provider*.

4. The *enrollee*'s consent is provided voluntarily, obtained by the *non-network provider* in the format required by applicable law, and not revoked by the *enrollee* before the services are provided.
5. The *non-network provider* provides the *enrollee* the notice document and the consent document together, but physically separate from other documents.
6. The *non-network provider* provides the *enrollee* a copy of the signed written *notice and consent* through email or mail.

Notice and consent will not waive *balance billing protections* for *emergency services*, air ambulance services, services furnished due to unforeseen and urgent medical needs, services provided by a *non-network provider* when there is no *network provider* available at the *facility*, or ancillary services (which are services related to emergency medicine, anesthesiology, pathology, radiology and neonatology; diagnostic services such as radiology and laboratory services; and services provided by non-*physician* practitioners, assistant surgeons, *hospitali*sts, and intensivists). It will also not waive ***balance billing protections*** provided under Texas law unless *Texas waiver* also occurs (see the definition of *balance billing protections* for more information).

In addition, *notice and consent* will waive *balance billing protections* for *post-stabilization services* only if all the following additional conditions are met:

1. The attending emergency *physician* or treating provider determines the *enrollee* is able to travel using nonmedical transportation or nonemergency medical transportation to an available *network provider* or *facility* located within a reasonable travel distance, taking into consideration the *enrollee*'s medical condition.
2. The *enrollee* (or the *enrollee*'s *authorized* representative) is in a condition to provide *notice and consent* as determined by the attending *physician* or treating provider using appropriate medical judgment.
3. The *non-network provider* satisfies any additional requirements or prohibitions as may be imposed under *applicable law*.

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 *contract*s, 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 or outpatient services mean that you are receiving treatment while not an *inpatient*. Services considered *outpatient* include, but are not limited to, services in an emergency room or *ambulatory surgical center* regardless of whether you are subsequently registered as an *inpatient* in a health care facility.

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

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily *injury* or *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 *enrollee* 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.

Post-stabilization services mean services furnished after an *enrollee*'s *emergency condition* is *stabilize*d and as part of outpatient observation or *inpatient*, including an out-of-*network hospital*, freestanding emergency medical care *facility*, or comparable emergency *facility* or *outpatient services* with respect to the visit in which other *emergency services* are furnished.

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. *PCP*s 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 or ***Preauthorization*** 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 be conducted in accordance with Texas Insurance Code, Chapter 843.261 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.

Quantitative treatment limitation (QTL) means a treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount, such as an annual or lifetime limit on days of coverage or number of visits. The term includes a *copayment, coinsurance*, or another out-of-pocket expense or annual or lifetime limits, or another financial requirement.

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

Referral means a formal recommendation made by your *PCP* to see a *network* specialist provider or other providers for additional healthcare services deemed *medically necessary*. A *referral* is required prior to a non-emergent visit with a practitioner outside of your *PCP*. Failure to obtain a *referral* will result in denial of benefit coverage.

Rehabilitation* or *rehabilitation services mean 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 program*s. An *inpatient hospital*ization will be deemed to be for *rehabilitation* at the time the *enrollee* has been *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 is licensed by the state as a rehabilitation facility. It 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, *custodial care*, assisted living (except for services related to an *acquired brain injury*), 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, and respiratory therapy. It may occur in either an outpatient or *inpatient* setting.

Rescission 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* in which 24-hour, on-site and structured care (non-acute care) is provided for the evaluation, stabilization and treatment of *substance use* and *mental health disorders*. *Residential treatment facilities* do not provide acute care. They are generally used as a step-down from more intensive/acute care settings. **Note**: The duration of stay covered under this *contract* for a *residential treatment facilities* admission is based on *medical necessity*.

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: Travis, Williamson, Collin, Dallas, Denton, Rockwall, Tarrant, Fort Bend, Harris, Montgomery, and Bexar. You can receive precise *service area* boundaries from our website or Member Services.

Skilled nursing facility (***SNF***) means a *facility* (which meets specific regulatory certification requirements) that primarily provides *inpatient* skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a *hospital*. This is a level of care that requires the daily involvement of skilled nursing or *rehabilitation* staff. Examples of *skilled nursing facility* care include, but not limited to intravenous injections and physical therapy.

Social determinants of health means the circumstances in which people are born, grow up, live, work, and age. This also includes the systems in place to offer health care and services to a community.

Specialist physician means a *physician* or medical practitioner who focuses on a specific area of medicine and has additional expertise to help treat specific disorders or *illness*es. 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.

Stabilize means, with respect to an *enrollee* who has not experienced an *emergency condition*, that the *enrollee* is no longer experiencing further deterioration as a result of a prior *illness* or *injury* 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 *enrollee* who has experienced an *emergency 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* of the *enrollee* to another *facility* or discharge of the *enrollee* (*See **Ambulance Services** provision under the **Covered Healthcare Services and Supplies** section of this *contract*).

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation licensed practitioner*s 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 *contract*.

Substance use disorder means a condition that falls under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter of the most current version of the International Classification of Diseases or that is listed as a substance-related and addictive disorder in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

Surgery or surgical procedure means an invasive diagnostic procedure or 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 gestational carrier who, as part of a s*urrogacy 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.

Texas waiver occurs when a patient elects to receive services from a *non-network provider* in writing in advance of the services, and when the *non-network provider* provides a written disclosure in advance of the services that explains the provider is not a *network provider*, discloses the projected amounts for which the patient may be responsible, and discloses the circumstances under which the patient would be responsible for those amounts. When there is *Texas waiver*, you may be responsible for the *non-network provider*'s balance bill, unless the No Surprises Act also provides *balance billing protections* and there is no *notice and consent* to receive the *non-network provider*'s services (see definition of *balance billing protections* for additional information).

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 *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.

Virtual 24/7 Care means a *telehealth services* benefit for virtual *urgent care* and virtual *behavioral health* provided to *enrollee*s through the *Ambetter-designated Telehealth Provider*. *Virtual 24/7 Care* services can be accessed through the *Ambetter-designated Telehealth Provider*'s website.

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 60th calendar day after 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 60th calendar 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 60 calendar days from birth, an additional premium for coverage of the newborn child will be charged for not less than 60 calendar days after the birth of the child. If notice is not given with the 60 calendar 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 calendar 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 60th calendar day after 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 calendar 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 calendar 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 calendar day following placement, unless we have received both: (A) Notification of the addition of the child from the Health Insurance Marketplace within 60 calendar days of the birth or placement; and (B) any additional premium required for the addition of the child within 90 calendar days of the date of placement.

As used in this provision, “placement” means the earlier of:

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

Adding Other Dependent Enrollees

If you are enrolled in an off-exchange plan and apply in writing, 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 member identification card for the added *dependent enrollee*.

ELIGIBILITY AND ENROLLMENT

Please Note: You must reside, live or work in the *service area* where the *contract* is issued.

For All Enrollees

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

1. The date that an *enrollee* is no longer within the Grace Period due to a failure to make timely payment. See the **Grace Period** provision for additional detail;
2. The primary *enrollee* resides outside the *service area* or moves 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.

For Dependent Enrollees

A *dependent enrollee* will cease to be an *enrollee* at the end of the premium period in which he/she ceases to be your *dependent enrollee*. For eligible children, coverage will terminate the 31st day of December the year that the dependent turns 26 years of age.

1. An *enrollee* will not cease to be a dependent *eligible child* solely because of age if the *eligible child* is:
2. Not capable of self-sustaining employment due to mental disabilities or physical disabilities; and
3. Mainly dependent on you for support and maintenance.

If you have material modifications (examples include a change in life event such as marriage, death or other change in family status), or questions related to your coverage, contact the Health Insurance Marketplace (Marketplace) at Healthcare.gov or 1-800-318-2596. If you enrolled through Ambetter, please contact Member Services.

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 *hospital*ization 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 calendar days of your *effective date* so we can review and authorize *medically necessary* services. If services are at a non-*contract*ed *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

Each year, there will be an open enrollment period where you may apply for or change coverage in a qualified health plan (QHP) through the Health Insurance Marketplace for yourself and/or your eligible *dependents*. The open enrollment period begins on November 1st of the current year and extends through January 15th of the following year. Coverage for *qualified individuals* who *enroll* on or before December 15th will have an effective date of coverage of January 1st of the following year.

Coverage under this *contract* is contingent upon timely receipt of any necessary information and the initial premium.

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

The *qualified individual* has not been determined eligible for *advance premium tax credit* or *cost sharing reductions*; or

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

A *qualified individual* has 60 calendar days to report a qualifying event to the Health Insurance Marketplace, and could be granted a 60 calendar day Special Enrollment Period as a result of one of the following events:

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 calendar days during the 60 calendar 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 credit*s 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 credit*s 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 *QHP*s 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 calendar days during the 60 calendar 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 calendar 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. A *qualified individual* or *enrollee*, or their *dependent enrollee*, who is eligible for *advance premium tax credit*, and whose household income is projected to be at or below 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 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 calendar 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 calendar 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 calendar day of the month following the date of the triggering event or, if the triggering event is on the first calendar 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 calendar day of the month following plan selection.

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 calendar 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 three months 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 credit*s 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 credit*s on behalf of the *enrollee* from the Department of the Treasury, and will return the *advance premium tax credit*s 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 30 calendar 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 calendar day of each month for coverage effective during such month. There is a 30 calendar day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *enrollee* during the grace period. We will notify 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

1. 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:
2. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
3. Indian tribes, tribal organizations or urban Indian organizations;
4. State and federal government programs;
5. Family members;
6. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan; or
7. 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 calendar 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 *Schedule 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 this *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 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:

Qualifies as a *covered service* expense under one or more benefit provisions; and

Is received while the *enrollee*'s plan is in force under the *contract* if the charge for the service or supply qualifies as an *eligible 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 amount*s, and *copayment amount*s 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 provider*s may be permitted to bill you for the difference between what we agreed to pay and the full billed amount 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. However, you are not responsible for *balance billing* when *balance billing protections* apply to *covered services*.

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*.

MANAGING YOUR HEALTH CARE

HMO Referral

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

*Referral*s are required for all *medically necessary* health care services not provided by your *PCP*, excluding emergency care, *urgent care*, *behavioral health*, OB/GYN, and physical therapy. If a *referral* is not obtained for non-emergent care, services will be denied. *Covered services* and/or specialties not requiring a *referral* may still require *prior authorization*.

If a *referral* is not obtained for non-emergent care, services will be denied. Emergency care does not require a *referral* or need to be in-*network*.

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

For any additional questions please contact Member Services.

