AMBETTER FROM SUPERIOR HEALTHPLAN
HEALTH MAINTENANCE ORGANIZATION
WRITTEN DESCRIPTION OF COVERAGE

PROVIDED BY AMBETTER FROM SUPERIOR HEALTHPLAN
(Hereafter referred to as "Ambetter from Superior HealthPlan")

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

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

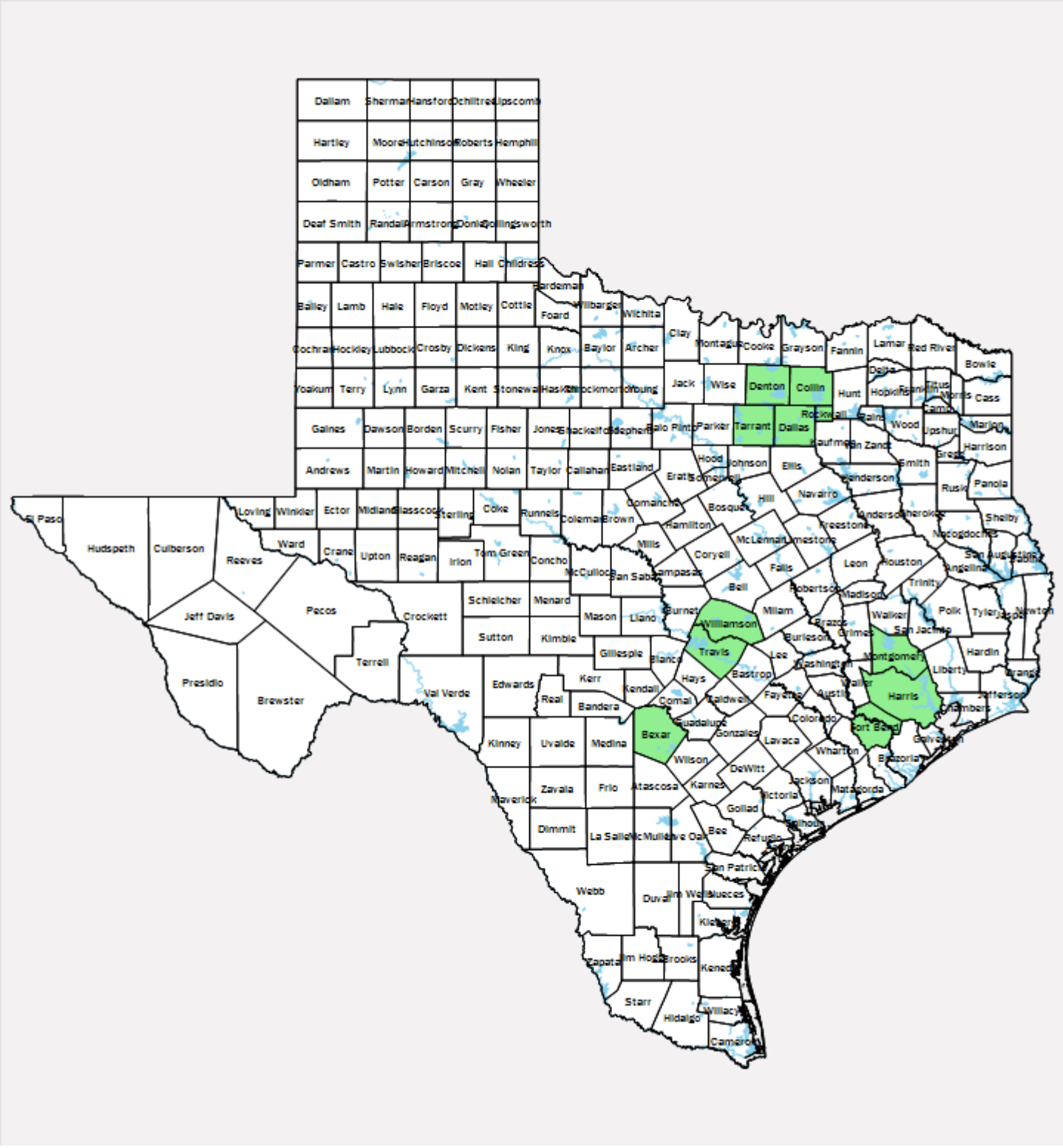
or assigned, benefits will be limited to coverage for *emergency care*. You may select any network *PCP* who is accepting new patients from any of the following health care professional types:

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.

