CELTIC INSURANCE COMPANY FOR AMBETTER FROM SUPERIOR HEALTHPLAN

Major Medical Expense Policy

THIS MAJOR MEDICAL EXPENSE POLICY (CONTRACT) IS ISSUED TO YOU, WHO HAVE ENROLLED IN CELTIC INSURANCE COMPANY FOR AMBETTER FROM SUPERIOR HEALTHPLAN

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

Celtic Insurance Company
[77 West Wacker Drive, Suite 1200]
[Chicago, IL 60601]
[877-687-1196]

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

IMPORTANT NOTICES:

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.
IMPORTANT NOTICE

To obtain information or make a complaint:
You may call Celtic’s toll-free telephone number for information or to make a complaint at:

1-877-687-1196

You may also write to us at:
2100 South IH-35, Suite 200
Austin, Texas 78704

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

YOU may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:
Usted puede llamar al número de teléfono gratuito de Celtic’s para obtener información o para presentar una queja’ al:

1-877-687-1196

Usted también puede escribir a Superior:
2100 South IH-35, Suite 200
Austin, Texas 78704

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.
Celtic Insurance Company
Major Medical Expense Policy

In this Major Medical Expense Policy (contract), "you" or "your" will refer to the Enrollee named on the Schedule of Benefits, and "we," "our," or "us" will refer to Celtic Insurance Company.

AGREEMENT AND CONSIDERATION

We issued this contract in consideration of the application and the payment of the first premium. A copy of your application is attached and is made a part of the contract. We will provide benefits to you, the Enrollee, for covered Health Care Services as outlined in this contract. Benefits are subject to contract definitions, provisions, limitations and exclusions.
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GENERAL PROVISIONS
INTRODUCTION

Welcome to Ambetter from Superior HealthPlan! This contract has been prepared by us to help explain your coverage. Please refer to this contract whenever you require medical services. It describes:
- how to access medical care.
- what health services are covered by us.
- what portion of the health care costs you will be required to pay.

This contract, the Schedule of Benefits, the application, and any amendments or riders attached shall constitute the entire contract under which covered services and supplies are provided or paid for by us.

This contract should be read and re-read in its entirety. Since many of the provisions of this contract are interrelated, you should read the entire contract to get a full understanding of your coverage. Many words used in the contract have special meanings, are italicized and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This contract also contains exclusions, so please be sure to read this contract carefully.

How To Contact Us:
Ambetter from Superior HealthPlan
2100 South IH-35, Ste. 200
Austin, Texas 78704
Member Services [877-687-1196]
TDD/TTY line Relay Texas [877-941-9237]
Fax [877-941-8077]
Emergency 911
NurseWise 1-877-687-1196 (24 hour nurse advice line)
Website: [http://ambetter.superiorhealthplan.com]

Normal Business Hours of Operation - 8:00 a.m. to 5:00 p.m. in both Texas time zones

Interpreter Services
Ambetter from Superior HealthPlan has a free service to help our enrollees who speak languages other than English. This service is very important because you and your physician must be able to talk about your medical or behavioral health concerns in a way you both can understand.

Our interpreter services are provided at no cost to you. We have representatives that speak Spanish and have medical interpreters to assist with other languages. Enrollees who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation. To arrange for interpretation services, call Member Services at [877-687-1196].

Your Provider Directory
A listing of network providers is available online at [http://www.ambetter.superiorhealthplan.com]. We have plan physicians, hospitals, and other providers who have agreed to provide you with your healthcare services. You may find any of our network providers on our website. There you will have the ability to narrow your search by provider specialty, zip code, gender, whether or not they are currently accepting
new patients, and languages spoken. *Your search will produce a list of providers based on your search criteria and will give you other information such as address, phone number, office hours, and qualifications.*

At any time, you can contact Member Services to request a provider directory, or for assistance in finding a provider.

**Your Enrollee ID Card**

When *you* enroll, *we* mail an Enrollee ID card to *you* within 5 business days of *our* receipt of *your* enrollment confirmation. *You* need to keep this card with *you* at all times and present it to your providers.

The ID card shows *your* name, Enrollee ID number, helpful phone numbers, and *copayment amounts* you will have to pay at the time of service. If *you* lose your card, please call Member Services; *we* will send *you* another ID card.

**Our Website**

*Our* website helps *you* get the answers to many of *your* frequently asked questions. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at [http://ambetter.superiorhealthplan.com](http://ambetter.superiorhealthplan.com). It also gives *you* information on *your* benefits and services such as:

1. Finding a *physician*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims.
4. Online form submission.
5. *Our* programs and services.
7. Notice of Privacy.
8. Current events and news.

**Quality Improvement**

*We* are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee on Quality Assurance (NCQA) standards. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *Enrollee* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *Enrollees* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee which includes *network providers* to help us develop and monitor our program activities.
7. Investigating any *Enrollee* concerns regarding care received.
**Ten-Day Right to Examine this Contract**

You shall be permitted to return this contract within 10 days of receiving it and to have any premium you paid refunded if, after examination of the contract, you are not satisfied with it for any reason. If you return the contract to us, the contract will be considered void from the beginning and the parties are in the same position as if no contract had been issued. If any services were rendered or claims paid by us during the 10 days, you are responsible for repaying us for such services or claims.
DEFINITIONS

In this contract, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this contract:

**Acute rehabilitation** means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five to seven days per week, while the Enrollee is confined as an inpatient in a hospital, rehabilitation facility, or extended care facility.

**Acquired Brain Injury** means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

**Advance premium tax credit** means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Marketplace. Advance premium tax credits can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance premium tax credit to apply to your premiums each month, up to a maximum amount. If the amount of advance premium tax credits you receive for the year is less than the total premium tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If the amount of advance premium tax credits for the year are more than the total tax credit that you’re due, you must repay the excess advance premium tax credit with your tax return.

**Adverse determination** means a determination by an insurer, health maintenance organization, or a utilization review agent that health care services provided or proposed to be provided to an enrollee are not medically necessary or are experimental or investigational.

**Allogeneic bone marrow transplant** or **BMT** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

**Autologous bone marrow transplant** or **ABMT** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

**Bereavement counseling** means counseling of Enrollees of a deceased person’s immediate family that is designed to aid them in adjusting to the person’s death.

**Center of Excellence** means a hospital that:
1. Specializes in a specific type or types of listed transplants or other services such as cancer, bariatric or infertility; and
2. Has agreed with us or an entity designated by us to meet quality of care criteria on a cost efficient basis. The fact that a hospital is a network provider does not mean it is a Center of Excellence.

**Chiropractic Care** involves neuromuscular treatment in the form of manipulation and adjustment of the tissues of the body, particularly of the spinal column and may include physical medicine modalities or use of durable medical equipment.
Cognitive Communication Therapy are services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitation Therapy are services designed to address therapeutic cognitive activities, based on an assessment and understanding of the insured person’s brain-behavioral deficits.

Community Reintegration Services are services that facilitate the continuum of care as an affected insured person transitions into the community.

Complaint means any dissatisfaction expressed orally or in writing by a complainant to an insurer or health maintenance organization regarding any aspect of the insurer’s or health maintenance organization’s operation. The term includes dissatisfaction relating to plan administration, procedures related to review or appeal of an adverse determination under the Texas Insurance Code, Section 843.261, the denial, reduction, or termination of a service for reasons not related to medical necessity, the manner in which a service is provided, and a disenrollment decision. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee; or a provider’s or enrollee’s oral or written expression of dissatisfaction or disagreement with an adverse determination.

Complications of pregnancy means:
1. conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Contract when italicized, means this contract issued and delivered to you. It includes the attached pages, the applications, and any amendments.

Copayment amount means the amount of covered services that must be paid by an Enrollee for each service that is subject to a copayment amount (as shown in the Schedule of Benefits), before benefits are payable for remaining covered services for that particular service under the contract or application of any coinsurance percentage.

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an injury, illness, or congenital anomaly.

Coinsurance percentage means the percentage of covered services that are payable by an enrollee.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace or for an individual who is an American Indian and/or Alaskan Native enrolled in a QHP in the Health Insurance Marketplace.
**Covered service or covered service expenses** means services, supplies or treatment as described in this contract which are performed, prescribed, directed or authorized by a physician. To be a covered service the service, supply or treatment must be

1. Provided or incurred while the Enrollee’s coverage is in force under this contract;
2. Covered by a specific benefit provision of this contract; and
3. Not excluded anywhere in this contract.

**Custodial Care** is treatment designed to assist an Enrollee with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes (but is not limited to) the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

**Deductible amount** means the amount of covered expenses, shown in the Schedule of Benefits, that must actually be paid during any calendar year before any benefits are payable. The family deductible amount is two times the individual deductible amount. For family coverage, the family deductible amount can be met with the combination of any one or more enrollees’ eligible service expenses.

The deductible amount does not include any copayment amounts.

**Dental services** means surgery or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered dental services regardless of the reason for the services.

**Dependent Enrollee** means the enrollee’s lawful spouse and/or an eligible child.

**Diabetes self-management training** means instruction enabling an enrollee and/or his or her caretaker to understand the care and management of diabetes, including nutritional counseling and proper use of diabetes equipment and supplies.

**Durable medical equipment** means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an illness or injury, can withstand repeated use, are generally not useful to a person in the absence of illness or injury, and are appropriate for use in the patient’s home.

**Effective date** means the applicable date an Enrollee becomes covered under this contract for covered services.

**Eligible child** means the child of an enrollee, if that child is less than 26 years of age. As used in this definition, “child” means:

1. A natural child;
2. A stepchild;
3. A legally adopted child and child for which the primary insured person must provide medical support under an order issued under Section 14.061, Family Code, or another order enforceable by a court in Texas;
4. A child placed with you for adoption for whom you are a party in a suit in which the adoption of the child is sought; or
5. A child for whom legal guardianship has been awarded to you or your spouse. It is your responsibility to notify the Marketplace if your child ceases to be an eligible child. You must reimburse us for any benefits that we provide or pay for a child at a time when the child did not qualify as an eligible child.
6. Any children of the enrollee’s children, if those children are dependents of the enrollee for federal income tax purposes at the time of application.
7. A child whose coverage is required by a medical support order.

**Eligible service expense** means a covered service expense as determined below.

1. For **network providers:** When a covered service is received from a network provider, the eligible service expense is the contracted fee with that provider.
2. For non-network providers:
   a. When a covered service is received from a non-network provider as a result of an emergency, the eligible service expense is the lesser of: (1) the negotiated fee, if any, that has been mutually agreed upon by us and the provider as payment in full, or (2) the usual and customary charge for such service. You will not be billed for the difference between the amount paid and the provider’s charge.
   b. When the service or supply is not of a type provided by any network provider and a covered service is received from a non-network provider or, if a list of non-network providers is provided by us, received from a non-network provider selected from the list provided by us, the eligible service expense is the negotiated fee, if any, that the provider has agreed to accept as payment in full. If there is no negotiated fee agreed to by the provider with us, the eligible service expense is the usual and customary charge for such service. You will not be billed for the difference between the amount paid and the provider’s charge.
   c. When the service or supply is not of a type provided by any network provider, a list of non-network providers is provided by us, and a covered service is received from a non-network provider not selected from the list provided by us, the eligible service expense is the negotiated fee, if any, that the provider has agreed to accept as payment in full (you will not be billed for the difference between the negotiated fee and the provider’s charge). If there is no negotiated fee agreed to by the provider with us, the eligible service expense is the usual and customary charge for such service. You may be billed for the difference between the amount paid and the provider’s charge.
   d. When a covered service is received from a non-network provider as approved or authorized by us, the eligible service expense is the negotiated fee, if any, that the provider has agreed to accept as payment in full (you will not be billed for the difference between the negotiated fee and the provider’s charge). If there is no negotiated fee agreed to by the provider with us, the eligible service expense is the usual and customary charge for such service. You may be billed for the difference between the amount paid and the provider’s charge.

