AMBETTER HEALTH SOLUTIONS
HEALTH MAINTENANCE ORGANIZATION
WRITTEN DESCRIPTION OF COVERAGE

PROVIDED BY AMBETTER HEALTH
(Hereafter referred to as “Ambetter Health”)

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

The entity providing this coverage to you is an HMO, Ambetter Health. Your Evidence of Coverage only provides benefits for services received from participating providers, except as otherwise noted in the contract and written description or as otherwise required by law.

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

For additional information please write or call:
Ambetter Health
5900 E. Ben White Blvd.
Austin, TX 78741
1-833-543-3145

A network provider (or participating provider) means any person or entity that has entered into a contract with Ambetter Health network to provide covered services to enrollees under the contract, including but not limited to, hospitals, specialty hospitals, urgent care facilities, physicians, pharmacies, laboratories and other health professionals within our service area. If you are admitted to an inpatient facility, a physician other than your PCP may direct and oversee your care.

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

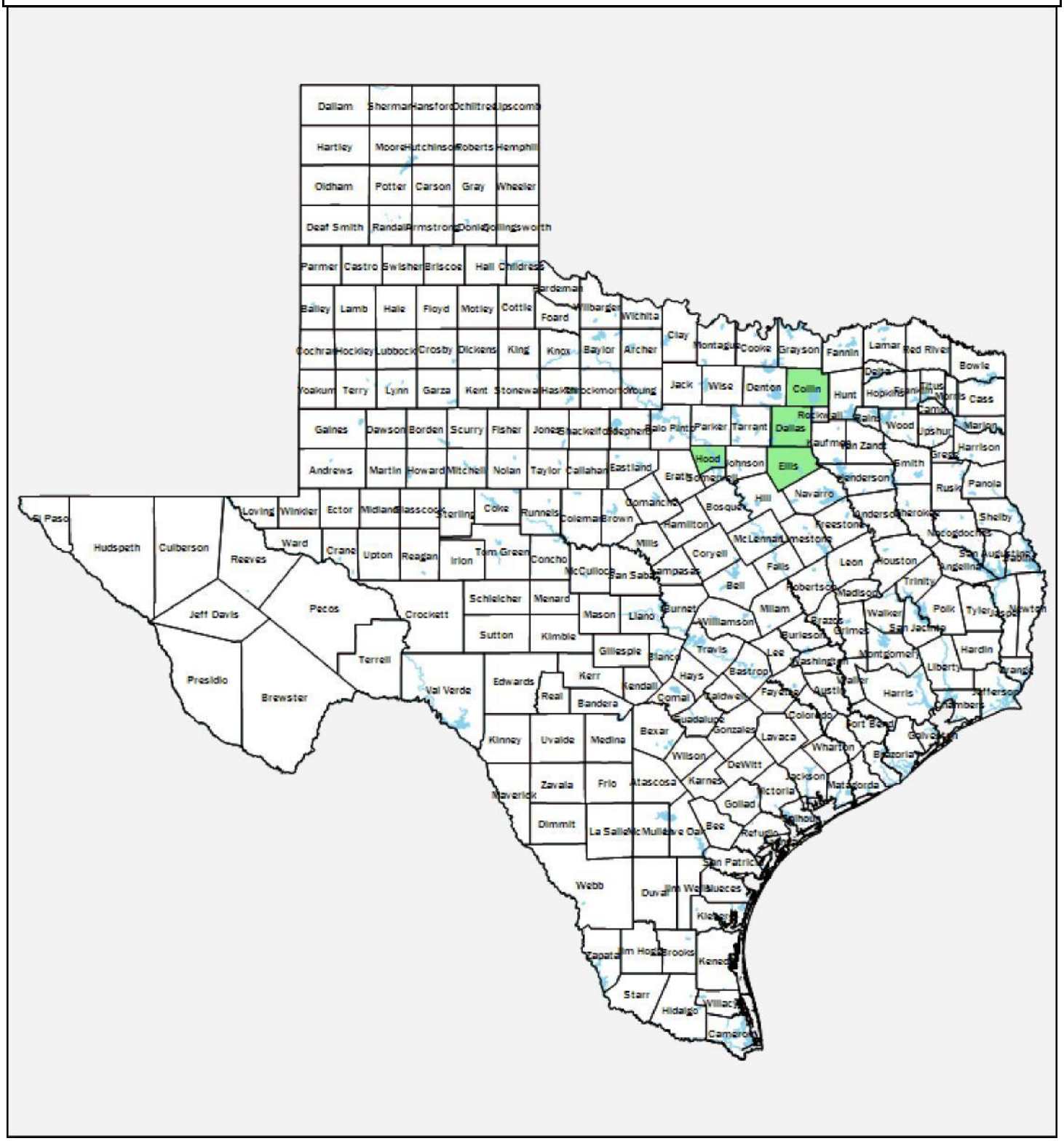
Your PCP coordinates your medical care, as appropriate, either by providing treatment or by issuing referrals to direct you to participating providers. When admitted to an inpatient facility, and only through the duration of your inpatient stay, a physician other than the PCP may direct and oversee your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