SERVICE AREA MAP



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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-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 or any other facility at which appropriate services or therapies may be provided. Service means the work of testing, treatment, and providing therapies to an individual with an acquired brain injury. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

To ensure that appropriate post-acute care treatment is provided, this plan includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

1. Has incurred an acquired brain injury;
2. Has been unresponsive to treatment;

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

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 skilled nursing, *rehabilitation facility,* and *enrollee's* home when *authorized* by Ambetter from Superior HealthPlan.
4. When ordered by an employer, school, fire or public safety official and the *enrollee* is not in a position to refuse; or
5. When an *enrollee* is required by us to move from a *non-network provider* to a *network provider*.

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

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. Speech therapy;
5. Occupational therapy;
6. Physical therapy;
7. Psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
8. Medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

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.

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 an *inpatient*.
2. Occupational therapy.
3. Speech-language therapy.
4. Respiratory therapy.
5. The rental of medical equipment while the *terminally ill enrollee* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *enrollee* had been confined in a *hospital*.
6. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
7. In home dialysis (except when End 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

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) for treatment of *Autism spectrum disorders*;
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 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 Ambetter.SuperiorHealthPlan.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*.

Emergency Services

Your *Evidence of Coverage* provides coverage for medical emergencies wherever they occur. In an emergency, always call 911 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 1-877-687-1196. 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 *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 from Superior HealthPlan *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*, 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 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-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 this *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

When an *enrollee* is receiving a premium subsidy:

Grace Period: A grace period of 60 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.

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 60 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 this *contract* will be available after satisfaction of the applicable *deductibles* as shown on your *Schedule of Benefits*. The *deductibles* are explained as follows:

Calendar Year *Deductible:* The individual *deductible amount* shown under "Deductibles" on your *Schedule of Benefits* must be satisfied by each 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 this *contract*.

The following are exceptions to the *deductibles* described above:

1. If you have several covered dependents, all charges used to apply toward an "individual" *deductible amount* will be applied toward the "family" *deductible amount* shown 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 from Superior HealthPlan has paid up to its *contract* limits and obligations.

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 this *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 this *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.
5. The reversal of sterilization and reversal of vasectomies.
6. For abortion, when certified by a physician that the *enrollee* is in danger of death or serious risk of substantial impairment of a major bodily function unless an abortion is performed.
7. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses*.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations between *providers*, except those meeting the definition of *telehealth services* or *telemedicine medical services*, or for failure to keep a scheduled appointment.
11. For 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 this *contract*.
12. For stand-by availability of a medical practitioner when no treatment is rendered.

13. 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.
14. 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.
15. For mental health examinations and services involving:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Marriage counseling;
    c. Pre-marital counseling;
    d. Court ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *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 this *contract*.
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Services provision.
17. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. While confined primarily to receive *rehabilitation*, *c*us*todial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
19. For vocational or recreational therapy.
20. 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*.
21. For treatment received outside the United States, except for a medical emergency while traveling.
22. 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.
23. 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.
24. For or related to treatment of hyperhidrosis (excessive sweating).
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,* or services provided to a non-*enrollee* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
31. Services of a private duty registered nurse 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. *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.
35. For all health care services obtained at an *urgent care facility* that is a *non-network provider*
36. 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.
37. For expenses, services, and treatments from a naturopathic specialists for treatment of prevention, self-healing and use of natural therapies.
38. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a hospice care program.

39. Dry needling.
40. 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 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*.

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 from Superior HealthPlan 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 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.

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 1-877-687-1196 (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.

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

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: 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 Superior HealthPlan 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 from Superior HealthPlan at 1-877- 687-1196 (Relay Texas/TTY: 1-800-735-2989).

Guaranteed Renewable

This *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 this *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 this *contract* or a change in a covered *enrollee's* health. While this *contract* is in force, we will not restrict coverage already in force. If we discontinue offering and refuse to renew all *contracts* issued on this form, with the same type and level of benefits, for all residents of the state where you reside, we will provide a written notice to you at least 90 days prior to the date that we discontinue coverage.

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

In addition to the above, this guarantee for continuity of coverage shall not prevent us from cancelling or non-renewing this *contract* in the following events: (1) non-payment of premium; (2) an *enrollee* fails to pay premiums or contributions in accordance with the terms of this

contract, including any timeliness requirements; (3) an *enrollee* has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact relating to this *contract*; or (4) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.