AMBETTER FROM SUPERIOR HEALTHPLAN WRITTEN DISCLOSURE OF COVERAGE

PROVIDED BY CELTIC INSURANCE FOR AMBETTER FROM SUPERIOR HEALTHPLAN

(Hereafter referred to as "Ambetter from Superior HealthPlan")

READ YOUR POLICY CAREFULLY. This written plan disclosure provides a very brief disclosure of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

The entity providing this coverage to you is an insurance company, Celtic Insurance Company. Your health insurance policy only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written disclosure or as otherwise required by law.

An exclusive provider network is a group of preferred physicians and health care providers available to you under an exclusive provider benefit plan and directly or indirectly contracted with us to provide medical or health care services to you and all individuals insured under the plan.

For additional information please write or call:
Ambetter from Superior HealthPlan
5900 E. Ben White Blvd.
Austin, TX 78741
1-877-687-1196

Network provider, or preferred provider, is the collective group of physicians and health care providers available to you under this exclusive provider benefit plan and directly or indirectly contracted to provide medical or health care services to you. Non-Network, or non-preferred provider, is a physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with Ambetter from Superior HealthPlan to provide medical care or health care on a preferred benefit basis to you through this health insurance policy. Services received from a non-network provider are not covered, except as specifically stated in the policy.

Covered Services and Benefits

The Ambetter from Superior HealthPlan Schedule of Benefits and plan brochures for all plan options can be found at the links below. These documents will explain all covered services and benefits, including payment for services of a participating provider and non-participating provider, and prescription drug coverage, both generic and name brand after the deductible has been met.

The Schedule of Benefits will also provide an explanation of your financial responsibility for payment for any premiums, deductibles, copayments, coinsurance or other out-of-pocket expenses for non-covered or non-preferred services. Please note that we will pay the negotiated fee or usual and customary rate to non-preferred or non-network providers, as explained under the “eligible service expense” definition found in your contract.

Bronze/Essential Care Plans

Silver/ Balanced Care Plans

Gold/Secure Care Plans

Emergency Care Service and Benefits

Your health insurance policy provides coverage for medical emergencies wherever they occur. In an emergency, always call 911 or for a behavioral health emergency condition, call 988 or go to the nearest hospital emergency room (ER).

Anything that could endanger your life (or your unborn child's life, if you're pregnant) without immediate medical attention is considered an emergency situation. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, you should contact the network provider or behavioral health practitioner before going to the hospital emergency room/treatment room. He/she can help you determine if you need emergency care or treatment for an accidental injury and recommend that care. If you cannot reach your provider and you believe the care you need is an emergency, you should go to the nearest emergency facility, whether or not the facility is a preferred/network provider.

If admitted for the emergency condition immediately following the visit, prior authorization of the inpatient hospital admission will be required, and inpatient hospital expenses will apply. All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for network benefits. After 48 hours, network benefits will be available only if you use preferred/network providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if you can safely be transferred to the care of a preferred/network provider but are treated by a non-network provider, only out-of-network benefits will be available.

Your policy also covers after-hours care. Sometimes you need medical help for non-life threatening conditions when your PCP's office is closed. If this happens, you have options. You can call our 24/7 Nurse Advice Line at 1-877-687-1196. A registered nurse is always available and ready to answer your health questions. You can get medical advice, a diagnosis or a prescription by phone or video by using our Telehealth services 24/7. Visit our website for details. You can also go to an urgent care center. An urgent care center provides fast, hands-on care for illnesses or injuries that aren't life threatening but still need to be treated within 24 hours. Typically, you will go to an urgent care if your PCP cannot get you in for a visit right away. Common urgent care issues include sprains, ear infections, high fevers and flu symptoms or vomiting.

Out-of-Area Service and Benefits

When outside of the service area, routine or maintenance care is not covered. However, your health insurance policy covers emergency care out of the service area, subject to deductibles, coinsurance and maximum out of pockets, as listed in the Covered Healthcare Services and Supplies section of your contract. A definition of the Ambetter from Superior HealthPlan service area is defined within this document.