Continuity of Care and Special Circumstances

Under the federal No Surprises Act, if an *enrollee* is a *continuing care patient* with respect to an *network provider* and the *contract*ual relationship with the provider is terminated — such that the provider is no longer in the *network* — or if benefits are terminated because of a change in the terms of the provider's participation as they pertain to the services the *enrollee* is receiving as a *continuing care patient*, the provider must identify and request that *enrollees* experiencing special circumstances may be permitted to continue treatment under their care. Special circumstances mean conditions regarding which a treating *physician* or provider reasonably believes that discontinuing care by that *physician* or provider could cause harm to a patient, except for reason of medical competence or professional behavior, an HMO is not released from the obligation of continuing to reimburse a *physician* or provider providing *medically necessary* treatment at the time of termination to an *enrollee* who has a special circumstance. Examples include disabilities, acute conditions, life-threatening *illness*, or are past the 24th week of *pregnancy* and the associated obligatory period. Coverage will extend through the delivery of the child and will apply to immediate postpartum care and a follow-up checkup within the six week period after delivery. Then we will:

1. Notify each *enrollee* who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the provider or *facility*;
2. Provide the individual with an opportunity to notify the health plan of the *enrollee*'s need for transitional care; and
3. Permit the *enrollee* 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

a. 90 calendar days after the notice described in (1) is provided;

b. The 9 month period for an *enrollee* that has been diagnosed with a *terminal illness* at the time of the provider termination; or the

c. The date on which the *enrollee* is no longer a *continuing care patient* with respect to the provider.

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 Value plan located in that state. You can locate Ambetter Value providers outside of Texas by searching the relevant state and the plan you are enrolled in on our provider directory at https://guide.ambetterhealth.com/. Not all states have Ambetter Value plans. If you intend to seek care from an Ambetter Value provider outside of the *service area*, you may be required to obtain *prior authorization* from the originating state for non-emergency services. Contact Member Services at the phone number on your member 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 experience an *emergency condition*, call 911 or for a *behavioral health emergency condition*, call 988 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*.

Hospital Based Providers

When receiving care at a *network hospital* it is possible that some hospital-based providers may not be *network providers*. You may not be *balance billed* for emergency care service, services provided by non-network *facility* based providers, non-network diagnostic imaging providers or laboratory services providers. However, if there is *notice and consent* and/or *Texas waiver* to waive *balance billing protections* for services other than *emergency care* services, you may be responsible for payment of all or part of the *balance bill*. 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 amount*. If you receive a *balance bill* from a hospital based provider, contact Member 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, medical procedures, drugs, devices, and applications 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)

All *enrollees* must select a *PCP* within a *medical group*. You may select any *network PCP* within a *medical group* who is accepting new patients, or you may select a *network provider* of which you are a current patient who is within a *medical group*. If you do not select a *network PCP* for each *enrollee*, one may be assigned. You may obtain a list of *network primary care physician* at ambetterhealth.com/en/txor by contacting Member Services. Until a *PCP* is selected or assigned, benefits will be limited to coverage for emergency care. You may select any *network PCP* who is accepting new patients from any of the following health care professional types:

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

Your *PCP* coordinates your medical care, as appropriate, either by providing treatment or by issuing *referral*s to direct you to participating providers. When admitted to an *inpatient facility*, and only through the duration of your *inpatient* stay, a *physician* other than the *PCP* may direct and oversee your care. Except for emergency care, only those services which are provided by or referred by your *PCP* will be covered. It is your responsibility to consult with your *primary care physician* in all matters regarding your medical care. If your *PCP* performs, suggests, or recommends a course of treatment for you that includes services that are not *covered services*, the entire cost of any such non-*covered services* will be your responsibility.

In addition to a *PCP*, female *enrollees* may also select a participating Obstetrician/Gynecologist (OB/GYN) for gynecological and obstetric conditions, including annual well-woman examinations and maternity care, without first obtaining a *referral* from a *PCP* or contacting us. Mental health or *substance use disorder* providers do not require a *referral*. *Enrollees* who have been diagnosed with a chronic, disabling or life threatening *illness*

may request approval to choose a participating specialist as a *PCP* using the process described in the **Specialist as a Primary Care Physician** provision.

Specialist as a Primary Care Physician (PCP)

If you have been diagnosed with a chronic, disabling, or life-threatening *illness*, you may contact Member Services at the number listed on the back of your member identification card to get information to submit for approval from us to choose a participating specialist as your *PCP*. We require both you and the participating specialist interested in serving as your *PCP* to sign a certification of medical need, to submit along with all supporting documentation. The participating specialist must meet our requirements for *PCP* participation and be willing to accept the coordination of all your health care needs. If your request is denied, you may *appeal* the decision as described in **Complaint and Appeal Procedures** provision. If your request is approved, the specialist's designation as your *PCP* will not be effective retroactively.

Contacting Your Primary Care 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 member 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. If you are experiencing an emergency condition, call 911 or for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room.

Your *network PCP* will assist you in coordinating all covered health services with other *network provider*s, if necessary. Should *medically necessary* covered health care services not be available through *network provider*s, 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. *Medically necessary referral*s to *non-network provider*s due to non-availability within the *network* will be subject to the *prior authorization* process.

Changing Your Primary Care Physician (PCP)

You can see any provider withing your assigned without having to formally change your *PCP*. You may change your assigned *medical group* or *network primary care physician* for any reason, but not more frequently than once a month, by submitting a written request, online at our website at ambetterhealth.com/en/tx or by contacting our office at the number shown on your identification card. The change to your *network primary care physician* of record will be effective no later than 30 calendar days from the date we receive your request.

Utilization Management

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

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

Pursuant to the federal No Surprises Act, *emergency services* received from a *non-network provider* are *covered services* without *prior authorization*.

In accordance with *applicable law*, certain providers do not require *prior authorization* for certain health care services, if in the most recent one year evaluation period:

a. We have approved or would have approved not less than 90 percent of the *preauthorization* requests submitted by the *physician* or provider for the particular health care service; and
b. The *physician* or provider has provided the particular health care service at least five times during the evaluation period.

Some medical, pharmaceutical and *behavioral health covered services* require *prior authorization*. In general, *network provider*s 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 *authorization* (medical and *behavioral health*) requests are submitted to us by Provider Portal/efax/phone call as follows:

1. At least five calendar 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 calendar days prior to the initial evaluation for organ transplant services.
3. At least 30 calendar days prior to receiving clinical trial services.
4. At least five calendar days prior to the scheduled start of *home health services*, except those *enrollees* needing *home health services* after *hospital* discharge.

Notification of an admission for emergent/urgent *inpatient* medical, *mental health* or *substance use disorder* treatment must be received within 24 hours.

After an *authorization* request has been received, we will notify you and your provider of our decision as required by *applicable law*:

1. For services that require prospective review, within three calendar days after receipt of the request.
2. For concurrent review, within 24 hours of receipt of the request. Notification is followed by a letter within one working day notifying you, your designated representative, and the provider of record of *adverse determination*.
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 retrospective review requests, within 30 calendar days of receipt of the request.

You do not need to obtain *prior authorization* from us or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a medical practitioner in our *network* who specializes in obstetrics or gynecology. The medical practitioner, however, may be required to comply with certain procedures, including obtaining *prior authorization* for certain services, following a pre-approved treatment plan or procedures for making *referral*s. For a list of participating medical practitioners who specialize in obstetrics or gynecology, contact Member Services.

Please note: For more information on the *prior authorization* requirements and information on the *prior authorization* process, please visit ambetterhealth.com/en/tx.

Prior Authorization Renewal Process

Medical Management will process requests for *prior authorization* renewals at least 60 calendar days before the date the *preauthorization* expires, as referenced 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 member 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 provider*s cannot bill you for services for which they fail to obtain *prior authorization* requirements for *emergency services*.

Emergency care does not require *prior authorization*.

In cases of emergency, benefits will not be reduced for failure to comply with *prior authorization* requirements

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*. We may not deny or reduce payment to the *physician* or provider once *prior authorization* is received.

Authorization Denials

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

COVERED HEALTH CARE SERVICES AND SUPPLIES

We provide coverage for health care services for you and your covered dependents when ordered or provided by your *PCP*. 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*, *hospital*ization, 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. Coverage is limited to essential health benefits and other benefits as required under *applicable laws*. Services that are not essential health benefits, and are not otherwise required to be covered under *applicable laws*, are not covered under this *contract*.

*Copayment amount*s must be paid to your provider at the time you receive services.

All *covered services* are subject to, including but not limited to, conditions, exclusions and limitations, defined terms, *prior authorization*s, benefit maximums, and provisions 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 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 if such services are necessary as a result of and related to an *acquired brain injury* and include.

1. *Cognitive rehabilitation therapy*;
2. *Cognitive communication therapy*;
3. Neurocognitive therapy and *rehabilitation*;
4. Neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment;
5. Neurofeedback therapy;
6. Remediation required for and related to treatment of an *acquired brain injury*;
7. *Post-acute transition services* and community reintegration services, including *outpatient day treatment services*, or any other post-acute treatment services are covered;

Under Insurance Code §1352.003(e), a health benefit plan must include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an *acquired brain injury*, been unresponsive to treatment, and becomes responsive to treatment at a later date.

Treatment for an acquired brain injury may be provided at a hospital, an acute or post-acute rehabilitation hospital, a skilled nursing facility, an assisted living facility, or any other facility where *covered services* are provided. Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration. Custodial care and long-term nursing care not covered services under this *contract*.

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 *enrollee* who has incurred an acquired brain injury, has been unresponsive to treatment, is medically stable, and is expected, with the provision of these services and support, to be able to return to a community-based setting rather than reside in a facility setting.

Allergy Care

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

Ambulance Services

Ground Ambulance Service Benefits (Ground and Water)

Covered service expenses will include ambulance services for ground and water transportation home, scene of accident, or *emergency condition*:

1. In cases where the *enrollee* is experiencing an *emergency condition*, to the nearest *hospital* that can provide *emergency services* appropriate to the *enrollee*'s *emergency condition*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illness*es, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospital*s or between a *hospital* and a more appropriate level of care 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. You should not be balance billed for services from a non-*network* emergency ambulance provider, beyond your cost share, for ground and water ambulance services. **NOTE**: Non-emergency ambulance transportation requires *prior authorization*. Unless otherwise required by federal or state law, if you receive non-emergency services from non-*network* ambulance providers, you may be balance billed.

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 *applicable law*.
2. Ambulance services provided for an *enrollee*'s comfort or convenience.
3. Non-emergency transportation.

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 *emergency condition*, subject to other coverage limitations discussed below:

1. In cases where the *enrollee* is experiencing an *emergency condition*, to the nearest *hospital* that can provide services appropriate to treat the *enrollee*'s *emergency condition*.
2. To the nearest neonatal special care unit for newborn infants for treatment of *illness*es, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between *hospital*s or between a *hospital* and a more appropriate level of care 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*.