In addition to a PCP, female enrollees may also select a participating Obstetrician/Gynecologist (OB/GYN) 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 Provider provision.

Superior HealthPlan, Inc.

SOLUTIONS (HMO)

Texas



Covered Services and Benefits

The Ambetter Health 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-participating services. Please note that we will pay the negotiated fee or usual and customary rate to non-participating 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

Acquired Brain Injury Services

Benefits for eligible service expenses incurred for medically necessary treatment of an acquired brain injury will be determined on the same basis as treatment for any other physical condition 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, if such services are necessary as a result of and related to an acquired brain injury.

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 the 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 individual covered who:

1. Has incurred an acquired brain injury;
2. Has been unresponsive to treatment;
3. Is medically stable; and
4. To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered with the expectation that with the provision of these services and support, the person can return to a community-based setting, rather than reside in a facility setting.

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

Allergy Care

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

Ambulance Services

Air Ambulance Service Benefits

Covered expenses will include ambulance services transportation by for ground, water, 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 emergency condition, subject to other coverage limitations discussed below emergency condition.

2. To the nearest neonatal special care unit for newborn infants for treatment of illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between hospitals or between a hospital and a more appropriate level of care when authorized by Ambetter Health.
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.

Ground Ambulance Service Benefits (Ground and Water)
Non-emergency air ambulance transportation requires prior authorization. Prior authorization is not required for ambulance transportation when the member is experiencing an emergency condition. NOTE: You should not be balance billed for covered air ambulance services.

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

1. In cases where the member 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 illnesses, injuries, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between hospitals or between a hospital and a more appropriate level of care when authorized by Ambetter Health.
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.

Autism Spectrum Disorder Benefits

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

1. Evaluation and assessment services;
2. Applied behavior analysis therapy;
3. Behavior training and behavior management;
4. Habilitation services for individuals with a diagnosis of autism spectrum disorder;
5. Speech therapy;
6. Occupational therapy;
7. Physical therapy;
8. Psychiatric care 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.

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.

Clinical Trial Coverage

Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition.

Dental Benefits – Adults 19 years of age or older

Coverage for dental services is provided for adults, age 19 and older, for Preventive and Diagnostic, Basic Services and Major Services from a provider.

1. Preventive and Diagnostic—Class 1 benefits include:
    a. Routine cleanings;
    b. Oral examinations;
    c. X-rays – bitewing, full-mouth and panoramic film; and
    d. Topical fluoride application.
2. Basic Dental Care— Class 2 benefits include:
    a. Minor restorative – metal fillings and resin-based filings;
    b. Endodontics;
    c. Periodontics – scaling, root planning and periodontal maintenance;
    d. Oral Surgery – non-surgical and surgical extractions; and
    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; and
    c. Oral Surgery – impacted and complex extractions, other surgical services.