As used in this section, usual and customary charges means based on generally accepted industry standards and practices for determining the customary billed charges for a service and fairly and accurately reflect market rates, including geographic differences in costs.

**Emergency care** means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson...
possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

1. placing the person's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of a bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Enrollee** means you, your lawful spouse and each eligible child:

1. Named in the application; or
2. Whom we agree in writing to add as an Enrollee.

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

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (USFDA) regulation, regardless of whether the trial is subject to USFDA oversight.
2. An unproven service.
3. Subject to USFDA approval, and:
   a. It does not have USFDA approval;
   b. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
   c. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA-approved drug is a use that is determined by us to be:
      i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
      ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
      iii. Not an unproven service; or
   d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has not been determined through peer reviewed medical literature to treat the medical condition of the Enrollee.
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase to phase I, II, III or IV USFDA clinical trials.

**Extended care facility** means an institution, or a distinct part of an institution, that:

1. Is licensed as a skilled nursing facility or rehabilitation facility by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a physician and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a physician; and
6. Provides each patient with active treatment of an illness or injury, in accordance with existing generally accepted standards of medical practice for that condition.

Extended care facility does not include a facility primarily for rest, the aged, treatment of substance abuse, custodial care, nursing care, or for care of mental disorders or the mentally incompetent.
**Facility** means a hospital, rehabilitation facility, or skilled nursing facility.

**Generally accepted standards of medical practice** are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is medically necessary and is a covered service under the policy. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by us.

**Habilitation** means ongoing, medically necessary, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a patient’s functional status over a lifetime and on a treatment continuum.

**Home health aide services** means those services provided by a home health aide employed by a home health care agency and supervised by a registered nurse, which are directed toward the personal care of a Enrollee.

**Home health services** means care or treatment of an illness or injury at the enrollee’s home that is:

1. Provided by a home health care agency; and
2. Prescribed and supervised by a physician.

**Home health care agency** means a business that:

1. provides home health services; and
2. is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

**Hospice** means an institution that:

1. Provides a hospice care program;
2. Is separated from or operated as a separate unit of a hospital, hospital-related institution, home health care agency, mental health facility, extended care facility, or any other licensed health care institution;
3. Provides care for the terminally ill; and
4. Is licensed by the state in which it operates.

**Hospice care program** means a coordinated, interdisciplinary program prescribed and supervised by a physician to meet the special physical, psychological, and social needs of a terminally ill Enrollee and those of his or her immediate family.

**Hospital** is a licensed institution and operated pursuant to law that:

1. Is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
2. Provide 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
3. Is an institution which maintains and operates a minimum of five beds; and
4. Have x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
5. Maintain permanent medical history records

Hospital does NOT include institutions where care is not directed toward treatment of the condition for which the patient is hospital confined, such as nursing homes, extended care facilities, skilled nursing facilities or psychiatric or substance abuse facilities or any other institution used mainly for convalescence, nursing, rest, housing the elderly or providing custodial care or educational care.

**Illness** means a sickness, disease, or disorder of an *Enrollee*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

**Immediate family** means the parents, *spouse*, children, or siblings of any *Enrollee*, or any person residing with an *Enrollee*.

**Injury** means accidental bodily damage sustained by an *Enrollee* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

**Inpatient** means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

**Intensive care unit** means a Cardiac Care Unit, or other unit or area of a *hospital*, which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

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

**Listed transplant** means one of the following procedures and no others:

1. Heart transplants
2. Lung transplants
3. Heart/lung transplants
4. Kidney transplants
5. Liver transplants
6. Bone marrow transplants for the following conditions:
   - *BMT* or *ABMT* for Non-Hodgkin's Lymphoma
   - *BMT* or *ABMT* for Hodgkin's Lymphoma
   - *BMT* for Severe Aplastic Anemia
   - *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia
   - *BMT* for Chronic Myelogenous Leukemia
   - *ABMT* for Testicular Cancer
   - *BMT* for Severe Combined Immunodeficiency
   - *BMT* or *ABMT* for Stage III or IV Neuroblastoma
   - *BMT* for Myelodysplastic Syndrome
   - *BMT* for Wiskott-Aldrich Syndrome
   - *BMT* for Thalassemia Major
• **BMT or ABMT** for Multiple Myeloma
• **ABMT** for pediatric Ewing’s sarcoma and related primitive neuroectodermal tumors, Wilm’s tumor, rhabdomyosarcoma, medulloblastoma, astrocytoma and glioma
• **BMT** for Fanconi’s anemia
• **BMT** for malignant histiocytic disorders
• **BMT** for juvenile

**Loss of Minimum Essential Coverage** means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, EPO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
3. In the case of coverage offered through an HMO, EPO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
4. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
5. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes the individual.
6. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee’s or dependent’s coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
7. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

**Managed drug limitations** means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

**Maximum out-of-pocket** amount is the sum of the deductible amount, prescription drug deductible amount (if applicable), copayment amount and coinsurance percentage of covered expenses, as shown in the Schedule of Benefits. After the maximum out-of-pocket amount is met for an individual, we pay 100% of eligible service expenses. The family maximum out-of-pocket amount is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more enrollees’ eligible service expenses.
The Dental out-of-pocket maximum limits do not apply to the satisfaction of the out-of-pocket maximum per calendar year as shown in the Schedule of Benefits.

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

**Medically necessary** means any medical service, supply or treatment authorized by a physician to diagnose and treat an Enrollee’s illness or injury which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to generally accepted medical practice standards;
3. Is not custodial care;
4. Is not solely for the convenience of the physician or the Enrollee;
5. Is not experimental or investigational;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a hospital confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not medically necessary are not eligible service expenses.

**Medically stabilized** means that the person is no longer experiencing further deterioration as a result of a prior injury or illness and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include acute rehabilitation.

**Mental disorder** is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions.

**Necessary medical supplies** means medical supplies that are:

1. Necessary to the care or treatment of an injury or illness;
2. Not reusable or durable medical equipment; and
3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

**Network** means a group of Medical Practitioners and providers who have contracts that include an agreed upon price for health care services or expenses.

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

**Non-Network Provider** means a Medical Practitioner who is NOT identified in the most current list for the network shown on your identification card. Services received from a non-network provider are not covered, except as specifically stated in this policy.

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**Network provider** means a *physician* or provider who is identified in the most current list for the *network* shown on *your* identification card.

**Neurobehavioral Testing** is an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the *insured person*, family, or others.

**Neurobehavioral Treatment** is interventions that focus on behavior and the variables that control behavior.

**Neurocognitive Rehabilitation** are services designed to assist cognitively impaired *insured person’s* to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

**Neurocognitive Therapy** are services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

**Neurofeedback Therapy** are services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

**Neurophysiological Testing** is an evaluation of the functions of the nervous system.

**Neurophysiological Treatment** means interventions that focus on the functions of the nervous system.

**Neuropsychological Testing** is the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

**Neuropsychological Treatment** means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

**Non-network eligible service expense** means the *eligible service expense* for services or supplies that are provided and billed by a non-network provider.

**Other plan** means any plan or policy that provides insurance, reimbursement, or service benefits for hospital, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization Enrollee contracts, self-insured group plans, prepayment plans, and Medicare when the *Enrollee* is enrolled in Medicare. *Other plan* will not include Medicaid.

**Out-of-pocket service expenses** means those expenses that an *Enrollee* is required to pay that:

1. Qualify as *covered service expenses*; and
2. Are not paid or payable if a claim were made under any other *plan*.

**Outpatient Day Treatment Services** means structured services provided to address deficits in physiological, behavioral and/or cognitive functions.
Outpatient surgical facility means any facility with a medical staff of physicians that operates pursuant to law for the purpose of performing surgical procedures, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, urgent care centers, ambulatory-care clinics, free-standing emergency facilities, and physician offices.

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

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law.

Post-Acute Transition Services are services that facilitate the continuum of care beyond the initial neurological consult through rehabilitation and community reintegration.

Pregnancy means the physical condition of being pregnant, but does not include complications of pregnancy.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription order means the request for each separate drug or medication by a physician or each authorized refill or such requests.

Primary care physician means a physician who is a family practitioner, general practitioner, pediatrician obstetrician/gynecologist (OB/GYN) or Internal Medicine physician.

Preauthorization means a form of prospective utilization review by a payor or its URA of health care services proposed to be provided to an enrollee.

Psychophysiological Testing is an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment are interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Qualified health plan or QHP means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Health Insurance Marketplace through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to a Health Insurance Marketplace, an individual who has been determined eligible to enroll through the Health Insurance Marketplace in a qualified health plan in the individual market.

Reconstructive surgery means surgery performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient’s appearance, to the extent possible. This includes craniofacial abnormalities for children younger than 18 years of age.
Rehabilitation means care for restoration (including by education or training) of one's prior ability to function at a level of maximum therapeutic benefit. This type of care must be acute rehabilitation, sub-acute rehabilitation, or intensive day rehabilitation, and it includes rehabilitation therapy and pain management programs. An inpatient hospitalization will be deemed to be for rehabilitation at the time the patient has been medically stabilized and begins to receive rehabilitation therapy or treatment under a pain management program.

Rehabilitation facility means an institution or a separate identifiable hospital unit, section, or ward that:
1. Is licensed by the state as a rehabilitation facility; and
2. Operates primarily to provide 24-hour primary care or rehabilitation of sick or injured persons as inpatients.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, custodial care, nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a physician, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A rehabilitation medical practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

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

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

Residential treatment facility means a facility that provides (with or without charge) sleeping accommodations, and:
1. Is not a hospital, extended care facility, or rehabilitation facility; or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

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

Routine patient care costs means the costs of any medically necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the enrollee is participating in a clinical trial. Routine patient care costs do not include:
1. The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. a cost associated with managing a clinical trial; or
5. the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

**Service Area** means a geographical area, made up of counties, where we have been authorized by the State of Texas to sell and market our health plans. Those counties are: Bandera, Bastrop, Bell, Bexar, Blanco, Brooks, Burnet, Caldwell, Cameron, Comal, El Paso, Fayette, Hays, Hidalgo, Kendall, Lee, McLennan, Travis, Willacy, and Williamson. You can receive precise **Service Area** boundaries from our website or our Member Services department.

**Specialist physician** means a physician who is not a primary care physician.

**Spouse** means your lawful wife or husband.

**Sub-acute rehabilitation** means one or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for one-half hour to two hours per day, five to seven days per week, while the **Enrollee** is confined as an inpatient in a hospital, rehabilitation facility, or extended care facility.

**Substance abuse** means alcohol, drug or chemical abuse, overuse, or dependency.

**Surgery** or **surgical procedure** means:
- An invasive diagnostic procedure; or
- The treatment of an **Enrollee’s illness or injury** by manual or instrumental operations, performed by a physician while the **Enrollee** is under general or local anesthesia.

**Surveillance tests for ovarian cancer** means annual screening using:
- CA-125 serum tumor marker testing;
- Transvaginal ultrasound; or
- Pelvic examination.

**Telehealth Service** means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional’s license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:
- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.