Insured's Financial Responsibility

The following are the features of your insurance policy with Ambetter from Superior HealthPlan that require you to assume financial responsibility for payment of premiums, deductibles, coinsurance or any other out-of-pocket expenses for non-covered services. You will be fully responsible for payment for any services that are not covered service expenses or are obtained out-of-network, with the exception of emergency services or prior authorized out-of-network services including access to non-preferred providers when a preferred provider is not reasonably available to you.

Premium Payment

PREMIUMS ARE SUBJECT TO CHANGE AT POLICY RENEWAL. Renewal premiums for this policy will increase periodically depending upon your age and policy year.

Each premium is to be paid to us 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. Ambetter reserves the right to apply any rewards that may be converted to monetary value earned through My Health Pays or similar program to any unpaid premium or related amounts you may owe.

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 advanced premium tax credits are received.

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

When an enrollee is not receiving a premium subsidy:
Grace Period: A grace period of 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.

Deductibles

In addition to your premium, your health insurance policy requires you to pay the amount of the deductible from one of the available plan options for each covered person for each calendar year.
The benefits of the plan will be available after satisfaction of the applicable deductibles as shown on your Schedule of Benefits. The deductibles are explained as follows:

Calendar Year Deductible: The individual deductible amount shown under “Deductibles” on your Schedule of Benefits must be satisfied by each participant under your coverage each calendar year.

This deductible, unless otherwise indicated, will be applied to all categories of eligible service expenses before benefits are available under the contract.

The following are exceptions to the deductibles described above:

1. If you have several covered dependents, all charges used to apply toward an “individual” deductible amount will be applied toward the “family” deductible amount shown on your Schedule of Benefits.
2. When that family deductible amount is reached, no further individual deductibles will have to be satisfied for the remainder of that calendar year. No enrollee will contribute more than the individual deductible amounts to the “family” deductible amount.

The deductible amount does not include any copayment amount.

After the deductible is satisfied, regular policy benefits will pay for covered expenses at the coinsurance percentage level for covered inpatient and outpatient expenses each calendar year. Your health insurance policy payments may be limited by policy exclusions and limitations. You will be responsible for any charge that is left unpaid after Ambetter from Superior HealthPlan has paid up to its policy limits and obligations.

Coinsurance Stop-Loss Amount

Most of your eligible service expense payment obligations, including copayment amounts, are considered coinsurance amounts and are applied to the coinsurance stop-loss amount maximum.

Your coinsurance stop-loss amount will **not** include:

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

Individual Coinsurance Stop-Loss Amount

When the coinsurance amount for the in-network or out-of-network benefits level for an enrollee in a calendar year equals the “individual” “coinsurance stop-loss amount” shown on your Schedule of Benefits for that level, the benefit percentages automatically increase to 100 percent for purposes of determining the benefits available for additional eligible service expenses incurred by that enrollee for the remainder of that calendar year for that level.

Family Coinsurance Stop-Loss Amount

When the coinsurance amount for the in-network or non-network benefits level for all enrollees under your coverage in a calendar year equals the “family” “coinsurance stop-loss amount” shown on your Schedule of Benefits for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional eligible service expenses incurred by all family enrollees for the remainder of that calendar year for that level. No enrollee will be required to contribute more than the individual coinsurance amount to the family coinsurance stop-loss amount.

Coinsurance Percentage

We will pay the applicable coinsurance in excess of the applicable deductible amount(s) and copayment amount(s) for a service or supply that:

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

When the annual maximum out-of-pocket 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 service expenses.
3. Any reduction for expenses incurred at a non-network provider

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

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 the contract.