Non-emergency air ambulance transportation requires *prior authorization*. *Prior authorization* is not required for ambulance transportation when the *enrollee* is experiencing an *emergency condition*. **NOTE**: You should not be *balance billed* for covered 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.

Exclusions

No benefits will be paid for:

1. Air ambulance services covered by a local governmental or municipal body, unless otherwise required by *applicable law*.
2. Non-emergency air ambulance services unless *prior authorization* is obtained.
3. Air ambulance services:
4. Outside of the 50 United States and the District of Columbia;

5. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
6. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
7. Air ambulance services provided for an *enrollee*'s comfort or convenience.
8. Non-emergency transportation (for example, commercial flights).

Autism Spectrum Disorder Benefits

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;
3. Who is certified as a provider under the TRICARE military health system; or
4. Who is acting under the supervision of a health care practitioner

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

1. Evaluation and assessment services;
2. Applied behavior analysis (ABA) therapy;
3. Behavior training and behavior management;
4. Habilitation services;
5. Speech therapy;
6. Occupational therapy;
7. Physical therapy;
8. *Behavioral health* services such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and
9. Medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

No limitation exists within the benefits for applied behavior analysis services. If applicable, 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.

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 specially trained to help you better understand and manage your health conditions, coordinate services and 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.

Chiropractic Services

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

Clinical Trial Coverage

Services must be provided or arranged by your provider. 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:
    a. The investigational item or service itself;
    b. 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
    c. 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;

h. The study or investigation is a drug trial that is exempt from having such an investigational new drug application;

i. An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services; and

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

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

One of the National Institutes of Health (NIH);

1. The Centers for Disease Control and Prevention;
2. The Agency for Health Care Research and Quality;
3. The Centers for Medicare & Medicaid Services;
4. An NIH Cooperative Group or Center;
5. The FDA in the form of an investigational new drug application;
6. The federal Departments of Veterans' Affairs, Defense, or Energy;
7. An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services; or
8. 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. Participation in clinical trials is subject to *prior authorization* requirements as outlined in this *contract*.

Dental Benefits – Adults 19 years of age or older

Coverage for *dental services* is provided for adults, age 19 or older, for diagnostic and preventive services, basic services, and major services rendered by dental *providers*.

1. Diagnostic and Preventive Services—Class 1 benefits include:

a. Routine cleanings
b. Oral examinations
c. X-rays – bitewing, full-mouth and panoramic film
d. Topical fluoride application

2. Basic Services— Class 2 benefits include:
   a. Minor restorative – metal or resin-based filings
   b. Endodontics - root canals
   c. Periodontics – scaling, and root planing and periodontal maintenance
   d. Oral *Surgery* – non-surgical and surgical extractions
   e. Removable prosthodontics – relines, rebase, adjustments and repairs.
3. Major Dental Care—Class 3 benefits include:
   a. Fixed prosthodontics – crowns and bridges
   b. Removable prosthodontics – partial and complete dentures
   c. Oral *surgery* – impacted and complex extractions, other surgical services

Services not covered:

1. Out-of-*network* services
2. *Dental services* that are not *medically necessary* or specifically covered
3. *Hospital*ization or other *facility* charges
4. *Prescription drugs* dispensed in the dental office
5. Any dental procedure performed solely as a cosmetic procedure
6. Charges for dental procedures completed prior to the *enrollee*'s *effective date* of coverage
7. Services provided by an anesthesiologist
8. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing ore repairing tooth structure lost by attrition (wear), abfraction, abrasion, or erosion, realignment of teeth, periodontal splinting, and gnathologic recordings
9. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles
10. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant services
11. Sinus augmentation
12. Surgical appliance removal
13. Intraoral placement of a fixation device
14. Oral hygiene instruction, *tobacco* counseling, nutritional counseling or high-risk substance abuse counseling

15. Services for teeth retained in relation to an overdenture.
16. Any oral *surgery* that includes surgical endodontics (apicoectomy and retrograde filling)
17. Analgesia (nitrous oxide)
18. Temporary procedures
19. Splinting
20. Temporomandibular joint (TMJ) disorder appliances, therapy, films and arthrograms
21. Oral pathology laboratory
22. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete)
23. Veneers (bonding of coverings to the teeth)
24. Orthodontic treatment procedures
25. Orthognathic *surgery*
26. Athletic mouth guards
27. Space maintainers

Please refer to your *Schedule of Benefits* for a detailed list of *cost sharing*, annual *maximum out-of-pocket amounts*. To see which dental providers are part of the network, please visit ambetterhealth.com/en/tx or call Member Services.

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. Training for diabetes self-management;
2. *Medically necessary* 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. Nutritional counseling.
18. Retinopathy examination screenings, as *medically necessary*.

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

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. You may receive hemodialysis in a *network* dialysis *facility* or peritoneal dialysis in your home from a *network provider*.

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.

Disposable Medical Supplies

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 amount*s.

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*. *Durable medical equipment* and supplies are subject to *prior authorization* as outlined in this *contract*.

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 a *network durable medical equipment* 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. 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. All types of *durable medical equipment* and supplies are subject to *prior authorization* as outlined by this *contract*. Please see your *Schedule of Benefits* for benefit levels or additional limits.

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. Augmentative 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/cold pack 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*.

Exclusions:

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

1. Adhesive tape, band aids, cotton tipped applicators.
2. Over the counter 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

Orthotic and *prosthetic device*s must be provided and arranged by your *PCP* and will require *prior authorization*. We will cover the most appropriate model of orthotic and *prosthetic device*s 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 device*s 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 device*s 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 device*s, 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. Darkened lenses for treatment of photophobia.
7. Cochlear implant.
8. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
9. Restoration prosthesis (composite facial prosthesis).
10. 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. Penile prosthesis when medical necessity criteria are not met or is strictly a cosmetic procedure.

Orthotic Devices

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

Covered *orthotic device*s 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.
10. Devices for correction of positional plagiocephaly.
11. Orthopedic shoes.
12. Standard elastic stockings

*Orthotic device*s may be replaced when *medically necessary* and when an appliance is damaged beyond repair; *prior authorization* may apply.

Exclusions:

1. Non-*covered services* and supplies may include, but are not limited to:
2. Foot support devices, such as arch supports, unless they are an integral part of a leg brace.
3. Garter belts, and other supplies not specially made and fitted (except as specified under the **Medical Supplies** provision above).
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.

Emergency Services

The plan provides coverage for *emergency conditions* wherever they occur. Examples of *emergency conditions* 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 you experience an *emergency condition*, you should call 911 for a *behavioral health emergency condition*, call 988 or go to the nearest emergency room. We cover *emergency services* both in and out of our *service area*. We cover these services 24 hours a day, 7 days a week.

If reasonably possible, contact your *network provider* or *behavioral health* practitioner before receiving *emergency services*. They can help you determine if you need *emergency services* 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 *hospital*ization or not, you must notify your *PCP* or *behavioral health* practitioner within 48 hours, or as soon as reasonably possible, of receiving any *emergency services* so he or she can recommend the continuation of any necessary medical services.

All treatment received from a *non-network provider* for an *emergency condition* prior to stabilization, and including services originating in an emergency *facility* following treatment or stabilization of an *emergency condition* until you can reasonably be expected to transfer to a *network facility* or as otherwise approved by us, will be treated as *covered services* received from a *network provider*.

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

NOTE: Some providers that provide *emergency services* may not be in your *network*. These services are subject to *balance billing protections* and the *non-network provider* may not balance bill you for the difference between our *allowed amount* and their billed amount. *Post-stabilization services* are also entitled to *balance billing protections* unless there is *notice and consent*.

Fertility Preservation

Medically necessary fertility preservation services for *enrollees* when a medical treatment will directly or indirectly result in “iatrogenic infertility,” which is an impairment of fertility by *surgery*, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes. Cost-sharing such as *deductibles*, *copayments*, and *coinsurance* may be imposed on *fertility preservation* services if the cost-sharing is consistent with other benefits in the *contract* and place of service. Services include the collecting, freezing, preserving of ova or sperm, and other standard services that are not *experimental or investigational*. (Storage is an exclusion.)

Coverage may be limited to in-*network provider*s for *fertility preservation* services unless the issuer does not have an in-*network provider* with the appropriate training and expertise to meet the needs of the *enrollee*. *Prior authorization* and/or *referral*s may be required.

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

Prior authorization may be required as outlined in this *contract*. *Covered services* 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. Covered service expenses for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
3. Daily room and board and nursing services.
4. Diagnostic testing.
5. Drugs and medicines that are prescribed by a provider, filled by a licensed pharmacist, and approved by the United States Food and Drug Administration.
6. Covered service expenses for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation licensed practitioner*s.
7. 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 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 *home infusion therapy* 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.

Home health care services and benefits are subject to *prior authorization* requirements as outlined in this *contract*. 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 applies to a *terminally ill enrollee* receiving *medically necessary* care under a *hospice* care program or in a home setting. *Respite care* is covered on an *inpatient* or home basis to allow 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. See your *Schedule of Benefits* for coverage limits. Benefits for *hospice inpatient*, home and outpatient care is subject to *prior authorization* as outlined in this *contract*. *Covered services* 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*.

Benefits for *hospice inpatient*, home or outpatient care are available to a *terminally ill enrollee* for one continuous period up to 365 days per benefit period. For each day the *enrollee* is

confined in a *hospice*, benefits for room and board will not exceed the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated.

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 services*, even if confinement is not required. See your *Schedule of Benefits* for limitations.
8. Administration of whole blood and blood plasma. (NOTE: Whole blood, including the cost of blood, blood plasma, and blood expanders that are not replaced by or for the *enrollee*).
9. Meals and special diets when *medically necessary*.
10. Private Duty Nursing when *medically necessary*.
11. Short term *rehabilitation therapy* services when in an acute *hospital* setting.

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, medically assisted reproduction (MAR) and other types of artificial or surgical means of contraception including drugs administered in connection with these procedures.

Long Term Acute Care

Long-term acute care *hospital*s (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. LTACH benefits are subject to *prior authorization* requirements as outlined in this *contract*.