**Terminal illness counseling** means counseling of the immediate family of a **terminally ill** person for the purpose of teaching the immediate family to care for and adjust to the illness and impending death of the terminally ill person.

**Terminally ill** means a physician has given a prognosis that an **Enrollee** has six months or less to live.

**Third party** means a person or other entity that is or may be obligated or liable to the **Enrollee** for payment of any of the **Enrollee’s expenses for illness or injury**. The term "third party" includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term "third party" will not include any...
insurance company with a policy under which the Enrollee is entitled to benefits as a named insured person or an insured dependent Enrollee of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit our right to recover from these sources.

Tobacco use or use of tobacco means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within no longer than the six months immediately preceding the date application for this contract was completed by the Enrollee, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Unproven service(s) means services, including medications, which are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or well-conducted cohort studies in the prevailing published peer-reviewed medical literature.

1. "Well-conducted randomized controlled trials" means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.
2. "Well-conducted cohort studies" means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care center means a facility, not including a hospital emergency room or a physician’s office, that provides treatment or services that are required:

1. To prevent serious deterioration of an Enrollee’s health; and
2. As a result of an unforeseen illness, injury, or the onset of acute or severe symptoms.
DEPENDENT ENROLLEE COVERAGE

**Dependent Enrollee Eligibility**
*Your dependent Enrollees* become eligible for coverage under this *contract* on the latter of:

1. The date *you* became covered under this *contract*; or
2. The date of a newborn's birth; or
3. The date that an adopted child is placed with the *enrollee* for the purposes of adoption or the *enrollee* assumes total or partial financial support of the child.

**Effective Date For Initial Dependent Enrollees**
The *effective date* for your initial *dependent Enrollees*, if any, is shown on the Schedule of Benefits. Only *dependent Enrollees* included in the application for this *policy* will be covered on your *effective date*.

**Coverage for A Newborn Child**
An *eligible child* born to *you* or a family *member* will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities.

Additional premium will be required to continue coverage beyond the 31st day after the date of birth of the child. The required premium will be calculated from the child's date of birth. If notice of the newborn is given to *us* by the Marketplace within the 31 days from birth, an additional premium for coverage of the newborn child will be charged for not less than 31 days after the birth of the child. If notice is not given with the 31 days from birth, we will charge an additional premium from the date of birth. If notice is given by the Marketplace within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure to notify *us* of the birth of the child or to pre-enroll the child. Coverage of the child will terminate on the 31st day after its birth, unless we have received notice by the Marketplace of the child's birth.

**Coverage for An Adopted Child**
An *eligible child* legally placed for adoption with *you* or your *spouse* will be covered from the date of *placement* until the 31st day after *placement*, unless the *placement* is disrupted prior to legal adoption and the child is removed from your or your spouse's custody.

The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement*.

Additional premium will be required to continue coverage beyond the 31st day following *placement* of the child and where we are notified by the Marketplace. The required premium will be calculated from the date of *placement* for adoption. Coverage of the child will terminate on the 31st day following *placement*, unless we have received both: (A) Notification of the addition of the child from the Marketplace within 60 days of the birth or placement; and (B) any additional premium required for the addition of the child within 90 days of the date of *placement*.

As used in this provision, "*placement*" means the earlier of:

1. The date that *you* or *your spouse* assume physical custody of the child for the purpose of adoption; or

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

**Adding Other Dependent Enrollees**
If you apply in writing for coverage on a dependent Enrollee and you pay the required premiums, then the effective date will be shown in the written notice to you that the dependent Enrollee is covered.
ONGOING ELIGIBILITY

For All Enrollees

An Enrollee’s eligibility for coverage under this contract will cease on the earlier of:
1. The date that a enrollee has failed to pay premiums or contributions in accordance with the terms of this contract or the date that we have not received timely premium payments in accordance with the terms of this contract;
2. The date the member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a member accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract;
3. The date a member’s employer and a member treat this contract as part of an employer-provided health plan for any purpose, including tax purposes; or
4. The date we receive a request from you to terminate this policy, or any later date stated in your request, or if you are enrolled through the Marketplace, the date of termination that the Marketplace provides us upon your request of cancellation to the Marketplace;
5. The date we decline to renew this policy, as stated in the Discontinuance provision;
6. The date of an enrollee’s death;
7. The date an enrollee’s eligibility for insurance under this policy ceases due to losing network access as the result of a permanent move.

For Dependent Enrollees

A dependent Enrollee will cease to be an Enrollee at the end of the premium period in which he or she ceases to be your dependent Enrollee. For eligible children, the Marketplace will send a termination letter with an Effective Date the last day of the dependent’s 26th birth month.

All enrolled dependent Enrollees will continue to be covered until the age limit listed in the definition of eligible child. At the dependent Enrollee’s request, eligibility will be continued past the age limit until the end of the month in which the dependent enrollee reaches age 28 if the dependent enrollee:
1. Is the natural child, stepchild or adopted child of the enrollee.
2. Is a resident of Texas or a full-time student at an accredited higher education institution.
3. Is not employed by an employer that offers any health benefit plan under which the dependent enrollee is eligible for coverage.
4. Is not eligible for coverage under Medicaid or Medicare.

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

Open Enrollment

There will be an open enrollment period for coverage on the Health Insurance Marketplace. The open enrollment period begins November 1, 2015 and extends through January 31, 2016. Qualified individuals who enroll prior to December 15, 2015 will have an effective date of coverage on January 1, 2016. Qualified individuals that enroll between the first and fifteenth day of any subsequent month during the initial open enrollment period, will have a coverage effective date of the first day of the following month. Qualified individuals that enroll between the sixteenth and last day of the month between December 2015 and January 31, 2016 will have a coverage effective date of the first day of the second following month.

The Health Insurance Marketplace may provide a coverage effective date for a Qualified individual earlier than specified in the paragraphs above, provided that either:
1. The Qualified individual has not been determined eligible for advance premium tax credit cost-sharing reductions; or
2. The Qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance premium tax credit and cost-sharing reduction payments until the first of the next month. Starting in 2014, we will send written annual open enrollment notification to each enrollee no earlier than September 1st, and no later than September 30th.

Special And Limited Enrollment
A Qualified individual has 60 days to report a qualifying event to the Marketplace and could be granted a 60 day Special Enrollment Period as a result of one of the following events:
1. A Qualified individual or dependent loses minimum essential coverage;
2. A Qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
4. A Qualified individual’s enrollment or non-enrollment in a Qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace or HHS, or its instrumentalities as evaluated and determined by the Health Insurance Marketplace. In such cases, the Health Insurance Marketplace may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
5. An enrollee adequately demonstrates to the Health Insurance Marketplace that the Qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
6. An individual is determined newly eligible or newly ineligible for advance premium tax credit or has a chance in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a Qualified health plan;
7. A Qualified individual or enrollee gains access to new Qualified health plans as a result of a permanent move;
8. Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
   a. The qualifying events for employees are:
      i. Voluntary or involuntary termination of employment for reasons other than gross misconduct
      ii. Reduction in the number of hours of employment
   b. The qualifying events for spouses are:
      i. Voluntary or involuntary termination of the covered employee’s employment for any reason other than gross misconduct
      ii. Reduction in the hours worked by the covered employee
      iii. Covered employee's becoming entitled to Medicare
      iv. Divorce or legal separation of the covered employee
      v. Death of the covered employee
   c. The qualifying events for dependent children are the same as for the spouse with one addition:
      i. Loss of dependent child status under the plan rules
9. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified health plan or change from one Qualified health plan to another one time per month; or
10. A Qualified individual or enrollee demonstrates to the Health Insurance Marketplace, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the
Health Insurance Marketplace may provide. Qualified individuals that enroll between the first and fifteenth day of the month will have a coverage effective date of the first day of the following month. Qualified individuals that enroll between the sixteenth and last day of the month will have a coverage effective date of the first day of the second following month. In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption, but advance premium tax credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. In the case of marriage, or in the case where Qualified individual loses minimum essential coverage, the effective date is the first day of the following month.

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

1. The Qualified individual has not been determined eligible for advance premium tax credit or cost-sharing reductions; or
2. The Qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance premium tax credit and cost-sharing reduction payments until the first of the next month.
PREMIUMS

Premium Payment
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.

Grace Period
When an enrollee is receiving a premium subsidy:

Grace Period: A grace period of 90 days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force.

If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance payment of the premium tax credits are received.

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

When an Enrollee is not receiving a premium subsidy:

Grace Period: A grace period of 30 days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force.

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, claims may pend for covered services rendered to the enrollee during the grace period. We will notify HHS, as necessary, of the non-payment of premiums, the enrollee, as well as providers of the possibility of denied claims when the enrollee is in the grace period.

Misstatement Of Age
If an Enrollee's age has been misstated, the benefits may be adjusted based on the relationship of the premium paid to the premium that should have been paid, based on the correct age.

Change Or Misstatement Of Residence
If you change your residence, you must notify the Marketplace of your new residence within 60 days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement Of Tobacco Use
The answer to the tobacco question on the application is material to our correct underwriting. If an Enrollee's use of tobacco has been misstated on the Enrollee's application for coverage under this contract, we have the right to rerate the contract back to the original effective date.

**Billing/Administrative Fees**
Upon prior written notice, we may impose an administrative fee for credit card payments. This does not obligate us to accept credit card payments. We will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.
DEDUCTIBLE, COINSURANCE, COPAYMENTS

Deductibles
The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Benefits. The Deductibles are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under “Deductibles” on your Schedule of Benefits must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Service Expenses before benefits are available under the Plan.

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 Participant will contribute more than the individual.
3. Deductible amounts to the “family” Deductible amount.

The deductible amount does not include any copayment amount.

Coinsurance Stop−Loss Amount
Most of your Eligible Service Expense payment obligations, including Copayment Amounts, are considered Coinsurance Amounts and are applied to the Coinsurance Stop−Loss Amount maximum. Your Coinsurance Stop−Loss Amount will not include:
- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Service Expenses paid by the Primary Plan when Celtic Insurance Company is the Secondary Plan for purposes of coordination of benefits;
- Any Deductibles;
- Penalties applied for failure to Preauthorize;
- Any Copayment Amounts paid under the Pharmacy Benefits;
- Any remaining unpaid Medical−Surgical Expense in excess of the benefits provided for Covered Drugs

Individual Coinsurance Stop−Loss Amount
When the Coinsurance Amount for the In−Network or Out−of−Network Benefits level for a Participant in a Calendar Year equals the “individual” “Coinsurance Stop−Loss Amount” shown on your Schedule of Benefits for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Service Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Coinsurance Stop−Loss Amount
When the Coinsurance Amount for the In−Network or Out−of−Network Benefits level for all Participants under your coverage in a Calendar Year equals the “family” “Coinsurance Stop−Loss Amount” shown on your Schedule of Benefits for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Service Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to
contribute more than the individual Coinsurance Amount to the family Coinsurance Stop–Loss Amount.

**Coinsurance Percentage**

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

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

When the annual out-of-pocket maximum has been met, additional covered service expenses will be provided or payable at 100% 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.

The applicable deductible amount(s), coinsurance percentage, and copayment amounts are shown on the Schedule of Benefits.

**Note:** The bill you receive for services or supplies from a non-network provider may be significantly higher than the eligible service expenses for those services or supplies. In addition to the deductible amount, copayment amount, and coinsurance percentage, you are responsible for the difference between the eligible service expense and the amount the provider bills you for the services or supplies. Any amount you are obligated to pay to the provider in excess of the eligible service expense will not apply to your deductible amount or out-of-pocket maximum.