Health Insurance Policy Limitations and Exclusions

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the enrollee or enrollee in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on the enrollee or enrollee by a provider (including a hospital) but that are actually the responsibility of the provider to pay.
3. Any services performed by a member of the 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.
4. Any services not identified and included as covered services 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 the 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 the contract.
2. For any portion of the charges that are in excess of the eligible service expense.
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery, except as specifically covered in the Major Medical Expense Benefits section of the 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
        v. Metoidioplasty;
        vi. Orchiectomy;

vii. Penectomy;
viii. Phalloplasty; and
ix. 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, unless performed to save the life or the health of the enrollee, consistent with the appropriate determination of the physician, and not illegal under applicable law.
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 services, or for failure to keep a scheduled appointment.
13. For stand-by availability of a medical practitioner when no treatment is rendered.
14. For dental service expenses, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under your Dental Benefit Rider, if applicable.
15. 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.
16. 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 the contract;
e. Testing of aptitude, ability, intelligence or interest; or
f. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services are medically necessary and that would otherwise be covered under the contract.
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Services provision.
18. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
19. While confined primarily to receive rehabilitation, custodial care, educational

care, or nursing services (unless expressly provided for in the contract).

20. For vocational or recreational therapy.
21. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in the contract.
22. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.
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. 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 appealed to the proper governmental agency and the denial is upheld by that agency.
25. For fetal reduction surgery.
26. 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.
27. 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).
28. 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.
29. As a result of any injury sustained while at a residential treatment facility.
30. For the following miscellaneous items: in vitro fertilization, artificial insemination (except where required by federal or state law); biofeedback; care or complications resulting from non-covered services; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods provision; health club memberships, unless otherwise covered; home test kits; care, 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 the contract;

31. Services of a private duty registered nurse or a Licensed Vocational Nurse (LVN) rendered on an outpatient basis.
32. Diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
33. For any medicinal and recreational use of cannabis or marijuana.
34. Vehicle installations (modifications) which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
35. For surrogacy arrangement. Health care services, including supplies and medication to a surrogate, including an enrollee acting as a surrogate or utilizing the services of a surrogate who may or may not be an enrollee. This exclusion applies to all health care services, supplies and medication relating to a surrogacy agreement, to a surrogate including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the surrogate following childbirth);
    d. Mental Health Services related to the surrogacy arrangement;
    e. Expenses relating to donor semen, including collection and preparation for implantation;
    f. Donor gamete or embryos or storage of same relating to a surrogacy arrangement;
    g. Use of frozen gamete or embryos to achieve future conception in a surrogacy arrangement;
    h. Preimplantation genetic diagnosis relating to a surrogacy arrangement;
    i. Any complications of the child or surrogate resulting from the pregnancy; or
    j. Any other health care services, supplies and medication relating to a surrogacy arrangement.
    k. Any and all health care services, supplies or medication provided to any child birthed by a surrogate as a result of a surrogacy arrangement are also excluded, except when the child possesses an active contract with us effective at the time of birth.
36. For all health care services obtained at an urgent care facility that is a non-network provider
37. For expenses, services, and treatments from a Naprapathic specialists for conditions caused by contracted, injured, spasmed, bruised, and/or otherwise affected myofascial or connective tissue.
38. For expenses, services, and treatments from a naturopathic specialists for treatment of prevention, self-healing and use of natural therapies.
39. Medical necessity of services or supplies, to the extent such services or supplies

are provided as part of a hospice care program.

40. Dry needling.
41. Assertive Community Treatment (ACT).
42. Umbilical cord blood collection.

Non-Covered Services and Exclusions:

No benefits will be paid under this benefit provisions 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-day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90-day supply is subject to the discounted cost sharing. Ambetter permits pharmacies to dispense at mail order discounted cost sharing should they request to join our mail order network and except all terms and conditions. Mail orders less than 90 days are subject to the standard cost sharing amount.
12. Foreign Prescription Medications, except those associated with an Emergency Medical Condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
13. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to enrollee’s vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
14. For medications used for cosmetic purposes.
15. For infertility drugs unless otherwise listed on the formulary.

16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
17. For drugs or dosage amounts determined by Ambetter's Pharmacy and Therapy committee to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
18. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
19. For any drug related to surrogate pregnancy.
20. For any injectable medication or biological product that is not expected to be self-administered by the enrollee at enrollee's place of residence unless listed on the formulary.
21. For any claim submitted by non-lock-in pharmacy while enrollee is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, enrollee's participation in lock-in status will be determined by review of pharmacy claims.
22. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
23. Medication refills where an enrollee has more than 15calendar days' supply of medication on hand.
24. Compound drugs, unless there is at least one ingredient that is an FDA approved drug.