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

1. Complex wound care:
    a. Daily *physician* monitoring of wound
    b. Wound requiring frequent complicated dressing changes, and possible repeated debridement of necrotic tissue
    c. Large wound with possible delayed closure, draining, and/or tunneling or high output fistulas
    d. Lower extremity wound with severe ischemia
    e. Skin flaps and grafts requiring frequent monitoring
2. Infectious disease:
    a. Parenteral anti-infective agent(s) with adjustments in dose
    b. Intensive sepsis management
    c. Common conditions include osteomyelitis, cellulitis, bacteremia, endocarditis, peritonitis, meningitis/encephalitis, abscess and wound infections
3. Medical complexity:
    a. Primary condition and at least two other actively treated co-morbid conditions that require monitoring and treatment
    b. Common conditions include metabolic disorders, stroke, heart failure, renal insufficiency, necrotizing pancreatitis, emphysema (COPD), peripheral vascular disease, and malignant/end-stage disease
4. *Rehabilitation*:
    a. Care needs cannot be met in a *rehabilitation* or *skilled nursing facility*
    b. Patient has a comorbidity requiring acute care
    c. Patient is able to participate in a goal-oriented *rehabilitation* plan of care
    d. Common conditions include CNS conditions with functional limitations, debilitation, amputation, cardiac disease, orthopedic *surgery*

5. Mechanical ventilator support:
    a. Failed weaning attempts at an acute care *facility*
    b. Patient has received mechanical ventilation for 21 consecutive calendar days for 6 hours or more per day
    c. Ventilator management required at least every 4 hours as well as appropriate diagnostic services and assessments
    d. Patient exhibits weaning potential, without untreatable and/or progressive lung and/or neurological conditions
    e. Patient is hemodynamically stable and not dependent on vasopressors
    f. Respiratory status is stable with maximum PEEP requirement 10 cm H2O, and FiO2 60 percent or less with O2 saturation at least 90 percent
    g. Common conditions include complications of acute lung *injury*, disorders of the central nervous and neuromuscular systems, and cardiovascular, respiratory, and pleural/chest wall disorders
    h. Patient continues to meet the criteria above and does not meet the criteria to be transitioned to alternate level of care.

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.

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. Coverage also includes post-delivery care for a woman discharged before the expiration of the minimum hours of coverage.

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 calendar days of enrollment or agreement to participate in a *surrogacy arrangement*, send us written notice using the Notification of Surrogacy form found at ambetterhealth.com/en/tx and send to:

Ambetter from Superior HealthPlan
Attn: Mailroom Department
C/o Surrogacy Forms
P.O. Box 5010
Farmington, MO 63640-5010

In the event that an *enrollee* fails to comply with this provision, we reserve our right to enforce this provision on the basis 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 an *enrollee* 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).

Medical and Surgical Expense Benefits

Covered services provided under this provision are subject to all other terms and conditions of the *contract*, including *deductible amount* and *cost sharing* provisions. *Covered services* may also be subject to *prior authorization*s and *cost sharing* requirements and include, but are not limited to, the following services:

1. For *surgery* in a provider's office, an *inpatient facility*, an outpatient *facility* or a surgical *facility*, including services and supplies
2. For pre-surgical and procedural testing, including but not limited to, diagnostic services using radiologic, ultrasonographic or laboratory services
    a. Laboratory tests or radiological examinations done on an outpatient basis in a *hospital* or other *facility* accepted by the *hospital* before *hospital* confinement or outpatient *surgery* or procedures
    b. The tests must be for the same bodily *injury* or *illness* causing the *enrollee* to be *hospital* confined or to have the outpatient *surgery* or procedure.
    c. Bone density studies
    d. Clinical laboratory tests
    e. Gastrointestinal laboratory procedures
    f. Pulmonary function tests
    g. Genetic testing
    h. For *medically necessary* genetic or molecular cancer testing, including but not limited to, tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomics testing, whole exome, genome sequencing
    i. For *medically necessary* biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an *enrollee*'s disease or condition to guide treatment, in a manner that limits disruptions in care, including limits to the number of biopsies and biospecimen samples.
3. For medical services in an office or *facility* that is provided by a licensed medical practitioner or specialist, including consultations and *surgery* related services.
4. For chemotherapy (including oral chemotherapy), inhalation therapy, infusion therapy, and radiation therapy or treatment in a *hospital* or office setting.

5. For *durable medical equipment*, *prosthetic device*s, *orthotic device*s or other *necessary medical supplies* following a medical or surgical procedure such as crutches, orthopedic splints, braces or casts. Please see the **Durable Medical Equipment Prosthetics, and Orthotic Devices** provision of this *contract*.
6. For hemodialysis and the charges by a *hospital* or *facility* for the processing and administration of genetic testing, blood or blood components, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for you.
7. For the cost and administration of anesthesia, oxygen, drugs, medications and biologicals.
8. For *medically necessary* reconstructive or cosmetic *surgery* including, but not limited to:
    a. 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 device*s necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedema, are covered at all stages of mastectomy. 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:
        i. 48 hours following a mastectomy, and
        ii. 24 hours following a lymph node dissection.
    b. 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.
    c. *Reconstructive surgery* for craniofacial abnormalities.
9. For *medically necessary* dental *surgery* due to:
    a. An accidental *injury*, which results in damage to natural teeth.
    b. *Injury* to the natural teeth will not include any *injury* as a result of chewing.
    c. *Surgery* to correct a functional defect which results from a congenital and/or acquired disease or anomaly.
    d. Cleft lip and cleft palate for an *eligible child* under the age of 18. *Covered services* include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the treating *physician* or surgeon and such *physician* or surgeon certifies that such services are *medically necessary* and consequent to treatment of the cleft lip or cleft palate.
    e. Dental anesthesia charges include coverage for the administration of general anesthesia and *hospital* charges for dental care, rendered by a dentist, provided to the following *enrollee*s:
        i. An *enrollee* whose treating health care professional, in consultation with the dentist, determines the *enrollee* has a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

ii. An *enrollee* who has one or more medical conditions that would create significant or undue medical risk for the individual during delivery of any dental treatment or *surgery* if not rendered in a *hospital* or ambulatory surgical center.

iii. Necessary dental treatment is that which, if left untreated, is likely to result in a medical condition. Use of general anesthesia in a *hospital* or ambulatory surgical center is subject to *prior authorization*. Please call Member Services to confirm your benefits for the use of general anesthesia in a *hospital* or ambulatory surgical center.

10. For infertility counseling and planning services when provided by a *network provider* and testing to diagnose infertility.

11. For the treatment of breast cancer by dose-intensive chemotherapy bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy bone marrow transplants or stem cell transplants.

12. For routine patient care for patients enrolled in an eligible cancer clinical trial that is deemed an *experimental or investigational* treatment if the services provided are otherwise considered *covered services* under this *contract*. See the **Clinical Trial Coverage** provision of this *contract*.

13. For the following types of *medically necessary* implants and tissue grafts:

    a. Cornea transplants

    b. Artery or vein grafts

    c. Heart valve grafts

    d. Prosthetic tissue replacement, including joint replacements

    e. Implantable prosthetic lenses, in connection with cataracts

    f. Skin grafts

14. For X-ray, Magnetic Resonance Imaging (MRI), Computer Tomography (CT scan), Positron Emission Tomography/Single Photon Emission Computed Tomography (PET/SPECT), and other diagnostic services. See **Radiology, Imaging and Other Diagnostic Testing** provision of this *contract*.

15. For *telehealth* and *telemedicine services*. *Telehealth services* not provided by *Ambetter-designated Telehealth providers* would be subject to the same *cost sharing* as the same health care services when delivered to an *enrollee* in-person. Services provided by an *Ambetter-designated Telehealth provider* is not intended to replace or substitute *telehealth* and *telemedicine services* provided by your *network provider*.

    Covered services delivered through *telemedicine, telehealth*, or *teledentistry* when the originating site or distant site is located outside of Texas on the same basis and to the same extent that we cover the service when both the originating site and distant site are located in Texas, provided that:

    a. You primarily reside in Texas; and

    b. The health professional providing the service is licensed or otherwise *authorized* to provide the service in Texas and maintains a physical office in Texas.

16. For *surgery* or services related to cochlear implants and bone-anchored hearing aids.
17. For *medically necessary* services for complications arising from medical and surgical conditions.
18. For respiratory, pulmonary, cardiac, physical, occupational and speech therapy services. Please see **Habilitation, Rehabilitation and Extended Care Facility Expense Benefits** and **Habilitation Expense Benefits** provisions of this *contract*.
19. For maternity care services including but not limited to prenatal, postnatal, diagnostic testing, laboratory services and *hospital services*.
20. 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.
21. For *medically necessary* footcare treatment that may require *surgery*; *prior authorization* may be required.
22. For dermatology services which are limited to the following: *medically necessary* minor *surgery*, tests and office visits provided by a dermatologist who is a *network provider*.
23. For *medically necessary* biofeedback services.
24. For abortion, only in cases where a physician certifies an instance of life-threatening physical condition aggravated by, caused by, or arising from pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced, in accordance with Chapter 170A if the Texas Health and Safety Code.
25. For elective sterilization procedures (e.g., vasectomies). Note: No cost-share applies, except for HSA-compatible plans.
26. For services associated with human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation or transplant procedure.
27. For *medically necessary chiropractic care* or manipulative therapy treatment on an outpatient basis only. See your *Schedule of Benefits* for benefit levels or additional limits. *Covered services* are subject to all other terms and conditions of the *contract*, including the *deductible amount* and *cost sharing* provisions.
28. For all *medically necessary* immunizations, monitoring, screenings, re-screenings and laboratory testing for a newborn in the early detection, diagnosis and intervention of a condition or disorder. This also includes, but not limited to, hearing or audiological services, follow-up examinations and pulse oximetry.
29. For *medically necessary* allergy testing and treatment including allergy injections and serum.
30. For *medically necessary* nutritional counseling.

31. For gender transition adverse effects and reversals for adults, age 18 and older, in accordance with Texas Insurance Code, Chapter 1373.003, or in accordance with the law in the state of Texas. Coverage for:
    a. All possible adverse consequences related to the enrollee's gender transition procedure or treatment, including any short- or long-term side effects of the procedure or treatment
    b. Any baseline and follow-up testing or screening necessary to monitor the mental and physical health of the enrollee on at least an annual basis without regard to the sex or gender identity designation in the enrollee's medical record
    c. Any procedure, treatment, or therapy necessary to manage, reverse, reconstruct from, or recover from the enrollee's gender transition procedure or treatment
32. For expenses or services related to immunizations and vaccinations for travel purposes.
33. For *medically necessary* services or treatment for:
    a. A medically verifiable disorder of sexual development; or
    b. *Behavioral health* treatment for gender dysphoria (e.g., psychotherapy).
34. For *medically necessary* chimeric antigen receptor T-cell therapy when administered by a health care provider that:
    a. Is qualified as a certified health care facility in accordance with the procedure for the applicable chimeric antigen receptor T-cell therapy product license approved by the U.S. Food and Drug Administration; and
    b. Participates in the plan’s network with respect to other *covered services*.