**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 fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth 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 Policy Provisions**

Charges for services and supplies that qualify as covered service expenses under one benefit provision will not qualify as covered service expenses under any other benefit provision of this contract.
MANAGING YOUR HEALTH CARE

Continuity of Care
In the event an Enrollee is under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider’s termination, the Enrollee has special circumstances such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, Celtic Insurance Company will continue providing coverage for that Provider’s services at the In-Network Benefit level.

Special circumstances means a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the Enrollee. Special circumstances shall be identified by the treating Physician or health care Provider, who must request that the Enrollee be permitted to continue treatment under the Physician’s or Provider’s care and agree not to seek payment from the Enrollee of any amounts for which the Enrollee would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Enrollee has been diagnosed with a terminal illness, beyond the date the Provider’s termination from the Network takes effect. However, for Enrollees past the first (1st) trimester of pregnancy at the time the Provider’s termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

Primary Care Physician
In order to obtain benefits, you must designate a network primary care physician for each Enrollee. You may select any network primary care physician who is accepting new patients. If you do not select a network primary care physician for each Enrollee, one may be assigned. You may obtain a list of network primary care physicians at our website or by contacting our Member Services department.

Your network primary care physician will be responsible for coordinating all covered health services and making referrals for services from other network providers. 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. For all other network specialist physicians, you may be required to obtain a referral from your network primary care physician in order to be eligible for maximum benefits under this contract. However, should medically necessary covered health care services not be available through network providers, upon the request of a network primary care physician, within the time appropriate to the circumstances relating to the delivery of the health care services and your condition, but in no event to exceed five business days after receipt of reasonably requested documentation, we shall allow a referral to a non-network provider and shall fully reimburse the non-network provider at the usual and customary rate or agreed rate.

You may change your network primary care physician online at our website, or by contacting Member Services at the number shown on your identification card. The change to your network primary care physician of record will be effective no later than 30 days from the date we receive your request.

Specialist as Primary Care Provider
If you have a chronic disabling or life-threatening illness, you may apply to the Health Plan Medical Director to request that your treating specialist become the coordinator of all of your care. Your specialist
must agree to:

- become the coordinator of all your care;
- meet and accept all of our requirements and payment schedules for Primary Care Physicians; and
- sign your request

If you are not satisfied with the Health Plan Medical Director’s response to your request, you may submit a complaint as described in the Complaint section of this contract.

Prior Authorization
Some covered service expenses require prior authorization. In general, network providers must obtain authorization from us prior to providing a service or supply to an Enrollee. However, there are some network eligible service expenses for which you must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, you must obtain authorization from us before the Enrollee:

1. Receives a service or supply from a non-network provider;
2. Is admitted into a network facility by a non-network provider; or
3. Receives a service or supply from a network provider to which the Enrollee was referred by a non-network provider.

How To Obtain Prior Authorization
To obtain prior authorization or to confirm that a network provider has obtained prior authorization, contact us by telephone at the telephone number listed on your health insurance identification card before the service or supply is provided to the Enrollee.

Failure To Obtain Prior Authorization
Failure to comply with the prior authorization requirements may result in benefits being reduced or not covered. Please see the contract Schedule of Benefits for specific details.

Network providers cannot bill you for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an emergency. However, you must contact us as soon as reasonably possible after the emergency occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. If a provider materially misrepresents the proposed medical or health care services, or has substantially failed to perform the proposed medical or health care services, we may deny or reduce payment to the provider. Eligibility for and payment of benefits are subject to all terms and conditions of the contract.

Verification of Benefits
Your provider may request a benefit verification. We will provide one if circumstances allow us to do so. However, we are not required to verify either coverage or benefits for any particular treatment or medical expense.

A review that shows one or more of the following may cause us to invalidate the verification of benefits:

1. The verification was based on incomplete or inaccurate information initially received by us.
2. The medical expense has already been paid by someone else.
3. Another party is responsible for payment of the medical expense.
On receipt of a request for verification from a provider, the Plan will issue a verification or declination not later than:

- five calendar days after the date of receipt of the request for verification;
- If the request is related to a concurrent hospitalization, the response will be sent not later than 24 hours after receipt of the request;
- If the request is related to post-stabilization care or a life-threatening condition, the response will be sent not later than one hour after receipt of the request for verification.

The verification or declination will be delivered via telephone call, in writing, or by other means, including the Internet, and will include (1) enrollee name; (2) enrollee ID number; (3) requesting provider’s name; (4) hospital or other facility name, if applicable; (5) a specific description, including relevant procedure codes, of the services that are verified or declined; (6) if the services are verified, the effective period for the verification, and any applicable deductibles, copayments, or coinsurance for which the enrollee is responsible; (7) a unique verification number; and (8) a statement that the proposed services are being verified or declined. If the verification is declined, the specific reason for the declination will be provided.

HOSPITAL BASED PROVIDERS

When receiving care at an Ambetter participating hospital it is possible that some hospital-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with Ambetter as participating providers. These providers may bill you for the difference between Ambetter's allowed amount and the providers billed charge – this is known as "balance billing". We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their participation status with Ambetter.

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.
COVERED HEALTH CARE SERVICES

The Plan provides coverage for health care services for you and your covered Dependents. Some services require preauthorization.

Copayment Amounts must be paid to your Network Physician or other Network Provider at the time you receive services.

The benefit percentages of your total eligible health care services shown on the Schedule of Benefits in excess of your Copayment Amounts, Coinsurance Amounts, and any applicable Deductibles shown are the Health Plan’s obligation. The remaining unpaid Medical–Surgical Expense in excess of the Copayment Amounts, Coinsurance Amounts, and any Deductibles is your obligation to pay.

To calculate your benefits, subtract any applicable Copayment Amounts and Deductibles from your total eligible Medical–Surgical Expense and then multiply the difference by the benefit percentage shown on your Schedule of Benefits. Most remaining unpaid health care services in excess of the Copayment Amounts and Deductible is your Coinsurance Amount.

Acquired Brain Injury Services

Benefits for Eligible Service Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post–acute transition services and community reintegration services, including outpatient day treatment services, or any other post–acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

Treatment for an Acquired Brain Injury may be provided at a hospital, an acute or post–acute rehabilitation hospital, an assisted living 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; and
3. Becomes responsive to treatment at a later date.

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

Ambulance Services

Covered service expenses will include ambulance services for local transportation:

1. To the nearest hospital that can provide services appropriate to the Enrollee’s illness or injury.
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.
Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*.
2. Those situations in which the *Enrollee* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law.
2. Non-*emergency* air ambulance.
3. Air ambulance:
   a. Outside of the 50 United States and the District of Columbia;
   b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
   c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States.
4. Ambulance services provided for an *Enrollee's* comfort or convenience.

**Autism Spectrum Disorder Benefits**

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the *Enrollee's* Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner.

Individuals providing treatment prescribed under that plan must be a health care practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a provider under the TRICARE military health system.

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

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

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

**Mental Health and Substance Use Disorder Benefits**

You do not need a referral from your PCP in order to initiate treatment. Deductibles, copayment or coinsurance amounts, and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and substance use disorder are included on a non-discriminatory basis for all *Enrollees* for the diagnosis and treatment of mental, emotional, and substance use disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. Diagnoses known as “V Codes” are eligible service expenses only.
when billed as a supporting diagnosis. When making coverage determinations, Cenpatico, a Partner company of Ambetter, utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance use disorder determinations. Services should always be provided in the least restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional.

Covered Inpatient, Intermediate, and Outpatient mental health and substance use disorder services are as follows:

Inpatient
1. Inpatient treatment;
2. Detoxification at a hospital or chemical dependency treatment center;
3. Observation;
4. Crisis Stabilization;
5. Electroconvulsive Therapy (ECT); and

Intermediate
1. Intensive Outpatient Program (IOP); and
2. Day Treatment.

Outpatient
1. Traditional outpatient services, including individual and group therapy services, medication management services and psychological testing; and
2. Medication Management services;
3. Psychological testing;
4. Applied Behavior Analysis (ABA) for a covered Dependent child

Expenses for these services are covered, if medically necessary and may be subject to prior authorization. Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any.

Emergency Care and Treatment of Accidental Injury

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.
In–Network and Out–of–Network Benefits for Eligible Service Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on your Schedule of Benefits. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room/treatment room visit as indicated on your Schedule of Benefits. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived. If admitted for the emergency condition immediately following the visit, Preauthorization 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 In–Network Benefits. After 48 hours, In–Network Benefits will be available only if you use 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 Network Provider but are treated by an Out–of–Network Provider, only Out–of–Network Benefits will be available.

Benefits for Urgent Care
Benefits for Eligible Service Expenses for Urgent Care will be determined as shown on your Schedule of Benefits. A Copayment Amount, in the amount indicated on your Schedule of Benefits, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk–in care outside of a hospital emergency room/treatment room department or physician’s office. The necessary medical care is for a condition that is not life–threatening.

Habilitation, Rehabilitation And Extended Care Facility Expense Benefits
Covered service expenses include services provided or expenses incurred for habilitation or rehabilitation services or confinement in an extended care facility, subject to the following limitations:

1. **Covered service expenses** available to an Enrollee while confined primarily to receive habilitation or rehabilitation are limited to those specified in this provision.

2. Rehabilitation services or confinement in a rehabilitation facility or extended care facility must begin within 14 days of a hospital stay of at least 3 consecutive days and be for treatment of, or rehabilitation related to, the same illness or injury that resulted in the hospital stay.

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 physician, must be filled by a licensed pharmacist, and are 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 medical practitioners.

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be rehabilitation upon our determination of any of the following:

1. The Enrollee has reached maximum therapeutic benefit.
2. Further treatment cannot restore bodily function beyond the level the Enrollee already possesses.
3. There is no measurable progress toward documented goals.
4. Care is primarily custodial care.

Exclusion:
No benefits will be provided or paid under these Habilitation, Rehabilitation and Extended Care Facility Service Expense Benefits for charges for services or confinement related to treatment or therapy for mental disorders or substance abuse.

**Home Health Care Service Expense Benefits**

*Covered service expenses for home health care* are limited to the following charges:

1. **Home health aide services.**
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for home health care.
3. I.V. medication and pain medication.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. Necessary medical supplies.
6. Rental of medically necessary durable medical equipment.

Charges under (4) are *covered service expenses* to the extent they would have been *covered service expenses* during an *inpatient hospital stay.*

At *our* option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

Please refer to the Schedule of Benefits for cost sharing, and any limitations associated with this benefit.

**Exclusion:**
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

**Hospice Care Benefits**
This provision only applies to a *terminally ill Enrollee* receiving *medically necessary* care under a *hospice care program.*

The list of *covered service expenses* in the Miscellaneous Medical Service Expense Benefits provision is expanded to include:

1. Room and board in a hospice while the Enrollee is an inpatient.
2. Occupational therapy.
4. 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.
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
6. Counseling the Enrollee regarding his or her terminal illness.
7. Terminal illness counseling of the Enrollee’s immediate family.
8. Bereavement counseling, refer to your Schedule of Benefits.

**Exclusions and Limitations:**
Any exclusion or limitation contained in the contract regarding:

1. An injury or illness arising out of, or in the course of, employment for wage or profit; or
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a hospice care program; or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for hospice inpatient or outpatient care are available to a terminally ill Enrollee for one continuous period up to 180 days in an Enrollee’s lifetime. For each day the Enrollee is confined in a hospice, benefits for room and board will not exceed:

1. For a hospice that is associated with a hospital or nursing home, the most common semiprivate room rate of the hospital or nursing home with which the hospice is associated.
2. For any other hospice, the lesser of the billed charge or $200 per day.