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

Services not covered:

1. Dental services that are not necessary or specifically covered;
2. Hospitalization or other facility charges;
3. Prescription drugs dispensed in the dental office;
4. Any dental procedure performed solely as a cosmetic procedure;
5. Charges for dental procedures completed prior to the member's effective date of coverage;
6. Services provided by an anesthesiologist;
7. Dental procedures, appliances, or restorations that are necessary to alter, restore, or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by abrasion, abfraction, or erosion, realignment of teeth, periodontal splinting, and gnathologic recordings;
8. Direct diagnostic surgical or non-surgical treatment procedures applied to jaw joints or muscles;
9. Any artificial material implanted or grafted into soft tissue, surgical removal of implants, and implant-related services;

10. Sinus augmentation;
11. Surgical appliance removal;
12. Intraoral placement of a fixation device;
13. Oral hygiene instruction, tobacco counseling, nutritional counseling or high-risk substance abuse counseling;
14. Services for teeth retained in relation to an overdenture. Overdenture appliances are limited to an allowance for a standard full denture;
15. Any oral surgery that includes surgical endodontics (apicoectomy and retrograde filling);
16. Analgesia (nitrous oxide);
17. Removable unilateral dentures;
18. Temporary procedures;
19. Splinting;
20. Temporomandibular Joint disorder (TMJ) appliances, therapy, films and arthrograms;
21. Oral pathology laboratory;
22. Consultations by the treating provider and office visits;
23. Occlusal analysis, occlusal guards (night guards), and occlusal adjustments (limited and complete);
24. Veneers (bonding of coverings to the teeth);
25. Orthodontic treatment procedures;
26. Orthognathic surgery;
27. Athletic mouth guards; and
28. Space maintainers.

Dialysis Services

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.

Durable Medical Equipment

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

1. Hemodialysis equipment.
2. Crutches and replacement of pads and tips.
3. Pressure machines.
4. Infusion pump for IV fluids and medicine.
5. Glucometer.
6. Tracheotomy tube.
7. Cardiac, neonatal and sleep apnea monitors.
8. Augmentive communication devices are covered when we approve based on the enrollee’s condition.
9. Home INR testing machines.

Medical and Surgical Supplies
Coverage for non-durable medical supplies and equipment for management of disease and treatment of medical and surgical conditions.

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

Habilitation, Rehabilitation, and Extended Care Facility Expense Benefits

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. Rehabilitation services or confinement in a rehabilitation facility or extended care facility must be determined medically necessary.
3. Covered service expenses for provider facility services are limited to charges made by a hospital, rehabilitation facility, or extended care facility for:
    a. Daily room and board and nursing services.
    b. Diagnostic testing.
    c. Drugs and medicines that are prescribed by a provider, filled by a licensed pharmacist, and approved by the U.S. Food and Drug Administration.
4. Covered service expenses for non-provider facility services are limited to charges incurred for the professional services of rehabilitation licensed practitioners.
5. Outpatient physical therapy, occupational therapy, and speech therapy.

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. This does not include personal attendant and/or custodial 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.

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 only for services related to hospice care in home and inpatient locations, and are subject to all forms of cost-sharing.

Covered services and supplies include:

1. Room and board in a hospice while the enrollee is 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 States Renal Disease (ERSD) is a 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.

Hospital Benefits

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

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

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 days for 6 hours or more/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

Maternity Care

An inpatient stay is covered for the mother and newborn for at least 48 hours following an uncomplicated vaginal delivery, and for at least 96 hours following an uncomplicated caesarean delivery. Coverage will include post-delivery care for a mother and newborn who are discharged before the expiration of the minimum hours of coverage.

Newborn Charges

Medically necessary services, including hospital services, are provided for a covered newborn child immediately after birth.

Medical Foods

We cover medical foods and formulas when medically necessary for the treatment of Phenylketonuria (PKU) or other heritable diseases regardless of the formula delivery method. Coverage for inherited diseases of amino acids and organic acids shall, in addition to the enteral formula, include food products modified to be low protein. Such coverage shall be provided when the prescribing physician has issued a written order stating that the enteral formula or food product is medically necessary.