Lock-in program

To help improve enrollee safety decrease overutilization and abuse, certain enrollees identified through our Lock-in Program, may be locked into a specific pharmacy for the duration of their participation in the lock-in program. Enrollees locked into a specific pharmacy will be able to obtain their medication(s) only at specified location. Ambetter pharmacy, together with Medical Management will review enrollee profiles and using specific criteria, will recommend enrollees for participation in lock-in program. Enrollees identified for participation in lock-in program and associated providers will be notified of enrollee participation in the program via mail. Such communication will include information on duration of participation, pharmacy to which enrollee is locked-in, and any appeals rights.

Prior Authorization Requirements for Services

Some medical, pharmaceutical and behavioral health covered services require prior authorization. In general, network providers do not need to obtain authorization from Ambetter from Superior HealthPlan 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 prior authorization from us before you or your dependent enrollee:

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

To obtain prior authorization or to confirm that a network provider has obtained prior authorization, contact Ambetter from Superior HealthPlan by telephone at the telephone number listed on your member identification card before the service or supply is provided to the enrollee.

Failure to comply with the prior authorization requirements may result in benefits being reduced or not covered. Network providers cannot bill you for services for which they fail to obtain prior authorization as required. Emergency care does not require prior authorization. In cases of emergency, benefits will not be reduced for failure to comply with prior authorization requirements. However, you must contact us as soon as reasonably possible after the emergency occurs. Please see your contract and Schedule of Benefits for specific details.

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

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

Continuity of Treatment In The Event of Termination of a Preferred Provider's Participation in the Plan

Under the federal No Surprises Act, if an enrollee who is a continuing care patient with respect to a network provider and: the contractual relationship with the provider is terminated such that the network provider is no longer in the network or benefits are terminated because of a change in the terms of the participation of the provider as it pertains to the services the member is receiving, as a continuing care patient, then the plan must identify that the enrollees meets the definition of continuing patient and may be permitted to continue treatment under their care. The plan must:

1. Notify each enrollee who is a continuing care patient on a timely basis of the termination and their right to receive continued transitional care from the provider or facility;
2. Provide the enrollees with an opportunity to notify the health plan of the individual's need for transitional care; and
3. Permit the enrollees to elect to continue to have their benefits for the course of treatment relating to the enrollee'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. the 90-day period beginning on such date; or the
    b. date on which such individual is no longer a continuing care patient with respect to their provider or facility.

Non-Emergency Services

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

Complaint Procedures

You may file a complaint regarding any aspect of the plan. We will not take any action against you due solely that you, your representative or your provider files a complaint against us.

You must send your complaint in writing to the address below. You can call Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) for assistance.

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

Expedited Complaints: If your complaint concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, we will resolve it no later than one working day, or72 hours, whichever is lesser, from the time that we receive it. You will get a letter with the resolution to your complaint within one business day of your request..

Non-Expedited (Standard) Complaints: If the complaint is not expedited, you will get the resolution within thirty (30) calendar days of the date we receive the complaint.

Appealing a Complaint Resolution: If you aren't satisfied with the resolution to your complaint, you can request an appeal of the complaint resolution. You must do so within 90 days from the date of the incident. In response to your complaint appeal, we will hold a complaint appeal panel at a location in your area. A complaint appeal panel includes our staff, provider(s) and enrollee(s). You will receive a hearing packet five days before the appeal panel hearing. You may attend the hearing, have someone represent you at the hearing or have a representative attend the hearing with you. The panel will make a recommendation for the final decision on your complaint. You will receive our final decision within 30 days of your complaint appeal request.

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 appealed 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 appealed a decision made by us.

Access to OB/GYN Services

Female members shall have direct access to an OB/GYN (who is an exclusive provider) for female services.