Respite Care Expense Benefits
Respite care is covered on an inpatient or outpatient basis to allow temporary relief to family members from the duties of caring for an enrollee. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any Maximum Benefit limit for these services. See your Schedule of Benefits for coverage limits.

Medical And Surgical Benefits

1. **Hospital Services**
   a. Hospital inpatient daily room and board and general nursing care, not to exceed the hospital's most common semi-private room rate.
   b. Hospital inpatient Daily room and board and general nursing care while confined in an intensive care unit.
   c. Inpatient use of an operating, treatment, or recovery room.
   d. Outpatient use of an operating, treatment, or recovery room for surgery.
   e. Services and supplies, including drugs and medicines that are routinely provided by the hospital to persons for use only while they are inpatients.
   f. Emergency treatment of an injury or illness, even if confinement is not required. However, charges for use of the emergency room itself for treatment of an illness may be reduced unless the Enrollee is directly admitted to the hospital for further treatment of that illness.
   g. Short-term rehabilitation therapy services in the inpatient hospital setting.

2. **Surgery** in a physician’s office or at an outpatient surgical facility, including services and supplies.

3. **Physician professional services**, including surgery.

4. **Assistant surgeon**, limited to 20 percent of the eligible service expense for the surgical procedure.

5. **Professional services** of a non-physician medical practitioner.

6. **Medical supplies** that are medically necessary, including dressings, crutches, orthopedic splints, braces, casts, or other necessary medical supplies.

7. **Diagnostic testing using radiologic, ultrasonographic, or laboratory services** (psychometric, behavioral and educational testing are not included).

8. **Chemotherapy, radiation therapy** or treatment (inpatient or outpatient), and inhalation therapy.

9. **Hemodialysis, and the charges by a hospital for processing and administration of blood or blood components.**

10. **Anesthetic** cost and administration.

11. **Oxygen** and its administration.

12. **Dental service expenses** when an Enrollee suffers an injury, after the Enrollee's effective date of coverage, that results in:
   a. Damage to his or her natural teeth; and
   b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a physician and began within six months of the accident. Injury to the natural teeth will not include any injury as a result of chewing.
13. *Surgery to treat craniomandibular disorders, malocclusions, or disorders of the temporomandibular joint*, to include necessary tooth extractions.

14. Cosmetic or plastic surgery for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases will be the same as for treatment of any other sickness as shown on your Schedule of Benefits.

15. **Reconstructive Surgery**—The following Eligible Service Expenses described below for Reconstructive Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Benefits:
   a. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
   b. Treatment provided for reconstructive surgery following cancer surgery; or
   c. Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
   d. Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19; or
   e. For the treatment or correction of a congenital defect other than conditions of the breast; or
   f. Reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas, are covered at all stages of mastectomy.

16. *Two mastectomy bras* per year if the Enrollee has undergone a covered mastectomy.

17. **Mastectomy or Lymph Node Dissection**
   Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:
   a. 48 hours following a mastectomy, and
   b. 24 hours following a lymph node dissection.
   The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

18. *Diabetic equipment and supplies* that are medically necessary and prescribed by a physician, *Outpatient chiropractic* treatment that is medically necessary. See the Schedule of Benefits for benefit levels or additional limits. Covered service expenses are subject to all other terms and conditions of the contract, including the deductible amount and coinsurance percentage provisions.

19. **Tissue transplants:**
   a. Cornea transplants.
   b. Artery or vein grafts.
   c. Heart valve grafts.
   d. Prosthetic tissue replacement, including joint replacements.
   e. Implantable prosthetic lenses, in connection with cataracts.

20. *Artificial eyes or larynx, breast prosthesis, or basic artificial limbs* (but not the replacement thereof, unless required by a physical change in the Enrollee and the item cannot be modified). If more than one prosthetic device can meet an Enrollee’s functional needs, only the charge for the most cost effective prosthetic device will be considered a covered expense.

21. *Genetic blood tests* that is medically necessary.

22. *Immunizations to prevent respiratory syncytial virus (RSV) that are medically necessary*

23. *Rental of medically necessary durable medical equipment*.

24. *Rental of Continuous Passive Motion (CPM) machine; one per Enrollee following a covered joint surgery.*
25. *One wig per Enrollee necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits.*

26. *One pair of eyeglasses or contact lenses per Enrollee following a covered cataract surgery.*

27. Benefits for Speech and Hearing Services Benefits as shown on your Schedule of Benefits are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function. Any benefit payments made for hearing aids will apply toward the benefit maximum amount.

**Diabetic Care**

a. *Diabetes self-management training;*

b. Blood glucose monitors, including noninvasive glucose monitors designed to be used by or adapted for the legally blind;

c. Test strips specified for use with a corresponding glucose monitor;

d. Lancets and lancet devices;

e. Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;

f. Insulin and insulin analog preparations;

g. Injection aids, including devices used to assist with insulin injection and needleless systems;

h. Insulin syringes;

i. Biohazard disposal containers;

j. Insulin pumps, both external and implantable, and associated appurtenances, which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin; and other required disposable supplies;

k. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer’s warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;

l. Prescription medications and medications available without a prescription for controlling the blood sugar level;

m. Podiatric appliances, including up to two pairs of therapeutic footwear per calendar year, for the prevention of complications associated with diabetes;

n. Routine foot care such as trimming of nails and corns;

o. Glucagon emergency kits;

p. On approval of the United States Food and Drug Administration, any new or improved diabetes equipment or supplies if medically necessary and appropriate as determined by a physician or other health care practitioner.

**Maternity care of the enrollee**

Outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other medically necessary reasons (less any applicable copayments, deductible amounts, or coinsurance percentage). An inpatient stay is covered for at least 48 hours following an uncomplicated vaginal delivery, and for at least 96 hours following an uncomplicated caesarean delivery.

a. Other maternity benefits include complications of pregnancy, parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests.
b. If services provided or expenses incurred for hospital confinement in connection with childbirth are otherwise included as covered Service expenses, we will not limit the number of days for these expenses to less than that stated in this provision.

c. Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following an uncomplicated vaginal delivery or less than 96 hours following an uncomplicated delivery by cesarean section. However, we may provide benefits for covered service expenses incurred for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

d. The level of benefits and out-of-pocket costs for any later part of the 48-hour (or 96-hour) stay will not be less favorable to the mother or newborn than any earlier part of the stay. We do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

**Note:** This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to covered service expenses for childbirth. This provision also does not require a woman who is eligible for coverage under a health benefit plan to:

1. give birth to a child in a hospital or other health care facility; or
2. remain under inpatient care in a hospital or other health care facility for any fixed term following the birth of a child.

In the event we cancel or do not renew this policy, there will be an extension of pregnancy benefits for a pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

**Clinical Trial Coverage**

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

1. drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition;
2. reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial; and
3. all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- The investigational item or service itself;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Phase I and II clinical trials must meet the following requirements:

1. Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
2. The insured is enrolled in the clinical trial. This section shall not apply to insureds who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

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

- One of the National Institutes of Health (NIH);
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- An NIH Cooperative Group or Center;
- The FDA in the form of an investigational new drug application;
- The federal Departments of Veterans’ Affairs, Defense, or Energy;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or
- A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Providers participating in clinical trials shall obtain a patient’s informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to us upon request.

Outpatient Prescription Drug Benefits

Covered service expenses 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.

Such covered service expenses shall include those for prescribed, orally administered anticancer medications. The covered service expenses shall be no less favorable than for intravenously administered or injected cancer medications that are covered as medical benefits under this contract. See the Schedule of Benefits and Ambetter Drug Formulary for benefit levels or additional limits.

Formulary means our list of covered drugs available on our website at ambetter.superiorhealthplan.com or by calling our Member Services department. The drug Formulary (approved drug list) is a list of Prescription Drugs that are covered by this Policy. The Formulary includes drugs for a variety of disease states and conditions. Periodically, the Formulary is reviewed and updated to assure that the most current and clinically appropriate drug therapies are being used. Sometimes it is Medically Necessary for a Member to use a drug that is not on the Formulary, or has been removed from the Formulary. When this occurs, the prescribing Provider may request an exception for coverage through our Member Services department. For a list of covered drugs please visit ambetter.superiorhealthplan.com or contact our Member Services department.

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

Coverage is provided for any prescription drug that was approved or covered under the plan Formulary for a medical condition or mental illness, regardless of whether the drug has been removed from the plan’s drug Formulary, at the contracted benefit level until the plan renewal date.
Non-Formulary and Tiered Formulary Contraceptives:
Under Affordable Care Act, you have the right to obtain contraceptives that are not listed on the formulary (otherwise known as “non-formulary drugs”) and tiered contraceptives (those found on a formulary tier other than “Tier 0 – no cost share”) at no cost to you on your medical practitioner’s request. To exercise this right, please get in touch with your medical practitioner. Your medical practitioner can utilize the usual prior authorization request process. See “Prior Authorization” below for additional details.

Non-Formulary Prescription Drugs:
Under Affordable Care Act, you have the right to request coverage of prescription drugs that are not listed on the plan formulary (otherwise known as “non-formulary drugs”). To exercise this right, please get in touch with your medical practitioner. Your medical practitioner can utilize the usual prior authorization request process. See “Prior Authorization” below for additional details.

Prescription Drug Exception Process
Standard exception request
An enrollee, an enrollee’s designee or an enrollee’s prescribing physician may request a standard review of a decision that a drug is not covered by the plan. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the enrollee, the enrollee’s designee or the enrollee’s prescribing physician with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited exception request
An enrollee, an enrollee’s designee or an enrollee’s prescribing physician may request an expedited review based on exigent circumstances. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the enrollee, the enrollee’s designee or the enrollee’s prescribing physician with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review
If we deny a request for a standard exception or for an expedited exception, the enrollee, the enrollee’s designee or the enrollee’s prescribing physician may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. We will make our determination on the external exception request and notify the enrollee, the enrollee’s designee or the enrollee’s prescribing physician of our coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

If we grant an external exception review of a standard exception request, we will provide coverage of the non-formulary drug for the duration of the prescription. If we grant an external exception review of an expedited exception request, we will provide coverage of the non-formulary drug for the duration of the exigency.

Non-Covered Services And Exclusions:
No benefits will be paid under this benefit subsection for services provided or expenses incurred:
   1. For prescription drugs for the treatment of erectile dysfunction or any enhancement of sexual performance.
2. For immunization agents, blood, or blood plasma, except when used for preventive care.
3. For medication that is to be taken by the Enrollee, in whole or in part, at the place where it is dispensed.
4. For medication received while the Enrollee is a patient at an institution that has a facility for dispensing pharmaceuticals.
5. For a refill dispensed more than 12 months from the date of a physician’s order.
6. Due to an Enrollee’s addiction to, or dependency on foods.
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 covered on the formulary or when the over-the-counter drug is used for preventive care.
9. For drugs labeled “Caution - limited by federal law to investigational use” or for investigational or experimental drugs.
10. For a prescription drug that contains (an) active ingredient(s) that is/are:
    a. Available in and therapeutically equivalent to another covered prescription drug; or
    b. A modified version of and therapeutically equivalent to another covered prescription drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate benefits for a prescription drug that was previously excluded under this paragraph.
11. For more than a 34-day supply when dispensed in any one prescription or refill (or for more than a 90-day supply when dispensed by mail order).
12. For prescription drugs for any Enrollee who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.