If your provider has the capability, your coverage will include online visit services. *Covered services* include a medical consultation using the internet via a webcam, chat or voice. Non-*covered services* include, but are not limited to, communications used for:

1. Reporting normal laboratory or other test results
2. Office appointment requests
3. Billing, insurance coverage or payment questions
4. Requests for *referral*s to doctors outside the online care panel
5. Benefit precertification
6. *Physician* to *physician* consultation

See your *Schedule of Benefits* for benefit levels or additional limits.

Medical Dental Services

Anesthesia and *hospital* charges for *medically necessary* dental care 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 anesthesia and sedation reference manuals of the American Academy of Pediatric Dentistry and American Dental Association, 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. *Medically necessary* oral *surgery* including, but not limited to, 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 jawbone and is *medically necessary* to attain functional capacity of the affected part.
    c. Oral/surgical correction of accidental injuries.
    d. Treatment for Temporomandibular joint (TMJ) disorder, 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 to create a more normal appearance.
    i. *Surgery*, excluding tooth extraction, to treat craniomandibular disorders, or malocclusions.
2. Service expenses when an *enrollee* suffers an *injury* that results in damage to the natural teeth not to include damage resulting from chewing or parafunctional habit.

Medical Foods

Coverage includes 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*.

We will cover the following:

1. Outpatient total parenteral nutritional therapy
2. Nutritional counseling
3. Outpatient elemental formulas for malabsorption
4. Dietary formula (when *medically necessary* and prescribed by a *network* medical practitioner/provider and administered by enteral tube feedings or when *medically necessary* for the treatment of Phenylketonuria (PKU) and inborn errors of metabolism)

Inpatient and outpatient benefits will be provided for *medically necessary* pasteurized donor human milk when prescribed by an infant's pediatrician or licensed pediatric provider when:

1. the infant is medically or physically unable to receive maternal human milk or participate in breastfeeding or
2. the infant's mother is medically or physically unable to produce maternal human milk in sufficient quantities.

Low-Protein Food Products for Treating Inherited Metabolic Diseases

Low-protein food products for treating certain inherited metabolic disease are covered. Inherited metabolic diseases are diseases caused by an inherited abnormality of body chemistry. Low-protein food products are foods that are especially formulated to have less than 1 gram of protein per serving and are intended to be used under the direction of a *physician* for the dietary treatment of an inherited metabolic disease. Low protein food products do not include natural foods that are naturally low in protein.

Benefits for low-protein food products are limited to treating the following diseases:

1. Phenylketonuria (PKU)
2. Maple Syrup Urine Disease (MSUD)
3. Methylmalonic Acidemia (MMA)
4. Isovaleric Acidemia (IVA)
5. Propionic Acidemia
6. Glutaric Acidemia
7. Urea Cycle Defects
8. Tyrosinemia

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

Medical Vision Services

Eye examinations for the treatment of medical conditions of the eye are covered when the service is performed by a *network provider* (optometrist or ophthalmologist). *Covered services* include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision. Excluded services for routine and non-routine vision include:

1. *Referrals* to a specialist for evaluation and diagnosis of refractive error, including presbyopia.
2. Visual therapy.
3. Low vision services and hardware for adults.
4. Eye examinations required by an employer or as a condition of employment.
5. Radial keratotomy, LASIK, and other refractive eye *surgery*.
6. Services or materials provided because of any workers' compensation law or required by any governmental agency.

7. Orthoptics, vision training, or subnormal vision aids.
8. *Non-network* care, except when *prior authorized*.
9. Any vision services, treatment or material not specifically listed as a *covered service*.

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.

Covered services will be provided on an *inpatient* and outpatient basis and include treatment for mental health and *substance use disorder* diagnoses. If you need mental health and/or *substance use disorder* treatment, you may choose any *behavioral health network provider*. *Deductible amounts*, *copayment* or *coinsurance amount*s and treatment limits for covered mental health and *substance use disorder* benefits will be provided on the same terms and conditions as medical and surgical benefits.

Covered services are included on a non-discriminatory basis for all *enrollees* for the diagnosis and *medically necessary* treatment of mental health and or *substance use disorders* as defined in this *contract*. Quantitative and non-quantitative treatment limitations applicable to mental health and *substance use disorder* benefits will not be applied more stringently than those placed on coverage for medical and surgical benefits.

When making coverage determinations, our *behavioral health* utilization management staff utilizes established level of care guidelines and medical necessity criteria that are based on *generally accepted standards of medical practice* and take into account legal and regulatory requirements. Our *behavioral health* staff utilize Change Healthcare InterQual criteria for mental health and American Society of Addiction Medicine (ASAM) criteria for *substance use disorder* determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not *medically necessary* will be made by a qualified licensed mental health professional.

Covered *inpatient* and outpatient mental health and/or *substance use disorder* services include:

Inpatient

1. *Inpatient* psychiatric *hospitali*zation;
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 (Office Visits and Other Outpatient Services)

1. Individual, family, and group therapy for *mental health disorders* and *substance use disorders*;

2. Partial *Hospitali*zation Program (PHP);
3. Psychological and *neuropsychological testing* and assessment;
4. Applied Behavior Analysis (ABA) therapy;
5. *Telehealth services* and *telemedicine medical service*s (individual/family therapy; medication monitoring; assessment and evaluation);
6. Electroconvulsive Therapy (ECT);
7. Intensive Outpatient Program (IOP);
8. Mental health day treatment;
9. Outpatient detoxification programs;
10. Evaluation and assessment for mental health and *substance use disorders*;
11. Eye Movement Desensitization and Reprocessing (EMDR);
12. Trauma Focused Cognitive Behavioral Therapy (TF-CBT);
13. Medication Assisted Treatment – combines *behavioral health* therapy and medications to treat *substance use disorders*; and
14. *Transcranial magnetic stimulation* (TMS).

In addition, Integrated *Care management* is available for all of your health care needs, including *behavioral health*. Please call Member Services to be referred to a care manager for an assessment.

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*.

Note: Please be aware that some services, addressed in other sections of this *contract*, may be provided to treat both medical/surgical and behavioral health diagnoses. *Cost share* determinations for such treatment will align with the primary billed diagnosis code billed (medical/surgical or *behavioral health*). For example, nutritional counseling provided and billed to treat an eating disorder diagnosis will fall under *behavioral health*, while nutritional counseling provided and billed to treat a diagnosis of diabetes will fall under medical/surgical care.

NOTE: We subclassify our outpatient *mental health disorder* and *substance use disorder* benefits into two categories; office visits and other *outpatient services*.

Office visits include individual therapy, group therapy, routine evaluation and management in an office setting, medication monitoring/management, *outpatient* detoxification, nutritional counseling, *urgent care* and *telehealth services*.

Other *outpatient services* include psychological testing, neuropsychological testing, electroconvulsive therapy, transcranial magnetic stimulation, *applied behavior analysis (ABA)*, medication assisted treatment, intensive outpatient programs, partial hospitalization/day treatment (eight hours), partial hospitalization/half day treatment (four hours), 23-hour observation, laboratory procedures and *habilitation/rehabilitation services* (physical therapy, speech therapy, occupational therapy).

Pediatric Vision Expense Benefits

Coverage for vision services is provided for children, under the age of 19 through the end of the plan year in which they turn 19 years of age This plan complies with the pediatric vision benefit requirements as defined by 45 CFR §156.110(b)(3).

1. Routine ophthalmological examination
    a. Refraction
    b. Eye evaluation including dilation
2. Standard frames
3. Prescription lenses
    a. Single
    b. Bifocal
    c. Trifocal
    d. Lenticular
4. Additional lens options (including coating and tints)
    a. Progressive lenses (standard or premium)
    b. Intermediate vision lenses
    c. Blended segment lenses
    d. Hi-Index lenses
    e. Plastic photosensitive lenses
    f. Photochromic glass lenses
    g. Glass-grey #3 prescription sunglass lenses
    h. Fashion and gradient tinting
    i. Ultraviolet protective coating
    j. Polarized lenses
    k. Scratch resistant coating
    l. Anti-reflective coating (standard, premium or ultra)
    m. Oversized lenses
    n. Polycarbonate lenses
5. Contact lens allowance (includes contact lens fitting)
6. Low vision evaluation/aids

Please refer to your *Schedule of Benefits* for a detailed list of *enrollee cost sharing* and annual *maximum out-of-pocket amounts*. To see which vision providers are part of the *network*, please visit ambetterhealth.com/en/tx or call Member Services.

Services not covered:

1. Deluxe frame/frame upgrade
2. Visual therapy
3. Two pairs of glasses as a substitute for bifocals
4. LASIK surgery
5. Replacement eyewear

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 law*, may be dispensed only upon the written prescription of a medical practitioner.
3. Off-label drugs that are:
    a. Recognized for the 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.
4. 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*. The appropriate drug choice for an *enrollee* is a determination that is best made by the *enrollee* and his or her *physician*.

Under Texas law, *prescription drugs* used to treat an autoimmune disease, hemophilia, or Von Willebrand disease will not be subject to more than one *prior authorization* annually. NOTE: This does not apply to:

1. Prescription opioids, benzodiazepines, barbiturates, or carisoprodol;
2. Drugs that have a typical treatment period of less than 12 months;
3. Drugs that:
    a. Have a boxed warning assigned by the United States Food and Drug Administration (FDA) for use;
    b. Have specific provider assessment; or
    c. The use of a drug approved for use by the United States Food and Drug Administration (FDA) in a manner other than the approved use.

Maximum Insulin Medication Cost Share:

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. Your insulin medication cost share responsibility will not exceed $25 per prescription for a 30 day supply. Emergency refills of insulin and insulin-related equipment will be covered in the same manner as non-emergency refills.

Formulary or Prescription Drug List

The formulary or *prescription 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. If we negatively modify the formulary we will perform such modifications at the time of coverage renewal. We will notify you at least 60 calendar days in advance of such modification if you are affected by the change in drug coverage. Negative changes are defined as removing the drug from the formulary, adding quantity limit, adding *prior authorization* requirements, and adding step therapy requirements of moving drug to higher tier. Negative changes are generally made once per year.

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 *Prescription drug* List or for more information about our pharmacy program, visit ambetterhealth.com/en/tx or call Member Services.

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

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

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

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

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

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

Generic Medication

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.

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 ambetterhealth.com/en/tx on the Find a Doctor page. You can also call Member Services to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your member identification card.

We also offer a 90-day supply of maintenance medications by mail or from a *network* retail pharmacies for specific benefit plans. These drugs treat long-term conditions or *illness*es, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on ambetterhealth.com/en/tx. You can also request to have a copy mailed directly to you.

Mail Order Pharmacy/Prescription Drug Delivery

Mail Order Pharmacy offers a convenient way to receive your prescriptions. Eligible 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, please refer to our Ambetter website. Once on our Ambetter website, you will find details on your in-*network* mail order pharmacies and next steps for enrollment.

Step Therapy

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

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.