Network Information

A current list of preferred providers, including names, locations of physicians and health care providers and which preferred providers are not accepting new patients can be found by visiting and using our Find a Provider tool: Ambetter.SuperiorHealthPlan.com/findadoc.

This tool will have the most up-to-date information about our provider network. It can help you find a Primary Care Provider (PCP), pharmacy, lab, hospital or specialist. The search can be narrowed by:

1. Provider specialty
2. ZIP code
3. Gender
4. Languages spoken
5. Whether or not he/she is currently accepting new patients

You can find all of the information listed below on our website using the Find a Provider tool. You can also call Member Services to get information on providers' medical school and residency information.

1. Name, address, telephone numbers
2. Professional qualifications
3. Specialty
4. Board certification status

A non-electronic copy may be obtained free of charge by contacting Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

Texas Department of Insurance Notice

1. An exclusive provider benefit plan provides no benefits for services you receive from non-network providers, with specific exceptions as described in your contract and below.
2. You have the right to an adequate network of network providers.
   a. If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at www.tdi.texas.gov/consumer.complfrm.html.
3. If your insurer approves a referral for non-network services because no network provider is available, or if you have received non-network emergency services, your insurer must, in most cases, resolve the non-network provider's bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts. Protections also apply when covered services are:
   a. 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.
   b. Air ambulance services provided to an enrollee by a non-network provider.
4. You may obtain a current directory of network providers at the following website: Ambetter.SuperiorHealthPlan.com or by calling Member Services for assistance in finding available network providers. If you relied on materially inaccurate directory information, you may be entitled to have a non-network claim paid at the network level of benefits.

Ambetter from Superior HealthPlan Service Area and Number of Enrollees

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

The number of effectuated members in Ambetter's service area under the Celtic EPO license is currently 255,205. Please refer to the table below for a breakdown of effectuated members based on service area.

County	Total Effectuated Members
Andrews	1,689
Aransas	936
Armstrong	114
Atascosa	162
Austin	2,192
Bandera	278
Bastrop	430
Bell	13
Bexar	3,488
Blanco	628
Bosque	80
Brazoria	13,715
Brazos	1
Brewster	26
Brooks	569
Brown	5,348

Burleson	3
Burnet	138
Caldwell	122
Calhoun	0
Cameron	767
Camp	860
Carson	1
Castro	510
Chambers	1,921
Cherokee	2,083
Coke	44
Coleman	374
Collin	719
Collingsworth	123
Colorado	1,363
Comal	354
Comanche	638
Concho	125
Cooke	1,933
Dallam	516
Dallas	5
Deaf Smith	1,383
Delta	0
Denton	0
DeWitt	50
Donley	165
Ector	17,590
Edwards	22
El Paso	1,449
Ellis	0
Falls	24
Fannin	1,246
Fayette	138
Fisher	0
Fort Bend	17,406
Freestone	58
Frio	80
Galveston	1,625
Gillespie	1,975
Goliad	1
Gonzales	100
Gray	1,151
Grayson	5,142

Gregg	3,752
Grimes	7
Guadalupe	159
Hamilton	244
Hardin	1,355
Harris	5,765
Hartley	114
Hays	0
Henderson	5,951
Hidalgo	178
Hill	145
Hood	1,940
Houston	922
Hunt	171
Irion	566
Jack	97
Jackson	556
Jefferson	17
Johnson	0
Kendall	398
Kerr	2,036
Kimble	1,305
Kinney	9
Lampasas	482
Lavaca	715
Lee	0
Leon	553
Liberty	6,407
Limestone	75
Llano	64
Madison	0
Mason	931
Matagorda	4
Maverick	133
McCulloch	3
McLennan	0
Medina	385
Menard	156
Milam	179
Mills	100
Mitchell	212
Montague	158
Montgomery	4