Mental Health and Substance Use Disorder Benefits

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

1. Inpatient psychiatric hospitalization;
2. Inpatient detoxification treatment;
3. Observation;
4. Crisis stabilization;
5. Inpatient rehabilitation;

6. Residential treatment facility for mental health and substance use disorder; and
7. Electroconvulsive Therapy (ECT).

Outpatient (Office Visits and Other Outpatient Services)

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

Pediatric Vision Expense Benefits

Covered service expenses in this benefit subsection include the following services performed by an optometrist, therapeutic optometrist, or ophthalmologist for an eligible child under the age of 19 who is an enrollee:

1. Routine vision screening, including dilation with refraction every calendar year;
2. One pair of prescription lenses (single vision, lined bifocal, lined trifocal, or lenticular) in glass or plastic, or initial supply of medically necessary contacts every calendar year;
    a. Other lens options included are: Fashion and Gradient Tinting, Ultraviolet Protective Coating, Oversized and Glass-Grey #3 Prescription Sunglass lenses, Polycarbonate lenses, Blended Segment lenses, Intermediate Vision lenses, Standard Progressives, Premium Progressives (Varilux®, etc.), Photochromic Glass Lenses, Plastic Photosensitive Lenses (Transitions®), Polarized Lenses, Standard Anti-Reflective (AR) Coating, Premium AR Coating, Ultra AR Coating, and Hi-Index Lenses
3. One pair of prescription frames per calendar year;
4. Scratch-resistant coating; and
5. Low vision aids as medically necessary.

Prescription Drug Benefits

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

1. A prescription drug.
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a medical practitioner.
3. 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.

For the most current Ambetter Formulary or preferred drug list or for more information about our pharmacy program, visit AmbetterHealth.com (under “For Members”, “Drug Coverage”) or call Member Services.

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-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.

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 drug used to treat hyperhidrosis.
21. For any injectable medication or biological product that is not expected to be self-administered by the enrollee at enrollee's place of residence unless listed on the formulary.
22. For any claim submitted by non-lock-in pharmacy while enrollee is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, enrollee's participation in lock-in status will be determined by review of pharmacy claims.
23. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
24. Medication refills where an enrollee has more than 15 days' supply of medication on hand.
25. 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 member 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.

Preventive Care Services

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

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.
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.

Additional Preventive Care Services include:

1. Preventive Care Services for Children
2. Preventive Care Services for Women, including Pregnant Women
3. Preventive Services for Adults
4. Routine Exams and Immunizations
5. Certain Tests for Detection of Human Papillomavirus, Ovarian and Cervical Cancer
6. Mammography Screening and Diagnostic Imaging
7. Detection and Prevention of Osteoporosis
8. Certain Tests for Detection of Prostate Cancer
9. Early Detection Tests for Cardiovascular Disease
10. Screening Tests for Hearing Impairment
11. Contraceptive Care
12. Medical Vision Services

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, mammogram, ultrasound). Prior authorization may be required, see the Schedule of Benefits for details.

Sleep Studies

Sleep studies are covered when determined to be medically necessary.

Transplant Services

Transplants are a covered benefit when an enrollee is accepted as a transplant candidate and obtain prior authorization in accordance with the contract

Vision Benefits – 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. 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 member cost sharing, annual maximum and appropriate service limitations. To see which vision providers are part of the network, please visit AmbetterHealth.com or call Member Services.

Services not covered:

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

.

Emergency Services

Your Evidence of Coverage 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 contract 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 1-833-543-3145. 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 Evidence of Coverage 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 Health service area is defined within this document.

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.

Hospital Based Providers

When receiving care at a network hospital or other facility, 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 you provide notice and consent 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.

Protection from Balance Billing

Under Federal law, effective January 1, 2022, non-network providers or facilities are prohibited from balance billing health plan enrollees for services that are subject to balance billing protections as described in the Definitions section of 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.

Enrollee's Financial Responsibility

The following are the features of your Evidence of Coverage with Ambetter Health 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-participating providers when a participating provider is not reasonably available to you.

Premium Payment

PREMIUMS ARE SUBJECT TO CHANGE AT CONTRACT RENEWAL. Renewal premiums for the contract will increase periodically depending upon your age and plan 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.

Grace Period

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 contract 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 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 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 contract benefits will pay for covered expenses at the coinsurance percentage level for covered inpatient and outpatient expenses each calendar year. Your Evidence of Coverage payments may be limited by contract exclusions and limitations. You will be responsible for any charge that is left unpaid after Ambetter Health has paid up to its contract limits and obligations.

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:

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

When the annual 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.

Evidence of Coverage 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 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 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 cosmetic breast reduction or augmentation, except for the medically necessary treatment of gender dysphoria for adults, age 18 and older.
5. 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..

6. The reversal of sterilization and reversal of vasectomies.
7. 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.
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in covered service expenses.
9. For expenses for television, telephone, or expenses for other persons.
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
11. For telephone consultations between providers, except those meeting the definition of telehealth services or telemedicine medical services, or for failure to keep a scheduled appointment.
12. For services provided outside of a primary care provider visit, when a referral is not obtained through your primary care provider, except in an emergency, or as specified elsewhere in the contract.
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:
    e. School funded/administered services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    f. Marriage counseling;
    g. Pre-marital counseling;
    h. 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;
    i. Testing of aptitude, ability, intelligence or interest; or
    j. 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.
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 state or federal law. If you enter into a settlement that waives an enrollee's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for an enrollee's workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
25. For or related to treatment of hyperhidrosis (excessive sweating).
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: 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, 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;
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. Surrogacy Arrangement. Health care services, including supplies and medication relating to a surrogacy agreement, to a Surrogate, including an enrollee acting as a surrogate or utilizing the services of a Surrogate who may or may not be an enrollee, and any child born as a result of a Surrogacy Arrangement. This exclusion applies to all health care services, supplies and medication relating to a Surrogacy Agreement, to a Surrogate including, but not limited to:
    a. Prenatal care;
    b. Intrapartum care (or care provided during delivery and childbirth);
    c. Postpartum care (or care for the Surrogate following childbirth);
    d. Mental Health Services related to the Surrogacy Arrangement;

e. Expenses relating to donor semen, including collection and preparation for implantation;
f. Donor gamete or embryos or storage of same relating to a Surrogacy Arrangement;
g. Use of frozen gamete or embryos to achieve future conception in a Surrogacy Arrangement;
h. Preimplantation genetic diagnosis relating to a Surrogacy Arrangement;
i. Any complications of the child or Surrogate resulting from the pregnancy;
j. Any other health care services, supplies and medication relating to a Surrogacy Arrangement; or
k. Any and all health care services, supplies or medication provided to any child birthed by a Surrogate as a result of a Surrogacy Arrangement are also excluded, except where the child is the adoptive child of enrollee's possessing an active contract with us and/ or the child possesses an active contract with us 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. Umbilical cord blood collection.

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 Health prior to providing a service or supply to an enrollee. However, there are some covered services for which you must obtain the prior authorization.

Enrollees are required to obtain a referral from their PCP for in-network specialists 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 care services (excluding emergencies, urgent care, behavioral/mental health care services, and ob/gyn services). This includes, but is not limited to, in-person office visits, specialist consultations, and diagnostic testing, as well as visits to an in-network facility. Emergency Room services do not require a referral. You do not need a referral from your network primary care physician for in-network mental or behavioral health services, obstetrical or gynecological treatment and may seek care directly from a network obstetrician or gynecologist.

NOTE: For female enrollees: You have the right to select and visit an obstetrician-gynecologist (OB-GYN) without first obtaining a referral from your PCP. Ambetter Health has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP.

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

For certain providers, we do not require prior authorization for certain health care services if in the most recent six-month evaluation period, 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.

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 Health 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.

Access to OB/GYN Services

Female enrollees shall have direct access to an OB/GYN (who is a network provider) for female services. You do not need a referral from your network primary care physician for obstetrical or gynecological treatment and may seek care directly from a network obstetrician or gynecologist.

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 a continuing care patient with respect to an network provider and: the contractual relationship with the provider is terminated, such that the 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, 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 receive continued transitional care from the provider or facility;
2. Provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and
3. Permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a continuing care patient during the period beginning on the date on which the above notice is provided and ending on the earlier of
    a. the 90-day period beginning on such date;
    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. date on which such individual is no longer a continuing care patient with respect to their provider or facility.

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 1-833-543-3145 (Relay Texas/TTY 711) for assistance.

You should send your written complaint to:
Ambetter Health
ATTN: Complaints Department
5900 E. Ben White Blvd.
Austin, TX 78741
Fax: 1-877-941-8077

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, or 72 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.

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

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

Retaliation Prohibited

1. We will not take any retaliatory action, including refusal to renew coverage, against you because you or person acting on your behalf has filed a complaint against us or appealed a decision made by us.
2. We shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a provider, because the provider has on your behalf, reasonably filed a complaint against us or has appealed a decision made by us.

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: AmbetterHealth.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 1-833-543-3145 (Relay Texas/TTY 711).

Texas Department of Insurance Notice

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 1-833-543-3145. 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.

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.

Ambetter Health 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 Health's service area includes the following counties: Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, and Williamson.

The number of effectuated members in Ambetter's service area under the Ambetter Health HMO license is 283,344. Please refer to the table below for a breakdown of effectuated members based on service area.

County	Total Effectuated Members
Bexar	896
Collin	1,929
Dallas	7,663
Denton	16,221
Fort Bend	37,451
Harris	196,398
Montgomery	11,950
Rockwall	337
Tarrant	9,773
Travis	509
Williamson	218

Network Demographics

	Provider Type					
County	**Primary Care**	**Pediatrics - Routine/Primary Care**	**Gynecology (OB/GYN)**	**Psychiatry**	**Surgery**	**Acute General Hospital**
Bexar	40	46	58	13	111	3
Collin	86	14	131	10	128	7
Dallas	111	17	144	12	172	12
Denton	117	17	143	11	176	17
Fort Bend	237	97	70	28	116	18
Harris	289	101	72	30	135	20
Montgomery	243	92	67	28	127	18
Rockwall	71	13	128	10	111	9
Tarrant	98	12	33	4	133	12
Travis	174	116	79	18	117	4
Williamson	174	109	80	20	121	4

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**
Bexar	X	X	X	X	X	X
Collin	X	X	X	X	X	X
Dallas	X	X	X	X	X	X
Denton	X	X	X			
Fort Bend			X			
Harris		X	X		X	X
Montgomery	X	X	X			
Rockwall			X			
Tarrant	X	X	X	X	X	X
Travis	X	X	X	X	X	X
Williamson	X	X	X			

This access plan may be obtained by contacting Ambetter Health at 11-833-543-3145 (Relay Texas/TTY: 711).

Guaranteed Renewable

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

1. You fail to pay premiums as required under the contract;
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 contract, including claims for benefits under the contract; or
3. We stop issuing the contract in Texas, but only if we notify you in advance.

Unless the contract is 'noncancellable,' as defined in the contract, we have the right to raise rates on your contract at each time of renewal, in a manner consistent with the contract and Texas law. We will provide a written notice of increase in a charge for coverage not less than 60 days before the date the increase takes effect. If the contract is noncancellable, our right to raise rates is limited by the definition of 'noncancellable' contained in the contract, and by Texas law.

Annually, we may change the rate table used for the contract form. Each premium will be based on the rate table in effect on that premium's due date. The 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 the contract or a change in a covered enrollee's health. While the contract is in force, we will not restrict coverage already in force. If we discontinue offering and refuse to renew all contracts issued on the 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.

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.