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 the plan formulary (otherwise known as “non-formulary drugs”). To exercise this right, please get in touch with your medical practitioner. Your medical practitioner can utilize the usual prior authorization request process. See “Prescription Drug Exception Process” below for additional details.

Prescription Drug Synchronization

Under Texas law, you have the right to request synchronization of your medications. Synchronization is alignment of your fill dates so that all of your medication-refill dates are on the same day. For example, if you fill medication A on the 5th of each month and your prescriber prescribes you a new prescription B on the 20th of the month, you have the right to request a refill for prescription B that is shorter or longer than 30 calendar 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.

Third-party Payment for Prescription drugs

We will apply any third-party payment, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by or on behalf of an *enrollee* to the *deductible*, *copayment*, *cost sharing* responsibility, or out-of-maximum.

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 the plan. The request can

be made in writing or by telephone. Within 72 hours of the request being received, we will provide the *enrollee*, the *enrollee*'s *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. The request can be made in writing or by telephone. 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:

1. The drug required under the step therapy protocol:
    a. Is contraindicated;
    b. Will likely cause an adverse reaction in or physical or mental harm to the patient;
    c. Is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the *prescription drug* regimen;
    d. 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;

2. 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:
    a. Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
    b. Worsen a comorbid condition of the patient; or
    c. Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.
3. The drug that is subject to the step therapy protocol was prescribed for the patient's condition and:
    a. The patient received benefits for the drug under the health benefit plan currently in force or a previous health benefit plan;
    b. The patient is stable on the drug; and
    c. 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.
4. Under Texas law, treatment for serious *mental health disorders* will be provided under the following terms:
    a. If the product is subject to utilization management technique such as *prior authorization*, we will only require trial and failure of one other product prior to approval of requested product;
    b. We may require that the *enrollee* try a generic version of the requested drug prior to the brand version of the same drug;
    c. We will require approval under section only once a year.

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.

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 *appeal*s rights.

Medication Balance-On-Hand

Medication refills are prohibited until an *enrollee*'s cumulative balance-on-hand is equal to or fewer than 15 calendar 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 calendar day supplies for the first 90 calendar days when starting new therapy using certain medications (like oral oncology). *Enrollees* pay half the 30 calendar day cost-share for a 15-day supply, and would be responsible for the other half of the 30 calendar day cost share for each additional 15-day supply. After 90 days, *enrollees* will fill their medications for 30 calendar day supplies.

Specialty Drugs

Specialty drugs and other select drug categories are limited to a 30-calendar day supply when dispensed by retail or mail order pharmacies. Please note that only the 90-calendar 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 calendar days are subject to the standard *cost sharing* amount.

"Provision of Physician Administered Drugs Through Pharmacy Benefit (White-Bagging)"

The *enrollee* can obtain *physician* administered drugs through any *network* pharmacy and will not be charged differential *copays*/co-insurance. All other standard claim processing and utilization management techniques apply. When an *enrollee* or an *enrollees physician* utilizes a non-*network* pharmacy, the *enrollee* has the right to seek reimbursement for the dispensed drug. We will cover drugs received dispensed by an non-*network* pharmacy in cases where the *enrollee* or the *enrollee*'s *physician* are obtaining specialty *physician* administered drugs due to:

1. A delay of care would make the *enrollee*'s disease progression probable or
2. The use of a *network* pharmacy would
    a. Cause death or patient harm probable;
    b. Cause barrier to the patient's adherence to or compliance with the plan of care; or
    c. Timeliness of the delivery or dosage requirements necessitate delivery by a different pharmacy.

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. This exclusion does not apply to prescribed FDA approved contraceptive methods.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that we identify as therapeutic duplication through the Drug *Utilization review* program.
11. For more than a 30 calendar day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90 calendar day supply when dispensed by mail order or a pharmacy that participates in extended day supply *network*.
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 Therapeutics 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 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.

21. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
22. Medication refills where an *enrollee* has more than 15 calendar days' supply of medication on hand.
23. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.
24. For *prescription drugs* for any *enrollee* who enrolls in Medicare Part D as of the date of his or her *enrollment* in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

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 to the extent the care is not illegal under applicable law.

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 HSA-compatible plans, the *deductible* cannot be waived for benefits that exceed the federal ACA preventive care requirements. For current information regarding available preventive care benefits, please access the federal government's website at: https://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.

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

Our Ambetter Health Preventive Care Guide is updated annually and contains detailed information regarding preventive care coverage available to you. It is accessible via our website ambetterhealth.com/en/tx. To request a paper copy, please contact Member Services for assistance.

Notification

As required by section 2715(d)(4) of the Public Health Service Act, we will provide 60 calendar 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 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 ambetterhealth.com/en/tx.

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 individuals). Follow up colonoscopies are covered if the results of the initial colonoscopy, test, or procedure were abnormal.

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 calendar 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*;

5. Immunizations – *Deductibles* will not be applicable to immunizations of a Dependent child age seven years of age or younger. Immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rotovirus, rubella, tetanus, varicella and any other immunization that is required by law for the child. Charges for immunization are not subject to *deductible*, *coinsurance* or *copayment* requirements. Charges for other services rendered at the same time as immunizations are subject to *deductible*, *coinsurance* and *copayment* in accordance with regular *contract* provisions; and
6. Newborn coverage includes all newborn test screenings and testing screening kits.

Benefits are not available for *inpatient hospital* expense or Medical/ Surgical Expense for routine physical examinations performed on an *inpatient* basis, except for the initial examination of a newborn child.

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

Benefits for Certain Tests for Detection of Human Papillomavirus, Ovarian and Cervical Cancer

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

Benefits for Mammography Screening and Diagnostic Imaging

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

35. pathology evaluations, and
36. low dose mammography including:
    a. digital mammography or
    b. breast tomosynthesis.

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

Such signs may include:

1. A lump
2. Breast pain

3. Nipple discharge
4. Thickening of skin on the breast
5. 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

For *medically necessary covered services* including an annual digital rectal examination and prostate specific antigen test performed to determine the level of prostate specific antigen in the blood. Coverage is available to all *enrollees*, regardless of age, when these services are rendered by a *medical practitioner*.

Benefits for Early Detection Tests for Cardiovascular Disease

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

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

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart

disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits for Screening Tests for Hearing Impairment

Benefits must be performed or *authorized* by your *PCP* and are available for *eligible expenses* incurred by a covered Dependent child:

1. For a screening test for hearing loss from birth through the date the child is 30 calendar 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 and Family Planning

All FDA-approved contraception methods (identified on www.fda.gov) are approved for *enrollees* without *cost sharing* when the care is legal under applicable law. *Enrollees* have access to the methods available and outlined on our drug formulary or *prescription 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*.

Family planning/contraception benefits are covered under preventive care, without *cost sharing* (when provided by a *network provider* and when the care is legal under applicable law. These benefits may include the following for adolescent and adult women, in accordance with the most recent guidelines supported by HRSA. Coverage includes, but is not limited to:

1. The full range of contraceptives currently identified by the U.S. Food and Drug Administration (FDA), including:
    a. Sterilization *surgery* for women,
    b. Implantable rods,

c. Copper intrauterine devices,
d. Intrauterine devices with progestin (all durations and doses),
e. Injectable contraceptives,
f. Oral contraceptives (combined pill),
g. Oral contraceptives (progestin only),
h. Oral contraceptives (extended or continuous use),
i. The contraceptive patch,
j. Vaginal contraceptive rings,
k. Diaphragms,
l. Contraceptive sponges,
m. Cervical caps,
n. Condoms,
o. Spermicides,
p. Emergency contraception (levonorgestrel) and
q. Emergency contraception (ulipristal acetate).

2. Coverage is also available for any additional contraceptives approved, granted, or cleared by the FDA (if the patient and the patient's attending provider have determined it to be medically appropriate).
3. For prescription contraceptive drugs, a 12-month supply is covered at one time the first time the *enrollee* obtains the drug, and a 12-month supply each subsequent time the *enrollee* obtains the same drug during each 12-month period.
4. Contraceptive care, such as: screening, education, provision of contraception, counseling and follow-up care (e.g., management, evaluation and changes, including the removal, continuation and discontinuation of contraceptives).
5. Instruction in fertility awareness-based methods, including lactation amenorrhea.

NOTE: Services that are integral to the furnishing of the above-listed preventive care coverage (e.g., anesthesia provided during sterilization *surgery*), are also included under preventive care, regardless of whether the service is billed separately.

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).

*Non-network provider*s should not bill you for *covered services* for any amount greater than your applicable participating *cost sharing* responsibilities when *balance billing protections* apply to the radiology, imaging, and other diagnostic testing services.

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.

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 and you may be *balance billed* for services received.

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 *contract* holder each will have their benefits paid by their own coverage program.

2. If you are the recipient of the transplant, 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 there is a 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://www.ambetterhealth.com/en/tx/resources/handbooks-forms/.

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 60 miles from their *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 companion(s) 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 an *enrollee* and/or companion(s) is utilizing their personal transportation vehicle; a mileage log is required for reimbursement.
    c. Maximum reimbursement for mileage is limited to the total miles traveled by the transplant recipient and by the donor and their respective companion(s), to and from their respective homes to the transplant *facility* plus miles traveled:
    d. Between the transplant *facility* and local lodging; and
    e. Between a transit hub (e.g., airport, train station, bus station) and either the transplant *facility* or local lodging.
    f. 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 companion(s) 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.

NOTE: Please refer to the Member Resources page for travel reimbursement forms and information at https://www.ambetterhealth.com/en/tx/resources/handbooks-forms/.

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 un*authorized* 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 or post-transplant services and/or travel related expenses for *enrollee* and donor, when performed outside of the United States.
10. For any organ that was procured by a sale or donation originating in another country known to have participated in forced organ harvesting.
11. The following ancillary items listed below, will not be subject to member reimbursement under this *contract*:
    a. Alcohol/*tobacco*
    b. Car, trailer, or truck 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(unless pre-approved by Case Management).
    e. Storage rental units
    f. Temporary housing incurring rent/mortgage payments.
    g. Loss of wages due to time off from work required for transplant for recipient, donor, or companion(s).
    h. Utilities, such as gas, water, electric, housekeeping services, lawn maintenance, etc.
    i. Moving violation or parking tickets
    j. Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
    k. Any services related to pet care, boarding, lodging, food, and/or travel expenses
    l. Expenses for persons other than the transplant recipient, donor or their respective companion(s)
    m. Expenses for lodging when the transplant recipient, donor, or their respective companion(s) are staying with a relative, friend, or otherwise have free lodging.
    n. Any expense not supported by a receipt
    o. Upgrades to first class travel (air, bus, and train)
    p. Personal care items (e.g., shampoo, deodorant, clothes)

q. 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

r. Souvenirs (e.g., t-shirts, sweatshirts, toys)

s. Telephone calls/mobile bills, replacement parts, or cellular purchases of any type.

t. All other items not described in the *contract* as *eligible expenses*.

u. Any tips, concierge, club level floors, and gratuities.

v. Salon, barber and spa services.

w. Insurance premiums.

x. Cost share amounts owed to the transplant surgeon, *facility*, or other provider.

y. Any fuel costs/charging station fees for any vehicle (but note that mileage is reimbursable), not related to travel to and from the *Center of Excellence* or our approved *facility*, when there is no *network* adequacy.