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. Covered service expenses for amino acid-based elemental formulas for treatment of an Enrollee who is diagnosed with the following disease or disorders:
- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein-induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Exclusions: any other dietary formulas, oral nutritional supplements, special diets, prepared foods/meals and formula for access problems.

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, including mammography.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual.
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration.
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women.
5. Covers without cost sharing:
   a. Screening for tobacco use; and
   b. For those who use tobacco products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
      i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
      ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

 Covered Preventive Care Services for Children including:
  1. Autism screening;
  2. Behavioral assessments for children of all ages. Ages: 0 to 11 months, 1 to 4 years, 5 to 10; years, 11 to 14 years, 15 to 17 years.
  3. Developmental screening for children under age 3, and surveillance throughout childhood;
  4. Fluoride Chemoprevention supplements for children without fluoride in their water source;
  5. Lead screening for children at risk of exposure;
  6. Tuberculin testing;
  7. Obesity screening and counseling;
  8. Oral Health risk assessment for young children. Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.

 Covered Preventive Care Services for Women, Including Pregnant Women:
  1. Anemia screening on a routine basis for pregnant women;
  2. BRCA counseling about genetic testing for women at higher risk;
  3. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
  4. Contraceptive care;
  5. Domestic and interpersonal violence screening and counseling for all women;
  6. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
  7. Gonorrhea screening for all women at higher risk;
  8. Hepatitis B screening for pregnant women at their first prenatal visit;
  9. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
  10. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
  11. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
  12. Sexually Transmitted Infections (STI) counseling for sexually active women;
  13. Well-woman visits.

 Covered Preventive Services for Adults including:
  1. Alcohol Misuse screening and counseling;
2. Blood Pressure screening for all adults;
3. Depression screening for adults;
4. Type 2 Diabetes screening for adults with high blood pressure;
5. HIV screening for all adults at higher risk;
6. Obesity screening and counseling for all adults
7. Tobacco Use screening for all adults and cessation interventions for tobacco users
8. Syphilis screening for all adults at higher risk.
9. Screening for colorectal cancer using fecal occult blood testing once every twelve months, a flexible sigmoidoscopy with hemoccult of the stool every five (5) years, or a colonoscopy in adults beginning at age 50 years and continuing until age 75 years every ten (10) years.

Benefits for Routine Exams and Immunizations
Benefits for routine exams are available for the following Preventive Care Services as indicated on your Schedule of Benefits:

a. Well−baby care (after newborn’s initial examination and discharge from the Hospital);
b. Routine annual physical examination;
c. Annual vision examination;
d. Annual hearing examinations, except for benefits as provided under Required Benefits for Screening Tests for Hearing Impairment. Screening tests for hearing impairment from birth through the date the child is 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. Charges are not subject to the deductible amount.
e. Immunizations. Deductibles will not be applicable to immunizations of a Dependent child age seven years of age or younger. Immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and any other immunization that is required by law for the child. Charges for immunization are not subject to deductible, coinsurance or copayment requirements. Charges for other services rendered at the same time as immunizations are subject to deductible, coinsurance and copayment in accordance with regular policy provisions.

Benefits are not available for Inpatient Hospital Expense or Medical−Surgical Expense for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

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

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer
Benefits are available for certain tests for the detection of Human Papillomavirus and Cervical Cancer, for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown on your Schedule of Benefits. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid–based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Mammography Screening
Benefits are available for a screening by low−dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older, as shown on your Schedule of Benefits, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis
If a Participant is a **Qualified Individual**, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant’s risk of osteoporosis and fractures associated with osteoporosis, as shown on your Schedule of Benefits.

**Qualified Individual means:**

a. A postmenopausal woman not receiving estrogen replacement therapy;

b. An individual with:
   1. vertebral abnormalities,
   2. primary hyperparathyroidism, or
   3. a history of bone fractures; or

c. An individual who is:
   1. receiving long-term glucocorticoid therapy, or
   2. being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

**Benefits for Certain Tests for Detection of Prostate Cancer**

Benefits are available for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

a. 50 years of age and asymptomatic; or

b. 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

**Benefits for Early Detection Tests for Cardiovascular Disease**

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

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

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

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

**Benefits for Screening Tests for Hearing Impairment**

Benefits are available for Eligible Service Expenses incurred by a covered Dependent child:

1. For a screening test for hearing loss from birth through the date the child is 30 days old; and

2. Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

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

**Contraceptive Care**

All FDA-approved contraception methods (identified on [www.fda.gov](http://www.fda.gov)) are approved for enrollees without cost sharing as required under the Affordable Care Act. **Enrollees** have access to the methods available and outlined on our Drug Formulary or Preferred Drug List without cost share. Some contraception methods are available through an enrollee’s medical benefit, including the insertion and removal of the contraceptive device at no cost share to the member. Emergency contraception is available to enrollees without a prescription and at no cost share to the enrollee.
Transplant Services

Covered Services For Transplant Service Expenses:
If we determine that an Enrollee is an appropriate candidate for a listed transplant, Medical Service Expense Benefits will be provided for:

1. Pre-transplant evaluation.
2. Pre-transplant harvesting.
3. Pre-transplant stabilization, meaning an inpatient stay to medically stabilize an Enrollee to prepare for a later transplant, whether or not the transplant occurs.
4. High dose chemotherapy.
5. Peripheral stem cell collection.
6. The transplant itself, not including the acquisition cost for the organ or bone marrow (except at a Center of Excellence).
7. Post-transplant follow-up.

*We* will cover the medical expenses incurred by a live donor as if they were medical expenses of the Enrollee if:

1. They would otherwise be considered covered service expenses under the contract;
2. The Enrollee received an organ or bone marrow of the live donor; and
3. The transplant was a listed transplant.

These medical expenses are covered to the extent that the benefits remain and are available under the Enrollee’s contract, after benefits for the Enrollee’s own expenses have been paid. In the event of such coverage, the otherwise existing coverage of a live donor shall be secondary to benefits under the Enrollee’s contract.

Ancillary "Center Of Excellence" Service Benefits:
An Enrollee may obtain services in connection with a listed transplant from any physician. However, if a listed transplant is performed in a Center of Excellence:

1. Covered service expenses for the listed transplant will include the acquisition cost of the organ or bone marrow.
2. *We* will pay for the following services when the Enrollee is required to travel more than 75 miles from the residence to the Center of Excellence:
   a. Transportation for the Enrollee, any live donor, and the immediate family to accompany the Enrollee to and from the Center of Excellence.
   b. Lodging at or near the Center of Excellence for any live donor and the immediate family accompanying the Enrollee while the Enrollee is confined in the Center of Excellence. *We* will pay the costs directly for transportation and lodging, however, you must make the arrangements.

Non-Covered Services And Exclusions:
No benefits will be provided or paid under these Transplant Service Expense Benefits:

1. For search and testing in order to locate a suitable donor.
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no listed transplant occurs.
3. For animal to human transplants.
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently.
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
6. To keep a donor alive for the transplant operation.
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.

8. Related to transplants not included under this provision as a listed transplant.

9. For a listed transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (“USFDA”) regulation, regardless of whether the trial is subject to USFDA oversight.

Limitations on Transplant Service Expense Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. Covered service expenses for listed transplants will be limited to two transplants during any 10-year period for each Enrollee.

2. If a designated Center of Excellence is not used, covered service expenses for a listed transplant will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.

3. If a designated Center of Excellence is not used, the acquisition cost for the organ or bone marrow is not covered.

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) or initial supply of standard contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating;

3. One pair of frames every calendar year.

4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered service expenses do not include:

1. Visual therapy;

2. Two pair of glasses as a substitute for bifocals;

3. Replacement of lost or stolen eyewear;

4. Any vision services, treatment or material not specifically listed as a covered service; or

5. Non-Network Providers;

6. Ultraviolet Protective Coating;

7. Blended Segment Lenses;

8. Intermediate Vision Lenses;

9. Standard Progressives;

10. Premium Progressives;

11. Photochromic Glass Lenses;

12. Plastic Photosensitive Lenses;

13. Polarized Lenses;

14. Premium AR Coating;

15. Ultra AR Coating;

16. Hi-Index Lenses;

17. Medically Necessary Contact Lenses;

18. Discount for laser vision correction.

Pediatric Services will extend through the end of the plan year in which they turn 19 years of age.
Vision Services - Adult 19 years of age and older

Routine eye exams, prescriptions eyeglasses, and initial supply of standard contact lenses are managed through AECC Total Vision Health Plan (TVHP). For information regarding your specific copayments and/or deductible please refer to your specific plan information listed in the Schedule of Benefits.

You may receive one routine eye exam and eyewear once every calendar year. Eyewear includes either one pair of eyeglasses or initial supply of standard contacts.

**Eyeglasses** - Covered lenses include single vision, lined bifocal, lined trifocal, or lenticular lenses, in glass or plastic. Covered lens add-ons include standard polycarbonate lenses, scratch resistant, and anti-reflective coating.

*If you require a more complex prescription lens, contact TVHP for prior authorization. Lens options such as progressive lenses, high index tints, and UV coating are not covered.*

Covered frames are to be selected from TVHP’s frame formulary, offering a wide range of frames that are available at no cost to you.

Should you elect to see a non-network provider, see Schedule of Benefits. Should you select glasses that are more than your maximum benefit, you will be financially responsible for the difference.

**Contact Lenses** - Coverage includes evaluation, fitting, and initial supply of contact lenses. If you elect contact lenses in lieu of glasses, please refer to your specific plan information listed in the Schedule of Benefits for your maximum allowance for contacts. If contacts are purchased through a non-network provider, you will be financially responsible for any differences above the allowances.

For additional information about covered vision services, participating TVHP providers, call Member Services at [877-687-1196].

Non-Routine Vision for Adults and Pediatric:

Eye exams for the treatment of medical conditions of the eye are covered when the service is performed by a participating provider (optometrist, therapeutic optometrist, or ophthalmologist). Covered services include office visits, testing, and treatment of eye conditions producing symptoms that if left untreated may result in the loss of vision.

Excluded services for routine and non-routine vision include:

- Visual Therapy for adults is excluded.
- Vision Therapy Development Testing for children, except when pre-approved
- Any vision services, treatment or material not specifically listed as a covered service.
- Low vision services and hardware for adults
- Out of network care, only as defined within this document and Schedule of Benefits.
- Reading glasses for children may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.
Wellness and Other Program Benefits

Benefits may be available to enrollees for participating in certain programs that we may make available in connection with this Contract. Such programs may include wellness programs, disease or case management programs, and other programs. The benefits available to enrollees as of the date of this Contract for participating in such programs are described below or on the Schedule of Benefits. You may obtain information regarding the particular programs available at any given time by visiting our website at [http://ambetter.superiorhealthplan.com] or by contacting Member Services by telephone at [877-687-1196]. The benefits are available as long as coverage remains active, unless changed by us as described below. Upon termination of coverage, the wellness program benefits are no longer available, and any remaining or unused balance on the rewards card is removed at the time of termination. All enrollees are automatically eligible for the program benefits upon obtaining coverage. The programs are optional, and the benefits are made available at no additional cost to the enrollees. The programs and benefits available at any given time are made part of this Contract by this reference and are subject to change by us through an update to program information available on our website or by contacting us.