Nacogdoches	2
Navarro	22
Nueces	5,688
Oldham	104
Orange	3
Palo Pinto	910
Panola	1,283
Parker	732
Parmer	385
Potter	10
Rains	462
Randall	4,392
Real	43
Refugio	0
Robertson	0
Rockwall	50
Runnels	374
Rusk	4
San Jacinto	1,523
San Saba	172
Schleicher	132
Scurry	779
Sherman	861
Smith	9,101
Somervell	167
Starr	14,816
Sterling	226
Stonewall	49
Sutton	195
Tarrant	3,297
Tom Green	8,621
Travis	0
Trinity	620
Tyler	535
Val Verde	112
Van Zandt	1,979
Victoria	5
Walker	1,765
Waller	19,862
Webb	42,912
Wharton	2,056
Wheeler	152
Willacy	0

Williamson	985
Wise	1
Wood	1,689
Zapata	4

Network Demographics

	Provider Type					
County	**Primary Care**	**Pediatrics - Routine/Primary Care**	**Gynecology (OB/GYN)**	**Psychiatry**	**Surgery**	**Acute General Hospital**
Andrews	6	0	2	0	2	1
Aransas	2	1	0	1	0	0
Armstrong	1	0	0	0	0	0
Atascosa	5	0	0	3	6	1
Austin	5	0	0	0	1	1
Bandera	5	0	0	0	0	0
Bastrop	17	8	3	0	6	1
Bell	25	11	4	8	13	2
Bexar	334	125	145	23	379	23
Blanco	1	0	0	0	0	0
Bosque	7	0	0	0	3	0
Brazoria	97	13	4	5	32	2
Brazos	83	9	3	8	39	3
Brewster	4	0	1	0	3	0
Brooks	4	0	0	0	0	0
Brown	5	0	0	0	3	1
Burleson	2	0	0	0	1	0
Burnet	10	1	1	2	5	0
Caldwell	12	1	1	0	2	0
Calhoun	7	0	2	0	1	0
Cameron	135	46	21	14	70	4
Camp	5	1	2	5	4	0
Carson	2	0	0	0	0	0
Castro	1	0	0	0	1	0
Chambers	7	0	0	1	2	0
Cherokee	10	4	3	0	3	1
Coke	0	0	0	0	0	0
Coleman	1	0	0	0	0	0
Collin	455	56	80	23	271	15

Collingsworth	0	0	0	0	0	0
Colorado	16	0	2	1	4	1
Comal	41	11	4	0	15	1
Comanche	17	1	0	0	2	0
Concho	0	0	0	0	1	0
Cooke	16	1	0	0	7	0
Dallam	1	0	0	0	0	0
Dallas	872	83	168	47	684	21
Deaf Smith	9	0	0	0	1	1
Delta	1	0	0	0	0	0
Denton	198	11	26	10	120	9
DeWitt	43	0	0	0	1	1
Donley	1	0	0	0	0	0
Ector	28	4	7	0	17	1
Edwards	0	0	0	0	0	0
El Paso	204	95	55	21	142	5
Ellis	75	7	2	0	17	2
Falls	4	0	0	0	1	0
Fannin	5	0	0	0	1	0
Fayette	8	4	1	2	3	0
Fisher	4	0	0	0	1	0
Fort Bend	228	30	24	18	71	5
Freestone	5	0	0	0	2	1
Frio	8	1	0	0	4	0
Galveston	51	2	2	5	14	0
Gillespie	26	2	1	0	9	1
Goliad	12	0	0	0	0	0
Gonzales	10	1	0	0	3	1
Gray	10	0	0	0	2	1
Grayson	28	7	1	7	18	2
Gregg	52	14	10	2	33	0
Grimes	5	0	0	0	1	0
Guadalupe	19	10	13	0	6	2
Hamilton	16	0	0	1	2	0
Hardin	14	0	0	0	0	0
Harris	1161	226	288	148	781	23
Hartley	2	1	0	0	2	0
Hays	59	19	26	2	24	1
Henderson	33	2	3	1	6	1
Hidalgo	428	90	49	10	146	8