Urgent Care Service Benefits

Urgent care services include *medically necessary* services by *network provider*s and services provided at an *urgent care* center including *facility* costs and supplies. Care that is needed after a *PCP*'s normal business hours is also considered to be *urgent care*. Your zero *cost sharing* Preventive Care Benefits may not be used at an *urgent care* center.

Enrollees are encouraged to contact their *PCP* for an appointment before seeking care from another provider, but *contract*ed *urgent care* centers and walk in clinics can be used when an urgent appointment is not available. If the *PCP* is not available and the condition persists, call the Nurse Advice Line, at 1-877-617-0390 (TTY 1--877-617-0392). The Nurse Advice Line is available 24 hours a day, 7 days a week. A registered nurse can help you decide the kind of care most appropriate for your specific need.

Vision Expense Benefit – Adults 19 years of age or older

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

1. Routine ophthalmological examination
    a. Refraction
    b. Eye examination including dilation
2. Frames
3. Prescription lenses
    a. Single
    b. Bifocal
    c. Trifocal
    d. Lenticular
4. Contact lenses and contact lens fitting (in lieu of glasses)

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

Services not covered:

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

WELLNESS PROGRAMS AND OTHER OFFERINGS

In connection with this *contract*, we may offer wellness programs and other services to *enrollees* that serve to remove barriers to accessing health services and improve overall health outcomes. These programs and services are available when your coverage begins and continue as long as your coverage remains active. Participation in these programs and services is optional and available at no additional cost to *enrollees*. The programs and services are available to you as part of this *contract* but are not insurance. We may make changes to the terms and conditions of the programs and services or discontinue them at any time. Program tools and service may vary within your market. To inquire about these programs and other offerings, and to learn about what programs are available in your area, please visit our website at ambetterhealth.com/en/tx or by contacting Member Services.

The Ambetter Health preventive care and wellness program includes offerings for health check-ups, screenings for common conditions and vaccinations. Rewards, including those that may be converted to monetary value, may be available through the “My Health Pays” program for completing specific activities that promote healthy behaviors and address *social determinants of health*. *Enrollees* may receive communications and outreach about this program.

We also offer general wellness, health improvement and *care management* programs that may include a reward or incentive that you may earn for completing different wellness-related activities.

If you have a medical condition that may prohibit you from participating in a wellness program, 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 can access other services in connection with this *contract*, under the “Ambetter Perks” programs. The “Ambetter Perks” programs have various programs which offer discounts on health focused products and items including, but not limited to, home gym equipment, healthy eating services, digital fitness classes, and local gym memberships These programs may be available to you through “Ambetter Perks.” To learn more or find out if you qualify to sign up, please visit our website at ambetterhealth.com/en/tx.

The discount program within Ambetter Perks offers discounts on a wide range of activities, goods and health and wellness-related services. *Enrollees* are responsible for paying for the discounted goods or services under using the programs delegated vendor, Abenity. Ambetter does not endorse any merchant, good or service associated with the program.

The medication adherence program offers an opportunity to save on out of pocket prescription expenses, incrementally, with timely refills of prescriptions. Ambetter utilizes “Sempre Health” to administer the program. The program is offered to *enrollee*s who take a defined medications and is aimed at increasing medication adherence.

Enrollees are responsible for paying for the discounted goods or services and we do not endorse any vendor, goods or services associated with the program. *Enrollees* may also have access to a zero-interest line of credit through the Ambetter Perks program for paying their *deductibles*, *copayments*, and *coinsurance* on *covered services*, with several repayment options to fit their needs. The Ambetter Perks program is offered to all *enrollees*. We are not involved in administering programs; you will communicate directly with any vendors if you choose to participate.

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 an *enrollee*'s *immediate family*, including someone who is related to an *enrollee* by blood, marriage or adoption or who is normally a member of the *enrollee*'s household. This exclusion does not apply to *eligible service expense*s 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*, except as specifically covered in the **Covered Health Care Services and Supplies Benefits** section of this *contract*.
4. For weight loss programs, gym memberships, exercise equipment, or meal preparation programs.
5. For cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of gender dysphoria for adults, age 18 and older.
6. For gender transitioning or gender reassignment procedures and treatments for children younger than 18 years of age. These services include the following:
   a. *Surgery* performed that sterilizes the child, including:

i. Castration;
ii. Vasectomy;
iii. Hysterectomy;
iv. Oophorectomy
i. Metoidioplasty;
v. Orchiectomy;
vi. Penectomy;
vii. Phalloplasty; and
viii. Vaginoplasty

b. Mastectomy;
c. Prescriptions drugs that induce transient or permanent infertility:
i. Puberty suppression or blocking drugs to stop or delay normal puberty;
ii. Supraphysiologic doses of testosterone to females;
iii. Supraphysiologic doses of estrogen to males;
d. Removal of any otherwise healthy or non-diseased body part or tissue.

7. For the reversal of elective sterilization procedures.
8. For abortions, except in the instance of a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that places the female at risk of death or poses a serious risk of substantial impairment of a major bodily function unless the abortion is performed or induced, in accordance with Chapter 170A of the Texas Health and Safety Code.
9. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in covered service expenses.
10. For expenses for television, telephone, or expenses for other persons.
11. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
12. For telephone consultations between providers, except those meeting the definition of *telehealth services* or *telemedicine medical service*s, or for failure to keep a scheduled appointment.
13. For services provided outside of a *PCP* visit, when a *referral* is not obtained through your *PCP*, except in an emergency, or as specified elsewhere in this *contract*.
14. For stand-by availability of a medical practitioner when no treatment is rendered.
15. For dental service expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under the **Medical and Surgical Benefits** provision.

16. 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.
17. For mental health examinations and services involving:
    a. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Marriage counseling;
    c. Pre-marital counseling;
    d. Court ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise 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*.
18. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the **Transplant Services** provision.
19. For eye refractive *surgery*, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
21. For vocational or recreational therapy.
22. 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*.
23. 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.
24. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.
25. 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 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 *appeal*ed to the proper governmental agency and the denial is upheld by that agency.
26. For fetal reduction *surgery*.

27. Except as specifically identified as a *covered service* expense under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
28. 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).
29. 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.
30. As a result of any *injury* sustained while at a *residential treatment facility*.
31. For the following miscellaneous items (except where required by federal or state law): in vitro fertilization, artificial insemination, biofeedback; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the **Medical Foods** provision; health club memberships, unless otherwise covered; home test kits, unless required by applicable law; care or services provided to a non-enrollee biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *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*.
32. Services of a private duty registered nurse rendered on an outpatient basis.
33. Diagnostic testing, laboratory procedures, screenings or examinations performed for the purpose of obtaining, maintaining or monitoring employment.
34. For any medicinal and recreational use of cannabis or marijuana.
35. 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.
36. For *surrogacy arrangements*. Health care services, including supplies and medication, to a *surrogate*, including an *enrollee* acting as a *surrogate* or using the services of a *surrogate* who may or may not be an *enrollee* 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 including but not limited to labs, imaging, and diagnostics;

i. Any complications of the *surrogate* resulting from the pregnancy;

j. Any other health care services, supplies and medication relating to a *surrogacy arrangement*;

k. Pre-counseling, advice on procreation, or consultations related to gestational carriers or donor services;

l. Any corrective surgeries or laparoscopic procedures for the sole purpose of *surrogacy arrangement*; or

m. Any other medical or healthcare services related to the pregnancy or preparations to become a *surrogate* or donor.

Any and all other 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 when the child has an active *contract* with us effective at the time of birth;

37. For all health care services obtained at an *urgent care facility* that is a *non-network provider*.

38. For expenses, services, and treatments from a naprapathic specialists for conditions caused by *contract*ed, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.

39. For expenses, services, and treatments from a naturopathic specialists for treatment of prevention, self-healing and use of natural therapies.

40. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice* care program.

41. Dry needling.

42. Assertive Community Treatment (ACT).

43. Umbilical cord blood collection.

44. Doula services.

45. For expenses or services related to immunizations and vaccinations for occupational purposes.

46. For any specified sex-trait modification procedures, in accordance with federal regulations in 45 CFR § 156.115(d), which include any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by intentionally:

    a. Disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or

b. Altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.

TERMINATION

Termination of Contract

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

1. Nonpayment of premiums when due, subject to the **Grace Period** provision in this *contract*.
2. For any reason or event of non-renewal or cancellation as outlined in the **Guaranteed Renewable** provision.
    a. The last day of coverage is the last day of the month following the month in which the notice is sent by us unless you request an earlier termination *effective date*.
3. For an *eligible child* reaching the limiting age of 26, coverage under this *contract*, for an *eligible child*, will terminate at 11:59 p.m. on the last day of the year in which the dependent member 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 disability 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 us. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. Upon cancellation or termination of the *contract*, we shall promptly return any unearned portion of the premium paid back to the original method of payment and/or payor, but in any event shall return the unearned portion of the premium within 20 calendar 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 all *contract*s 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 and electronic communication to you at least 90 calendar 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 all individual *contract*s in the individual market in the state where you reside, we will provide a written and electronic notice to you and the Commissioner of Insurance at least 180 calendar days prior to the date that we stop offering and terminate all existing individual *contract*s in the individual market in the state where you reside.

Portability of Coverage

If a person ceases to be an *enrollee* due to the fact that the person no longer meets the definition of *dependent enrollee* under the *contract*, the person will be eligible for continuation of coverage. If elected, we will continue the person's coverage under the *contract* by issuing an individual plan. The premium rate applicable to the new *contract* will be determined based on the *residence* of the person continuing coverage. All other terms and conditions of the new *contract*, as applicable to that person, will be the same as this *contract*, subject to any applicable requirements of the State in which that person resides. Any *deductible amounts* and maximum benefit limits will be satisfied under the new *contract* to the extent satisfied under this *contract* at the time that the continuation of coverage is issued. (If the original coverage contains a family *deductible* which must be met by all *enrollees* combined, only those expenses incurred by the *enrollee* continuing coverage under the new *contract* will be applied toward the satisfaction of the *deductible amount* under the new *contract*.)

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 calendar 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 through the Health Insurance Marketplace, the Health Insurance Marketplace should be contacted for reinstatement. If your contract lapses due to nonpayment of premium, it may be reinstated provided we receive from you a written request for reinstatement within 60 calendar days after the date coverage lapsed and the written request 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 calendar 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 Superior retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the *enrollee* that are associated with the *third-party* injuries. Superior's rights of recovery apply to any recoveries made by or on behalf of the *enrollee* from any sources, including but not limited to:

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

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

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

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

1. To fully cooperate with us in order to obtain information about the loss and its cause.

2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of an *enrollee* in connection with the loss.
3. To include the amount of benefits paid by us on behalf of an *enrollee* in any claim made against any *third-party*.
4. That we:
    a. Will have a lien on all money received by an *enrollee* in connection with the loss we have provided or paid to the extent permitted by Texas law.
    b. May give notice of that lien to any *third-party* or *third-party*'s agent or representative.
    c. Will have the right to intervene in any suit or legal action to protect our rights.
    d. Are subrogated to all of the rights of the *enrollee* against any *third-party* to the extent permitted by Texas law of the benefits paid on the *enrollee*'s behalf.
    e. May assert that subrogation right independently of the *enrollee*.
5. To take no action that prejudices our reimbursement and subrogation rights. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan to the extent permitted by Texas law.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a *third-party* without providing us with written notice within 30 calendar 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.

We may recover the full cost of all benefits provided under this plan without regard to any claim of fault on the part of the member, whether by comparative negligence 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 an*other 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

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

    a. 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 *contract*s, individual insurance *contract*s and *subscriber contract*s that pay or reimburse for the cost of dental or vision care; medical care components of individual and group long-term care *contract*s; 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 *contract*s; and Medicare or other governmental benefits, as permitted by law.

    b. 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 *contract*s 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 *contract*s 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 plan*s. 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 an*other plan* and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

2. "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 *contract*ual agreement is prohibited from charging a covered *enrollee* is not an allowable expense. The following are examples of expenses that are not allowable expenses:

    a. 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.

    b. 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 amount*s, 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.

    c. 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.

    d. 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 an*other 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 *contract*ed 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.

e. 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.

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

3. "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 amount*s for which the *enrollee* is responsible.
4. "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 *physician*s that have *contract*ed with or are employed by the plan, and that excludes coverage for services provided by other health care providers and *physician*s, except in cases of emergency or *referral* by a panel member.
5. "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:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any *other plan*.
2. Except as provided in (c), a plan that does not contain a **COB** provision that is consistent with this *contract* is always primary unless the provisions of both plans state that the complying plan is primary.
3. 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.
4. A plan may consider the benefits paid or provided by an*other plan* in calculating payment of its benefits only when it is secondary to that *other plan*.
5. 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-*contract*ed health care provider or *physician*, except for *emergency services* or *authorized referral*s that are paid or provided by the primary plan.

6. When multiple *contract*s 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 *contract*s is governed by the terms of the *contract*s. 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.
7. 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.
8. Each plan determines its order of benefits using the first of the following rules that apply.
    a. Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, *enrollee*, *contract* holder, *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*, *contract* holder, *subscriber*, or retiree is the secondary plan and the *other plan* is the primary plan. An example includes a retired employee.
    b. 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.
        i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
        A. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
        B. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
        ii. For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
        A. 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.
        B. 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.

C. 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.

D. 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.

iii. 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.

iv. 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.

v. 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*.

c. 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.

d. 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 an*other 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.

e. 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.

f. 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

1. 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.
2. 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.
3. 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 plan*s. 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 plan*s 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 an*other 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 calendar 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 calendar days of the date of service.

Claim Submission

Providers will typically submit claims on your behalf, but sometimes you may have to pay for a *covered service* and file a claim for reimbursement. This may happen if your provider is not *contract*ed with us.

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 Medical Claim Form posted at ambetterhealth.com/en/tx. 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 calendar days or less.

We will notify you, in writing, that we have either accepted or rejected your claim for processing within 15 calendar 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 calendar 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 calendar 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 calendar 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.

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:

1. Dissatisfaction with plan administration;
2. Procedures related to review or *appeal* of an *adverse determination*;
3. The denial, reduction, or termination of a service for reasons not related to medical necessity;
4. The way a service is provided; or
5. Disenrollment decisions.

Complaints are considered standard unless they concern an emergency or denial of continued stay for *hospitali*zation, 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
ATTN: Complaints 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 *hospitali*zation 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 your health condition and we will send you a letter with our resolution within three business days.

You may use the *appeal*s 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 *appeal*s process no later than the 30 calendar days after the date of the receipt of the request for *appeal*, except with respect to *appeal*s relating to ongoing emergencies or denial of continued stays for *hospital*ization which 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*.
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 *appeal*s relating to ongoing emergencies or denial of continued stays for *hospital*ization 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 *contract*ual criteria used to reach the final decision.

Appeal of Adverse Determination

If you, your designated representative, or your provider of record disagree with an *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*.

Expedited *appeal*s of *adverse determination*s 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, or 72 hours, whichever is lesser, upon receipt of your request.

With respect to retrospective *utilization review*, if additional time is needed due to matters beyond our control, you or your designated representative will be notified before the thirtieth (30th) calendar day with specific reasons why the additional time is needed and the additional time will be no greater than 15 calendar days.

You can also request an expedited *appeal* for an *urgent care* denial. We will answer your *appeal* for *urgent care* within one 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.

You may submit your written appeal by mail or fax to:

Ambetter from Superior HealthPlan
ATTN: Appeals Department
5900 E. Ben White Blvd.
Austin, TX 78741
Fax: 1-866-918-2266

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. You or your designated representative can ask for an external review within four months after the date you receive the final internal *appeal* determination notice. The purpose of the external review is to find out if the health plan's decision was right. There is a *standard* external review and, for urgent cases, an *expedited* (faster than usual) external review.

If you request an external review, it will be conducted by an Independent Review Organization (IRO). An IRO is not affiliated with us or our *utilization review* agent. You may request an external review if your internal *appeal* rights have already been exhausted. In some specific limited cases, a consumer can ask for an external review without completing the plan's internal appeals process first. In those cases, the consumer can request an external review of the plan's original decision to deny a benefit or refuse payment. A written notice of the final external review decision for standard external review will be provided as quickly as possible, but no later than 45 days after the request for an external review is received.

In circumstances involving a life-threatening condition, emergency *care*, *hospitalized* enrollees, denials of *prescription drugs*, intravenous infusions, or a denied step therapy protocol exception, you, your designated representative, or your provider is entitled to an expedited external review. Expedited external reviews decisions will be provided as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. An expedited review may be requested when:

1. The person has asked for an expedited internal appeal and wants an expedited external review at the same time, and the timeframe for an expedited internal appeal would place the person's life, health or ability to regain maximum function in danger.

OR

2. The person has completed an internal appeal with the plan and the decision was not in his or her favor, and:
    a. The timeframe to do a standard external review (45 days) would place the person's life, health or ability to regain maximum function in danger, or
    b. The decision is about admission, care availability, continued stay, or emergency health care services where the person has not been discharged from the facility.

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.

You can submit an external review request via mail, fax, or through the designated online consumer portal. For additional information or for assistance, please visit https://maximusferp.my.site.com/FERP/s/external-reviews or call 1-888-975-1080, Monday – Friday 8:00AM to 5:00PM EST.

Manual form can be accessed at: https://maximusferp.my.site.com/FERP/s/forms.

MAXIMUS Federal Services
State Appeals East
3750 Monroe Avenue, Suite 708
Pittsford, NY 14534
Fax: 1-888-866-6190

Simultaneous Expedited Appeal and Expedited External Review

In the case of an *appeal* involving urgent care, you or your *authorized* representative may request an expedited internal appeal and an expedited external review at the same time. For additional information, please call MAXIMUS Federal Services at 1-888-975-1080, Monday – Friday 8:00AM to 5:00PM EST.

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, Texas 78711-2030
2. **In person or by delivery service**: Texas Department of Insurance, Consumer Protection (111-1A), 1601 Congress Avenue, 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 calendar 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

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 *appeal*ed a decision made by us.

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 *appeal*ed a decision made by us.

ENROLLEE RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as an *enrollee*.
2. Encouraging open discussions between you, your provider and medical practitioners.
3. Providing information to help you become an informed health care consumer.
4. Providing access to *covered services* and our *network provider*s.
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 providers, medical practitioners, *hospital*s, 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 the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally *authorized* 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, *authorization*s, benefit denials, *enrollee* rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 calendar 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 provider*s. You can also get information on your *network provider*s' 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 *PCP*. 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. You will be assigned to one of the primary care providers within the primary care *medical group* available in your Ambetter Value *network*, but you may request to change your assigned primary care provider and *medical group*.
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. Determine what actions should be taken regarding your health if you are no longer able to make decisions for yourself because of *illness* or because you are incapacitated. You have the right to have your wishes known by completing Advance directives forms. Make advance directives forms for health care decisions. This includes planning treatment before you need it. Advance directives forms 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. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; or
    c. “Do Not Resuscitate” Orders. *Enrollees* also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this entire *contract*.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past *illness*es, *hospital*izations, 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 member 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 health care 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 health benefit plan 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 amount*s, and *coinsurance amount*s 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 calendar days from the date of the event.

Your rights with a Health Maintenance Organization (HMO) plan

Notice from the Texas Department of Insurance

Your plan

A health maintenance organization (HMO) plan contracts with doctors, *facilities*, and other health care providers to treat its *enrollees*. Providers that contract with the health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's *network*. Your plan will only pay for health care you get from doctors and *facilities* in the *network*. However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network

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

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

List of doctors

You can get a directory of health care providers that are in your plan's *network* services . You can get the directory online at AmbetterHealth.com or by calling 1-877-687-1196. If you used your health plan's directory to pick an in-network provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care

If you got health care from a doctor that was out-of-network when you were at an in-network *facility*, and you didn't pick the doctor, you won't have to pay more than your regular *copay, coinsurance*, and *deductible*. Protections also apply if you got *emergency services*, at an out-of-network facility or lab work or imaging in connection with in-network care. If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

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 Applicable laws

Any part of this *contract* in conflict with *applicable laws* on this *contract*'s *effective date* or on any premium due date is changed to conform to the minimum requirements of *applicable laws*.

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 calendar 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://www.ambetterhealth.com/en/tx/privacy-practices/ or call Member.

We protect all of your PHI. We follow HIPAA to keep your health care information private.

Language Assistance

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://www.ambetterhealth.com/en/tx/language-assistance/.

Time Limit on Certain Defenses:

1. 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 plan may not be used to void the *contract* or to deny a claim for loss incurred or disability (as defined in the *contract*) beginning after that anniversary.
2. 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*.