Members will be able to earn reward dollars for doing three specific healthy behaviors for a total of $125 per calendar year

   a. Welcome Survey: $50
   b. Annual Well Visit: $50
   c. Flu Shot: $25

Rewards will be loaded onto the enrollees’s “My Health Pays” Rewards card. The card is similar to a Health Reimbursement Account (HRA). Dollars are notional and expire after 12 months. Reward dollars can be used in two ways: a) Enrollee cost share: copays, deductibles, coinsurance payments and b) Enrollee Premiums. Cards will be mailed to the enrollee automatically when the first reward is earned. The “My Health Pays” Rewards card will be attached to a single page mailer outlining the program, as well as the reward the generated the card, other ways to earn rewards, how to use the reward dollars, and where to go to find out more about the program. There is a $5 replacement fee for lost or stolen cards.

The Gym Reimbursement Program features two parts:

   a. Discounted Gym memberships within the GlobalFit network
   b. $20 per month reimbursement for Gym utilization
      • At least 8 visits per month
      • Reimbursement dollars loaded onto the My Health Pays Rewards card

Enrollees will be able to log into the GlobalFit gym network to purchase a discounted gym membership if they do not already have a membership, or if they want a better rate. Additionally, enrollees will have access to exclusive discounts for healthier lifestyles through the GlobalFit Store. Regardless of whether enrollees purchase their gym membership through GlobalFit, they will be able to earn the Gym Reimbursement benefit. Enrollees will have the ability to register their gym membership information on the GlobalFit portal, and will be able to load monthly utilization information with corresponding documentation to get reimbursed up to $20 per month, for a maximum of $240 per year. Enrollees can upload proof of use via the enrollee secure portal. For additional information or questions regarding this program, please visit our website at [http://ambetter.superiorhealthplan.com] or by contacting Member Services by telephone at [877-687-1196].

In the event we replace GlobalFit with a similar vendor or discontinue the gym reimbursement program, we will provide enrollees with 60-days advanced written notice of said change.

Member Services Department: [877-687-1196]
Log on to: [http://ambetter.superiorhealthplan.com]
Member Services Department: [877-687-1196]
Log on to: [http://ambetter.superiorhealthplan.com]
GENERAL NON-COVERED SERVICES AND EXCLUSIONS

No benefits will be provided or paid for:
1. Any service or supply that would be provided without cost to the Enrollee or Enrollee in the absence of insurance covering the charge.
2. Expenses/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 Enrollee of an Enrollee's immediate family.
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.

Even if not specifically excluded by this contract, no benefit will be paid for a service or supply unless it is:
1. Administered or ordered by a physician; and
2. Medically necessary to the diagnosis or treatment of an injury or illness, or covered under the Preventive Care Expense Benefits 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, except as expressly provided for under the Benefits After Coverage Terminates clause in this policy’s Termination section.
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.
4. For breast reduction or augmentation.
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the Enrollee, such as sex-change surgery.
6. The reversal of sterilization and reversal of vasectomies.
7. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
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 or for failure to keep a scheduled appointment.
12. For hospital room and board and nursing services for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency, or medically necessary inpatient surgery is scheduled for the day after the date of admission.
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 Medical Service Expense Benefits.
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 in a child who has been an enrollee from its birth until the date surgery is performed.
16. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
17. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.
18. For high dose chemotherapy prior to, in conjunction with, or supported by ABMT/BMT, except as specifically provided under the Transplant Service Expense Benefits.

19. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

20. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for in this contract).

21. For alternative or recreational therapy, vocational rehabilitation, outpatient speech therapy, or occupational therapy, except as expressly provided for in this contract.

22. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs.

23. For eyeglasses, contact lenses, hearing aids, except for a screening test for hearing loss for a covered child from birth through the date the child is 30 days old eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this contract.

24. 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.

25. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.

26. 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.

27. As a result of:
   a. Intentionally self-inflicted bodily harm, except for an act of domestic violence or a medical condition.
   b. An injury or illness caused by any act of declared or undeclared war.
   c. The Enrollee taking part in a riot.
   d. The Enrollee’s commission of a felony, whether or not charged.

28. For or related to durable medical equipment or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Miscellaneous Medical Service Expense Benefits provision.

29. For any illness or injury incurred as a result of the Enrollee being intoxicated, as defined by applicable state law in the state in which the loss occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a physician, except as expressly provided for under the Mental Health and Substance Abuse Expense Benefits.

30. For or related to surrogate parenting.

31. For or related to treatment of hyperhidrosis (excessive sweating).

32. For fetal reduction surgery.

33. Except as specifically identified as a covered service expense under the contract, services or expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

34. As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle;
professional or Semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any Non-motorized vehicle or conveyance (if the Enrollee is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; 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).

35. 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.

36. As a result of any injury sustained while at a residential treatment facility.

37. For prescription drugs for any Enrollee who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date.

38. 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 section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-Enrollee biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this contract;

39. Services of a private duty registered nurse rendered on an outpatient basis.
**CONTRACT TERMINATION**

**Termination Of Contract**

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

1. Nonpayment of premiums when due, subject to the Grace Period provision in this contract.
2. The date you are no longer eligible for coverage
   i) the last day of coverage is the last day of the month following the month in which the notice is sent by us unless you request an earlier termination effective date.
3. You obtain other minimum essential coverage.

We will refund any premium paid and not earned due to contract termination.

If this contract is other than an Individual Plan, it may be continued after your death:

1. By your spouse, if an enrollee; otherwise,
2. By the youngest child who is an enrollee.

This contract will be changed to a plan appropriate, as determined by us, to the member(s) that continue to be covered under it. Your spouse or youngest child will replace you as the primary enrollee. A proper adjustment will be made in the premium required for this contract to be continued. We will also refund any premium paid and not earned due to your death.

**Discontinuance**

90-Day Notice: 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. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this contract. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice: If we discontinue offering and refuse to renew all individual contracts in the individual market in the state where you reside, we will provide a written notice to you and the Commissioner of Insurance at least 180 days prior to the date that we stop offering and terminate all existing individual contracts in the individual market in the state where you reside.

**Portability Of Coverage**

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

If an enrollee’s coverage terminates due to a change in marital status, you may be issued coverage that most nearly approximates the coverage of the policy which was in effect prior to the change in marital status.
Notification Requirements
It is the responsibility of you or your former dependent Enrollee to notify us within 31 days of your legal divorce or your dependent Enrollee's marriage. You must notify us of the address at which their continuation of coverage should be issued.

Reinstatement
If your contract lapses due to nonpayment of premium, it may be reinstated provided:

1. We receive from you a written application for reinstatement within one year after the date coverage lapsed; and
2. The written application for reinstatement is accompanied by the required premium payment.

Premium accepted for reinstatement may be applied to a period for which premium had not been paid. The period for which back premium may be required will not begin more than 60 days before the date of reinstatement.

The Rescissions provision will apply to statements made on the reinstatement application, based on the date of reinstatement.

Changes may be made in your contract in connection with the reinstatement. These changes will be sent to you for you to attach to your contract. In all other respects, you and we will have the same rights as before your contract lapsed.

Benefits After Coverage Terminates
Benefits for covered service expenses incurred after an Enrollee ceases to be covered are provided for certain illnesses and injuries. However, no benefits are provided if this contract is terminated because of:

1. A request by you;
2. Fraud or material misrepresentation on your part; or
3. Your failure to pay premiums.

The illness or injury must cause a period of extended loss. The period of extended loss must begin before coverage of the Enrollee ceases under this contract. No benefits are provided for covered service expenses incurred after the period of extended loss ends.

In addition to the above, if this contract is terminated because we refuse to renew all contracts issued on this form, with the same type and level of benefits, to residents of the state where you live, termination of this contract will not prejudice a claim for a continuous loss that begins before coverage of the Enrollee ceases under this contract. In this event, benefits will be extended for that illness or injury causing the continuous loss, but not beyond the earlier of:

1. The date the continuous loss ends; or
2. 12 months after the date renewal is declined.
THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

If an enrollee’s illness or injury is caused by the acts or omissions of a third party, we will not cover a loss to the extent that it is paid as part of a settlement or judgment by any third party.

However, if payment by or for the third party has not been made by the time we receive acceptable proof of loss, we will pay regular contract benefits for the enrollee’s loss. We will have the right to be reimbursed to the full extent permitted by Texas law for benefits we provided or paid for the illness or injury if the enrollee subsequently receives any payment from any third party. The enrollee (or the guardian, legal representatives, estate, or heirs of the enrollee) shall promptly reimburse us from the settlement, judgment, or any payment received from any third party.

As a condition for our payment, the enrollee or anyone acting on his or her behalf (including, but not limited to, the guardian, legal representatives, estate, or heirs) agrees:
1. To fully cooperate with us in order to obtain information about the loss and its cause.
2. To immediately inform us in writing of any claim made or lawsuit filed on behalf of an Enrollee in connection with the loss.
3. To include the amount of benefits paid by us on behalf of an enrollee in any claim made against any third party.
4. That we:
   a. Will have a lien on all money received by an enrollee in connection with the loss we have provided or paid to the extent permitted by Texas law.
   b. May give notice of that lien to any third party or third party’s agent or representative.
   c. Will have the right to intervene in any suit or legal action to protect our rights.
   d. Are subrogated to all of the rights of the enrollee against any third party to the extent permitted by Texas law of the benefits paid on the enrollee’s behalf.
   e. May assert that subrogation right independently of the enrollee.
5. To take no action that prejudices our reimbursement and subrogation rights.
6. To sign, date, and deliver to us any documents we request that protect our reimbursement and subrogation rights.
7. To not settle any claim or lawsuit against a third party without providing us with written notice of the intent to do so.
8. To reimburse us from any money received from any third party, to the extent permitted by Texas law for benefits we paid for the illness or injury, whether obtained by settlement, judgment, or otherwise, and whether or not the third party’s payment is expressly designated as a payment for medical expenses.
9. That we may reduce other benefits under the contract by the amounts an enrollee has agreed to reimburse us.

Furthermore, as a condition of our payment, we may require the enrollee or the enrollee's guardian (if the enrollee is a minor or legally incompetent) to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

We have a right to be reimbursed in full regardless of whether or not the enrollee is fully compensated by any recovery received from any third party by settlement, judgment, or otherwise.

In the event of a recovery from a third party, we will pay attorney fees or costs associated with the enrollee’s claim or lawsuit only to the extent required by Texas law unless otherwise agreed.
If a dispute arises as to the amount an enrollee must reimburse us, the enrollee (or the guardian, legal representatives, estate, or heirs of the enrollee) agrees to place sufficient funds in an escrow or trust account to satisfy the maximum lien amount asserted by us until the dispute is resolved.

**COORDINATION OF THIS CONTRACT’S BENEFITS WITH OTHER BENEFITS**

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

**DEFINITIONS**

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

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers’ compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a “24-hour” or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under (a)(1) or (a)(2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

(b) This plan” means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any
other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

c) "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan’s payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the health care provider’s or physician’s contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

(d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the
carrier’s payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

(g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and
the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
   (ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
   (i) If a court order states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
   (ii) If a court order states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.
   (iii) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.
   (iv) If there is no court order allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
      (I) the plan covering the custodial parent;
      (II) the plan covering the spouse of the custodial parent;
      (III) the plan covering the noncustodial parent; then
      (IV) the plan covering the spouse of the noncustodial parent.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

(D) For a dependent child who has coverage under either or both parents’ plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.
(E) In the event the dependent child’s coverage under the spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child’s parent(s) and the dependent’s spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsible for COB administration] will comply with federal and state law concerning confidential information for the purpose
of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give [Organization responsible for COB administration] any facts it needs to apply those rules and determine benefits.