Hill	11	0	0	0	1	0
Hood	25	6	0	1	10	1
Houston	8	0	0	0	0	0
Hunt	39	9	1	2	15	1
Irion	0	0	0	0	0	0
Jack	3	0	0	0	3	2
Jackson	4	0	1	0	2	0
Jefferson	65	7	2	8	25	1
Johnson	33	2	4	1	9	2
Kendall	25	6	1	0	8	0
Kerr	39	5	4	0	13	1
Kimble	0	0	0	0	0	0
Kinney	2	0	0	0	0	0
Lampasas	6	1	1	0	2	0
Lavaca	14	0	1	0	2	0
Lee	3	0	0	2	0	0
Leon	4	0	0	0	0	0
Liberty	38	4	0	2	2	0
Limestone	9	0	0	2	2	0
Llano	2	1	0	0	0	0
Madison	4	0	0	0	1	0
Mason	2	0	0	0	0	0
Matagorda	22	3	1	1	3	1
Maverick	16	4	3	0	2	1
McCulloch	3	0	0	0	2	0
McLennan	154	11	23	2	27	1
Medina	11	1	1	0	13	0
Menard	0	0	0	0	0	0
Milam	8	1	1	0	0	0
Mills	1	0	0	0	0	0
Mitchell	3	0	0	0	2	0
Montague	6	0	0	0	0	0
Montgomery	160	18	24	11	103	7
Nacogdoches	19	2	4	0	14	1
Navarro	15	2	4	0	10	1
Nueces	65	50	17	8	55	2
Oldham	0	0	0	0	0	0
Orange	11	1	0	0	2	0
Palo Pinto	9	1	2	0	3	1
Panola	8	0	1	0	1	1

Parker	42	3	4	1	15	1
Parmer	6	0	0	0	0	0
Potter	83	20	16	11	46	1
Rains	1	0	0	0	0	0
Randall	19	0	0	0	5	0
Real	0	0	0	0	0	0
Refugio	2	0	0	0	4	0
Robertson	5	0	0	0	0	0
Rockwall	51	3	11	2	31	3
Runnels	0	0	0	1	1	0
Rusk	12	1	2	0	3	1
San Jacinto	6	0	0	0	0	0
San Saba	0	0	0	0	0	0
Schleicher	0	0	0	0	0	0
Scurry	16	0	0	0	3	0
Sherman	2	0	0	0	0	0
Smith	66	20	24	19	86	3
Somervell	8	0	0	0	1	1
Starr	32	5	2	0	5	1
Sterling	0	0	0	0	0	0
Stonewall	2	0	0	0	1	0
Sutton	3	0	0	0	2	0
Tarrant	754	67	179	46	464	25
Tom Green	78	13	10	5	29	2
Travis	400	138	164	34	313	9
Trinity	3	0	0	0	0	0
Tyler	3	0	0	0	1	1
Val Verde	15	4	4	0	11	1
Van Zandt	2	1	0	1	1	0
Victoria	28	6	6	0	24	3
Walker	15	1	1	1	8	1
Waller	4	0	0	0	0	0
Webb	100	17	10	5	28	2
Wharton	5	3	2	1	1	0
Wheeler	0	0	0	0	2	0
Willacy	12	1	0	0	0	0
Williamson	135	103	37	16	70	4
Wise	36	4	4	1	10	0
Wood	10	0	2	0	3	0
Zapata	3	1	0	0	0	0

Waivers and Local Market Access Plan

A waiver and local market access plan applies to the services provided by the below listed providers in each service area denoted by an "X."

	Provider Type					
County	**Primary Care**	**Pediatrics - Routine/Primary Care**	**Gynecology (OB/GYN)**	**Psychiatry**	**Surgery**	**Acute General Hospital**
Andrews						
Aransas			X		X	
Armstrong						
Atascosa		X	X			
Austin			X			
Bandera						
Bastrop	X	X	X		X	
Bell		X	X		X	
Bexar		X	X	X	X	
Blanco						
Bosque		X	X			
Brazoria		X	X		X	X
Brazos		X	X		X	
Brewster		X	X	X	X	X
Brooks			X			
Brown		X	X		X	
Burleson		X	X			
Burnet			X			
Caldwell						
Calhoun		X				
Cameron					X	
Camp						
Carson						
Castro						
Chambers		X	X		X	
Cherokee						
Coke						
Coleman						
Collin	X	X	X	X	X	X
Collingsworth		X	X			
Colorado						
Comal		X	X		X	
Comanche			X			
Concho						

Cooke			X			
Dallam		X	X		X	X
Dallas			X			
Deaf Smith		X	X			
Delta						
Denton		X	X			
DeWitt		X	X	X		
Donley		X	X			
Ector		X	X	X		
Edwards		X	X			
El Paso						
Ellis		X	X	X		
Falls		X	X			
Fannin						
Fayette						
Fisher		X				
Fort Bend			X			
Freestone		X	X			
Frio		X	X			
Galveston		X	X	X	X	X
Gillespie						
Goliad						
Gonzales			X			
Gray		X	X	X		
Grayson	X	X	X		X	
Gregg		X	X		X	
Grimes						
Guadalupe		X	X		X	
Hamilton						
Hardin		X	X		X	
Harris		X	X		X	
Hartley		X	X			
Hays			X			
Henderson			X			
Hidalgo						
Hill		X	X			
Hood		X	X		X	
Houston		X	X			
Hunt	X	X	X		X	
Irion						
Jack						
Jackson		X				

Jefferson		X	X		X	
Johnson		X	X			
Kendall						
Kerr				X		
Kimble		X	X			
Kinney						
Lampasas						
Lavaca		X				
Lee		X				
Leon		X	X			
Liberty		X	X			
Limestone		X	X		X	
Llano			X			
Madison		X	X			
Mason						
Matagorda						
Maverick				X	X	
McCulloch		X	X			
McLennan	X	X	X		X	
Medina		X	X			
Menard		X	X			
Milam		X	X			
Mills						
Mitchell						
Montague		X	X			
Montgomery		X	X			
Nacogdoches					X	
Navarro			X			
Nueces		X	X		X	
Oldham		X				
Orange		X	X		X	
Palo Pinto						
Panola		X				
Parker	X	X	X			
Parmer		X	X		X	
Potter			X			
Rains		X	X			
Randall		X	X			
Real						
Refugio						
Robertson		X	X			
Rockwall			X			

Runnels						
Rusk		X				
San Jacinto			X			
San Saba						
Schleicher						
Scurry		X	X	X	X	X
Sherman		X	X		X	
Smith		X	X			
Somervell						
Starr				X	X	
Sterling						
Stonewall		X	X		X	
Sutton		X	X			
Tarrant		X	X			
Tom Green						
Travis		X	X		X	X
Trinity		X	X			
Tyler		X	X		X	
Val Verde				X	X	
Van Zandt		X	X			
Victoria	X	X	X	X	X	
Walker	X	X	X		X	
Waller	X	X	X		X	
Webb					X	
Wharton						
Wheeler			X			
Willacy						
Williamson		X	X			
Wise						
Wood		X				
Zapata			X		X	

This access plan may be obtained by contacting Ambetter from Superior HealthPlan at 1-877- 687-1196 (Relay Texas/TTY: 1-800-735-2989).

Guaranteed Renewable

This policy is guaranteed renewable. That means that you have the right to keep the policy in force with the same benefits, except that we may discontinue or terminate the policy if:

1. You fail to pay premiums as required under the policy;
2. You have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy; or
3. We stop issuing the policy in Texas, but only if we notify you in advance.

Unless the policy is 'noncancellable,' as defined in the policy, we have the right to raise rates on your policy at each time of renewal, in a manner consistent with the policy and Texas law. If the policy is noncancellable, our right to raise rates is limited by the definition of 'noncancellable' contained in the policy, and by Texas law.

Annually, we may change the rate table used for this policy form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of covered 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.

At least 31 days' notice of any plan to take an action or make a change permitted by this clause will be delivered to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this policy or a change in a covered enrollee's health. While this policy is in force, we will not restrict coverage already in force. If we discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage.

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

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing the 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 the 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 the 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.