**FACILITY OF PAYMENT**
A payment made under another plan may include an amount that should have been paid under this plan. If it does, [Organization responsible for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. [Organization responsible for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

**RIGHT OF RECOVERY**
If the amount of the payments made by [Organization responsible for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.
ENROLLEE CLAIM REIMBURSEMENT

Notice Of Claim
We must receive a request for reimbursement through receipt of a claim within 90 days of the date of service.

Claim Forms
The insurer, on receipt of a notice of claim, will provide to the claimant the forms usually provided by the insurer for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

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

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

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

All benefits payable under this policy on behalf of a dependent child insured by this policy for which benefits for financial and medical assistance are being provided by the Texas Department of Human Services shall be paid to said department whenever:

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

Complaint Process
“Complaint” means any dissatisfaction expressed by you orally or in writing to us with any aspect of our operation, including but not limited to, dissatisfaction with plan administration, procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. An Enrollee has 90 days from the date of the incident to file an appeal.

If you notify us orally or in writing of a Complaint, we will, not later than the fifth business day after the date of the receipt of the Complaint, send to you a letter acknowledging the date we received your Complaint. If the Complaint was received orally, we will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to us for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from you, we will investigate and send you a letter with our resolution. The total time for acknowledging, investigating and resolving your Complaint will not exceed thirty (30) calendar days after the date we receive your Complaint.

Your Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of your Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

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

Appeals to the Health Plan

1. If the Complaint is not resolved to your satisfaction, you have the right either to appear in person before a Complaint appeal panel where you normally receive health care services, unless another site is agreed to by you, or to address a written appeal to the Complaint appeal panel. We shall complete the appeals process not later than the thirtieth (30th) calendar day after the date of the receipt of the request for appeal.
2. We shall send an acknowledgment letter to you not later the fifth day after the date of receipt of the request of the appeal.
3. We shall appoint Enrollees to the Complaint appeal panel, which shall advise us on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of our staff, Physicians or other Providers, and enrollees. A Member of the appeal panel may not have been previously involved in the disputed decision.
4. Not later than the fifth business day before the scheduled meeting of the panel, unless you agree otherwise, we shall provide to you or your designated representative:
   a. any documentation to be presented to the panel by our staff;
   b. the specialization of any Physicians or Providers consulted during the investigation; and
   c. the name and affiliation of each of our representatives on the panel.
5. You, or your designated representative if you are a minor or disabled, are entitled to:
   a. appear in person before the Complaint appeal panel;
   b. present alternative expert testimony; and
   c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.
6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one business day after your request for appeal.

7. Due to the ongoing Emergency or continued Hospital stay, and at your request, we shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

8. Notice of our final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

Internal Appeal of Adverse Determination

An "Adverse Determination" is a decision that is made by us or our Utilization Review Agent that the health care services furnished or proposed to be furnished to you are not medically necessary or appropriate.

If you, your designated representative or your child's Physician or Provider of record disagree with the Adverse Determination, you, your designated representative or your child's Physician or Provider may appeal the Adverse Determination orally or in writing.

Within 5 business days after receiving a written appeal of the Adverse Determination, we or our Utilization Review Agent will send you, your designated representative or your child's Physician or Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that you, your designated representative or your child's Physician or Provider should send to us or to our Utilization Review Agent for the appeal.

If you, your designated representative or your child's Physician or Provider orally appeal the Adverse Determination, we or our Utilization Review Agent will send you, your designated representative or your child's Physician or Provider a one-page appeal form. You are not required to return the completed form, but we encourage you to because it will help us resolve your appeal.

Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than 1 business day from the date all information necessary to complete the appeal is received. All other appeals will be resolved no later than 30 calendar days after the date we or our Utilization Review Agent receives the appeal.

External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, you, your designated representative or your child's Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When we or our Utilization Review Agent deny the appeal, you, your designated representative or your child's Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, your child is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, you, your designated representative or your child's Physician or Provider of record may contact us or our Utilization Review Agent by telephone to request the review by the IRO and we or our utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, we will abide by the IRO's decision. We will pay for the IRO review.
The appeal procedures described above do not prohibit you from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if you believe that the requirement of completing the appeal and review process places your child’s health in serious jeopardy.

**Filing Complaints with the Texas Department of Insurance**

Any person, including persons who have attempted to resolve complaints through our complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. Complaints to the Texas Department of Insurance may also be filed electronically at [www.tdi.texas.gov](http://www.tdi.texas.gov).

The Commissioner of Insurance shall investigate a complaint against us to determine compliance within sixty (60) days after the Texas Department of Insurance’s receipt of the Complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. additional information is needed;
2. an on-site review is necessary;
3. We, the Physician or Provider, or you do not provide all documentation necessary to complete the investigation; or other circumstances beyond the control of the Department occur.

**Retaliation Prohibited**

1. We will not take any retaliatory action, including refusal to renew coverage, against a child because the child or person acting on behalf of the child 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 Physician or Provider, because the Physician or Provider has, on behalf of a child, reasonably filed a Complaint against us or has appealed a decision made by us.
ENROLLEE RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting you as an Enrollee.
2. Encouraging open discussions between you, your physician and medical practitioners.
3. Providing information to help you become an informed health care consumer.
4. Providing access to covered services and our network providers.

You have the right to:

1. Participate with your physician and medical practitioners in making decisions about your health care. This includes working on any treatment plans and making care decisions. You should know any possible risks, problems related to recovery, and the likelihood of success. You shall not have any treatment without consent freely given by you or your legally authorized surrogate decision-maker. You should be informed of your care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which you have coverage.
4. Be treated with respect and dignity.
5. Privacy of your personal health information, consistent with state and federal laws, and our policies.
6. Receive information or make recommendations, including changes, about our organization and services, our network of physicians and medical practitioners, and your rights and responsibilities.
7. Candidly discuss with your physician and medical practitioners appropriate and medically necessary care for your condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your primary care physician about what might be wrong (to the level known), treatment and any known likely results. Your primary care physician can tell you about treatments that may or may not be covered by the plan, regardless of the cost. You have a right to know about any costs you will need to pay. This should be told to you in words you can understand. When it is not appropriate to give you information for medical reasons, the information can be given to a legally authorized person. Your physician will ask for your approval for treatment unless there is an emergency and your life and health are in serious danger.
8. Make recommendations regarding the rights and responsibilities policy.
9. Voice complaints about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
10. Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician[s] of the medical consequences.
11. See your medical records.
12. Be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, Enrollee rights and responsibilities, and our other rules and guidelines. We will notify you at least 60 days before the effective date of the modifications. Such notices shall include the following:
   a. Any changes in clinical review criteria
b. A statement of the effect of such changes on the personal liability of the Enrollee for the cost of any such changes.

13. A current list of network providers. You can also get information on your network providers’ education, training, and practice.

14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.

15. Adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.

16. Access medically necessary urgent and emergency services 24 hours a day and seven days a week.

17. Receive information in a different format in compliance with the Americans with Disabilities Act, if you have a disability.

18. Refuse treatment to the extent the law allows. You are responsible for your actions if treatment is refused or if the primary care physician’s instructions are not followed. You should discuss all concerns about treatment with your primary care physician. Your primary care physician can discuss different treatment plans with you, if there is more than one plan that may help you. You will make the final decision.

19. Select your primary care physician within the network. You also have the right to change your primary care physician or request information on network providers close to your home or work.

20. Know the name and job title of people giving you care. You also have the right to know which physician is your primary care physician.

21. An interpreter when you do not speak or understand the language of the area.

22. A second opinion by a network physician, at no cost to you, if you believe your network provider is not authorizing the requested care, or if you want more information about your treatment.

23. Make advance directives for healthcare decisions. This includes planning treatment before you need it. Advance directives are forms you can complete to protect your rights for medical care. It can help your primary care physician and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself. Examples of advance directives include:
   a. Living Will
   b. Health Care Power of Attorney
   c. “Do Not Resuscitate” Orders. Enrollees also have the right to refuse to make advance directives. You should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this contract in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about your health. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your physician until you understand the care you are receiving.
4. Review and understand the information you receive about us. You need to know the proper use of covered services.
5. Show your I.D. card and keep scheduled appointments with your physician, and call the physician’s office during office hours whenever possible if you have a delay or cancellation.
6. Know the name of your assigned primary care physician. You should establish a relationship with your physician. You may change your primary care physician verbally or in writing by contacting our Member Services Department.

7. Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.

8. Understand your health problems and participate, along with your health care professionals and physicians in developing mutually agreed upon treatment goals to the degree possible.

9. Supply, to the extent possible, information that we and/or your health care professionals and physicians need in order to provide care.

10. Follow the treatment plans and instructions for care that you have agreed on with your health care professionals and physician.

11. Tell your health care professional and physician if you do not understand your treatment plan or what is expected of you. You should work with your primary care physician to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.

12. Follow all health benefit plan guidelines, provisions, policies and procedures.

13. Use any emergency room only when you think you have a medical emergency. For all other care, you should call your primary care physician.

14. When you enroll in this coverage, give all information about any other medical coverage you have. If, at any time, you get other medical coverage besides this coverage, you must tell us.

15. Pay your monthly premium, all deductible amounts, copayment amounts, or coinsurance percentages at the time of service.

NOTE: Let our customer service department know if you have any changes to your name, address, or family Enrollees covered under this contract.

Texas Department of Insurance Notice

- An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.

- You have the right to an adequate network of preferred providers (known as “network providers”)
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

- If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider’s bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.

- You may obtain a current directory of preferred providers at the following website: [http://www.ambetter.superiorhealthplan.com] or by calling [877-687-1196] for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.
Member Services Department: [877-687-1196]
Log on to: [http://ambetter.superiorhealthplan.com]
GENERAL PROVISIONS

Entire Contract
This contract, with the application and any rider-amendments is the entire contract between you and us. No change in this contract will be valid unless it is approved by one of our officers and noted on or attached to this contract. No agent may:
1. Change this contract;
2. Waive any of the provisions of this contract;
3. Extend the time for payment of premiums; or
4. Waive any of our rights or requirements.

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

Rescissions
No misrepresentation of fact made regarding an Enrollee during the application process that relates to insurability will be used to void/rescind the coverage or deny a claim unless:
1. The misrepresented fact is contained in a written application, including amendments, signed by an Enrollee;
2. A copy of the application, and any amendments, has been furnished to the Enrollee(s) or to the Enrollee's personal representative; and
3. The misrepresentation of fact was intentionally made and material to our determination to issue coverage to any Enrollee. An Enrollee’s coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. “Rescind” has a retroactive effect and means the coverage was never in effect.

Repayment For Fraud, Misrepresentation Or False Information
During the first two years an Enrollee is covered under the contract, if an Enrollee commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any Enrollee under this contract or in filing a claim for contract benefits, we have the right to demand that Enrollee pay back to us all benefits that we provided or paid during the time the Enrollee was covered under the contract.

Conformity With State Laws
Any part of this contract in conflict with the laws of the state in which your contract was issued on this contract’s effective date or on any premium due date is changed to conform to the minimum requirements of that state’s laws.

Conditions Prior To Legal Action
Legal Actions: An action at law or in equity may not be brought to recover on this policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

On occasion, we may have a disagreement related to coverage, benefits, premiums, or other provisions under this contract. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, you must give...
written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

1. Identify the coverage, benefit, premium, or other disagreement;
2. Refer to the specific *contract* provision(s) at issue; and
3. Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within 30 days after *we* receive *your* notice of intention to sue *us*.

**Time Limit on Certain Defenses:**

(a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.

(b) A claim for loss incurred or disability (as defined in the policy) beginning after the second anniversary of the date this policy is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy.