AMBETTER FROM SUPERIOR HEALTHPLAN, INC.

EVIDENCE OF COVERAGE

HEALTH MAINTENANCE ORGANIZATION

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHO HAVE ENROLLED IN

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 EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR COVERED HEALTH SERVICES AND BENEFITS.

Superior HealthPlan, Inc.
2100 S. IH-35, Ste. 200
Austin, Texas 78704
1-877-687-1196

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. 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 Superior's toll-free telephone number for information or to make a complaint at:

1-877-687-1196

You may also write to Superior 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 Superior'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 la compañía primero. Si la disputa no es resuelta, 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.

Superior HealthPlan, Inc.

Individual Enrollee Contract

In this *contract, "you"* or *"your"* will refer to the *enrollee* named on the Schedule of Benefits, and *"we," "our,"* or *"us"* will refer to Superior.

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 *Healthcare Services* as outlined in this *contract*. Benefits are subject to *contract* definitions, provisions, limitations and exclusions.

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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

Normal Business Hours of Operation - 8:00 a.m. to 5:00 p.m. in both Texas time zones, Monday through Friday
Customer Service: 1-877-687-1196
Relay Texas/TTY: 711
Fax: 877-941-8077
Emergency: 911
24/7 Nurse Advice Line: 1-877-687-1196
Website: Ambetter.SuperiorHealthPlan.com

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 *provider* 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 Customer Service for an oral interpretation. To arrange for interpretation services, call Customer Service at 1-877-687-1196.

Your Provider Directory
A listing of *network providers* is available online at 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 Customer Service 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 materials, which includes receipt of your initial binder payment. This card is proof that *you* are enrolled in Ambetter and is valid once *your* binder payment has been paid and enrollment processing is complete. *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 Customer Service. *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 Ambetter.SuperiorHealthPlan.com. It also gives *you* information on *your* benefits and services such as:

1. Finding a *provider*.
2. Programs to help *you* get and stay healthy.
3. A secure portal for *you* to check the status of *your* claims and make payments.
4. Online forms.
5. Our programs and services.
6. *Enrollee's* Rights and Responsibilities.
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 *providers* 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 licensed 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.

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. The term does not include a denial of health care services due to the failure to request prospective or concurrent *utilization review*.

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.

Appeal is *our* or *our* utilization review agent's formal process by which an *enrollee*, or an individual acting on behalf of an *enrollee*, or an *enrollee's provider* of record may request reconsideration of an adverse determination.

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism spectrum disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder - - Not Otherwise Specified.

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.

Balanced billing means the practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

Basic health care services means health care services that the commissioner determines an enrolled population might reasonably need to be maintained in good health.

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.

Case Management is a program in which a registered nurse, known as a case manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a *member*. Case management is instituted at the sole option of us when mutually agreed to by the *member* and the *member's physician*.

Center of Excellence means a *hospital* that:

1. Specializes in a specific type or types of 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 subscriber's brain-behavioral deficits.

Community Reintegration Services are services that facilitate the continuum of care as an affected subscriber 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, provider 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, Copay, or ***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 *cost-sharing 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.

Cost-sharing percentage means the percentage of covered services that are payable by an *enrollee*.

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 *provider.* To be a *covered service* the service, supply or treatment must be

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

Custodial Care 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*. A deductible will only be charged for services performed outside our service area or for services performed by a physician who is not in our network.

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*.

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 legally adopted child and child for which the primary subscriber must provide medical support under an order issued under Section 14.061, Family Code, or another order enforceable by a court in Texas ;
3. 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
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*. It is *your* responsibility to notify *us* if *your child* ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* provide or pay for a child at a time when the child did not qualify as an *eligible child*.
5. 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.
6. 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 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). However, if the provider has not agreed to accept a negotiated fee as payment in full, the *eligible service expense* is the greatest of the following:
        i. the amount that would be paid under Medicare,
        ii. the amount for the *covered service* calculated using the same method we generally use to determine payments for out-of-network services (the usual and customary amount), or
        iii. the contracted amount paid to *network providers* for the *covered service*. If there is more than one contracted amount with *network providers* for the *covered service*, the amount is the median of these amounts.

    You may be billed for the difference between the amount paid and the provider's charge.

b. 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 amount that would be paid under Medicare for such service. *You* may be billed for the difference between the amount paid and the provider's charge.
c. When a *covered service* is received from a *non-network provider* because the service or supply is not of a type provided by any *network provider*, 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 *non-network provider* is fully reimbursed at the usual and customary amount that would be paid for such service.

Emergency means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the *subscriber's* health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; and
4. 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 *provider* 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 *provider;* 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*.

Facility-based Provider (or ***Hospital based provider***) means a radiologist, an anesthesiologist, a pathologist, an emergency department provider, a neonatologist, or an assistant surgeon

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 provider specialty society recommendations or professional standards of care may be considered. *We* reserve the right to consult medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered service* under the *evidence of coverage*. The decision to apply provider specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Habilitation 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 care 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 *provider*.

Home health care agency means a public or private agency, or one of its subdivisions, that:
1. Operates pursuant to law as a *home health care agency*;

2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing generally accepted standards of medical practice for the *injury* or *illness* requiring the *home health care.*

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Home infusion therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting.

Hospice means 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 healthcare 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 providers), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; 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 services, supplies, or treatment, for medical, behavioral health, or substance abuse, 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 licensed practitioners* and performed for three or more hours per day, five to seven days per week.

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 *cost-sharing 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 *provider* 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 *provider* 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 (or ***provider network***) means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan.

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 (or ***non-preferred provider****)* means a provider or other health care provider, or an organization of providers or health care providers that does not have a contract with *us* to provide medical care or health care on a preferred benefit basis to the *enrollee* through this health insurance contract. These can also be referred to as non-preferred provider.

Network provider (or ***preferred 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 *subscriber*, 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 *subscriber'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.*

Orthotic device means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Other plan means any plan or evidence of coverage that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization member 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 surgical facility means any facility with a medical staff of *providers* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *provider* offices.

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.

Preauthorization means a determination by an HMO that medical care or health care services proposed to be provided to an enrollee are *medically necessary* and appropriate.

Provider 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 *provider* or each authorized refill or such requests.

Primary care provider means a *provider* 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.

Prosthetic device means an artificial device designed to replace, wholly or partly, an arm or leg.

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.

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.

Reconstructive surgery for craniofacial abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease

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 licensed practitioner means, but is not limited to, a *provider*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation licensed practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

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

Rescission of an evidence of coverage 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.

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 Customer Service department.

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

Spouse means *your* lawful wife or husband.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation licensed 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:

1. An invasive diagnostic procedure; or
2. The treatment of an *enrollee's illness* or *injury* by manual or instrumental operations, performed by a *provider* while the *enrollee* is under general or local anesthesia.

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. 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:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and

3. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine medical service means a health care service initiated by a physician or provided by a health professional acting under physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. 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 *provider* 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 an evidence of coverage under which the *enrollee* is entitled to benefits as a named subscriber or an insured *dependent enrollee* of a named subscriber 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 *provider's* office, that provides treatment or services that are required:

1. To prevent serious deterioration of a *enrollee's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

Utilization review means a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or

retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

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 newborns 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 *contract* 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* 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 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 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. 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 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
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 an *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 *contract*;
5. The date *we* decline to renew this *contract,* 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 *contract* 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.*

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; and
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. The open enrollment period begins November 1, 2016 and extends through January 31, 2017. *Individuals* who enroll prior to December 15, 2016 will have an *effective date* of coverage on January 1, 2017. *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. *Individuals* that enroll between the sixteenth and last day of the month between December 2016 and January 31, 2017 will have a coverage *effective date* of the first day of the second following month.

Special and Limited Enrollment

An individual has 60 days to report a qualifying event and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

1. An individual or *dependent loses minimum essential coverage*;
2. An 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. An individual's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent;
5. An individual or enrollee gains access to new health plans as a result of a permanent move; or
6. 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

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 20th of the month in which coverage is effective.

Grace Period

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. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, claims may pend for *covered services* rendered to the *Enrollee* during the grace period. *We* will notify 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 *us* 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.

Premium Rate Increases
Pursuant to federal law, issuers in the individual market may update rates annually, effective January 1. If *we* increase the premium to be paid for coverage under this *contract*, *we* will provide *you* with written notice of such increase no less than 60 days before the date on which such increase shall take effect.

DEDUCTIBLE, COST-SHARING PERCENTAGE, 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 *enrollee* 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 *enrollee* will contribute more than the individual.
3. Deductible amounts to the "family" Deductible amount.

The *deductible amoun*t does not include any *copayment amount*.

Cost-Sharing Percentage Stop–Loss Amount

Most of your *Eligible Service Expense* payment obligations, including Copayment Amounts, are considered Cost-Sharing Percentage Amounts and are applied to the Cost-Sharing Percentage Stop–Loss Amount maximum.

Your Cost-Sharing Percentage 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 Superior 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 Cost-Sharing Percentage Stop–Loss Amount

When the Cost-Sharing Percentage Amount for the In–Network or Out–of–Network Benefits level for an *enrollee* in a Calendar Year equals the "individual" "Cost-Sharing Percentage 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 *enrollee* for the remainder of that Calendar Year for that level.

Family Cost-Sharing Percentage Stop–Loss Amount

When the Cost-Sharing Percentage Amount for the In–Network or Out–of–Network Benefits level for all

enrollees under your coverage in a Calendar Year equals the "family" "Cost-Sharing Percentage Stop−Loss Amount" shown on your Schedule of Benefits for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional *eligible service expenses* incurred by all family *enrollees* for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual cost-sharing percentage Amount to the family cost-sharing percentage Stop−Loss Amount.

Cost-Sharing Percentage
We will pay the applicable *cost-sharing 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), cost-sharing 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 *cost-sharing 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 Contract Provisions
Charges for services and supplies that qualify as *covered service expenses* under one benefit provision will not qualify as *covered service expenses* under any other benefit provision of this *contract.*

MANAGING YOUR HEALTH CARE

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) undergoing active treatment for a chronic or acute medical condition, (3) life–threatening illness, or (4) second (2nd) or third (3rd) trimester of pregnancy and is receiving treatment in accordance with the dictates of medical prudence, Superior 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 Provider

In order to obtain benefits, *you* must designate a *network primary care provider* for each *enrollee. You* may select any *network primary care provider* who is accepting new patients. If *you* do not select a *network primary care provider* for each *enrollee,* one may be assigned. *You* may obtain a list of *network primary care providers* at *our* website or by contacting our Customer Service department.

Your network primary care provider 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 provider* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist. *For all other network specialist providers, you may be required to* obtain a referral from *your network primary care provider* 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 provider*, 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 provider* online at *our* website, or by contacting Customer Service at the number shown on *your* identification card. The change to *your network primary care provider* 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 Providers; 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.*

Prior Authorization requests must be received by phone/eFax/Provider portal as follows:

1. At least 5 days prior to an elective admission as an inpatient in a Hospital, extended care or Rehabilitation facility, or Hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services.
3. At least 30 days prior to receiving clinical trial services.
4. At least 5 days prior to a scheduled inpatient behavioral health or Substance Abuse treatment admission.
5. At least 5 days prior to the start of Home Health Care.

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

1. For post-stabilization treatment or life-threatening conditions, within the time appropriate to the circumstances relating to the delivery of the services and condition of the Enrollee, but not to exceed one (1) hour from receipt of the request.
2. For inpatient concurrent review within 24 hours of receipt of the request.
3. For non-hospitalized pre-service requests within 3 calendar days of receipt of the request.
4. For post-service requests, within 3 calendar days of receipt of the request.

Initial Adverse Determination

A Utilization Review Agent shall provide notice of an adverse determination to you and the Provider as follows:

1. If hospitalized, within 1 business day by either telephone or electronic transmission, followed by a letter within 3 business days.
2. If not hospitalized, in writing within 3 business days.

3. For circumstances relating to the delivery of the services to you and to your condition, then within the time appropriate to the circumstances; however, if denying post stabilization care subsequent to emergency treatment as requested by a treating Provider or other health care Provider, then no later than one hour after the time of the request
4. If a concurrent review of the provision of prescription drugs or intravenous infusions for which you're receiving health benefits, no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued

If a Retrospective Utilization Review is necessary, a Utilization Review Agent shall provide notice of an adverse determination to you and the Provider in writing within 30 days of receipt of the claim. This 30 day period may be extended once by the Utilization Review Agent for an additional 15 days, if the following conditions are met:

1. Utilization Review Agent determines that the extension is necessary due to matters beyond the Agent's control; and
2. Utilization Review Agent notifies you and the Provider of the circumstances requiring the extension and the expected date of determination before the initial 30 day period expires.

However, if an extension is required because you or your Provider did not provide the necessary information to reach a determination, you and the Provider will be provided 45 days from receipt of notice to provide the necessary information. Thus, the period for making the determination is then tolled from the date on which the Utilization Review Agent sends the notice of extension to you or the Provider or the earlier of:

1. The date on which you or the Provider responds to the request for additional information; or
2. The date by which the specified information was to have been submitted.

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 will 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. 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 cost-sharing percentage 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

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 Ambetter, other professional services may be or have been provided at or through the facility by physicians and other health care providers (for example, anesthesiologists, radiologists, pathologists) who are not members of the Ambetter network. Thus, 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. 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.

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 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, Cost-sharing Percentage Amounts, and any applicable Deductibles shown are the Health Plan's obligation. The remaining unpaid Medical–Surgical Expense in excess of the Copayment Amounts, Cost-sharing Percentage 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 cost-sharing percentage 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*, in cases of *emergency*.

2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.
3. Transportation between hospitals when approved by *us*.

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.
5. Non-emergency transportation excluding ambulances.

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.

Contraception

All FDA-approved contraception methods (identified on www.fda.gov) are approved for members without cost sharing as required under the Affordable Care Act. Members 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 a member's medical benefit, including the insertion and removal of the contraceptive device at no cost share to the member. Emergency contraception is available to members without a prescription and at no cost share to the member. For further detail, please see the definition of "Family Planning Services," below.

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 Provider 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 Provider 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.

Family Planning Services

Covered service expenses for Family Planning include:

1. Medical history review.
2. Physical examinations.
3. Laboratory tests related to physical examinations.
4. Contraceptive counseling.
5. All FDA-approved contraception methods are covered without cost sharing as outlined at www.fda.gov (see "Contraception" section above). This benefit contains both pharmaceutical and medical methods, including but not limited to:
   a. Intrauterine devices (IUD), including insertion and removal;
   b. Barrier methods including: male and female condoms (Rx required from Provider, limited to 30 per month), diaphragm with spermicide, sponge with spermicide, cervical cap with spermicide and spermicide alone;
   c. Oral contraceptives including the pill (combined pill and extended/continuous use), and the mini pill (Progestin only), patch;
   d. Other hormonal contraceptives, including inserted and implanted contraceptive devices, hormone contraceptive injections and the vaginal contraceptive ring;
   e. Emergency contraception (the morning after pill); and
6. FDA-approved tubal ligation.
7. Vasectomy and services related to this procedure.
8. For Prescription Drug contraceptives.

Please note: The following requirements must be met for prescription birth control to be covered at 100%: (1) the drug is generic; or (2) the drug is a brand name drug and (a) a generic version is not available or (b) the generic version is medically inappropriate, as determined by your *medical practitioner*.

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 *provider*, 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 licensed practitioners.*
5. Outpatient physical therapy, occupational therapy, and speech therapy.
6. *Covered service expenses* for an *eligible child* determined to be necessary and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention, including:
   a. occupational therapy evaluations and services;

b. physical therapy evaluations and services;
c. speech therapy evaluations and services; and
d. dietary or nutritional evaluations.

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

Care ceases to be *rehabilitation*, unless deemed medically necessary services or therapies that meet or exceed treatment goals for the *enrollee*, 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 treatment goals. For an *enrollee* with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.
4. Care is primarily *custodial care*.

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. *Home infusion therapy.*
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.
3. Speech-language therapy.
4. Respiratory therapy.

5. The rental of medical equipment while the *terminally ill enrollee* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *Enrollee* had been confined in a *hospital.*
6. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
7. Counseling the *enrollee* regarding his or her *terminal illness.*
8. *Terminal illness counseling* of the *enrollee's immediate family.*
9. *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;
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 inpatien*t or outpatient basis to allow* temporary relief to family members from the duties of caring for an *enrollee* under Hospice Care. 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.

Infertility
Covered service expenses under this benefit are provided for *medically necessary diagnostic services* and exploratory procedures to determine infertility including surgical procedures to correct a medically diagnosed disease or condition of the reproductive organs including, but not limited to, treatment of the following:

- Endometriosis;
- Collapsed/clogged fallopian tubes; or
- Testicular failure.

This benefit is subject to deductible and coinsurance/copayment.

No benefits will be payable for charges related to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT).

Mental Health and Substance Use Disorder Benefits

You do not need a referral from your PCP in order to initiate treatment. Deductibles, copayment or cost-sharing percentage 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
6. Psychiatric residential treatment.

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.

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 provider'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 *provider* 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 enrollee; or
    b. Treatment provided for reconstructive surgery following cancer surgery; or
    c. For the treatment or correction of a congenital defect other than conditions of the breast; or
    d. 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 provider determine that a shorter period of inpatient care is appropriate.

18. *Diabetic equipment and supplies* that are medically necessary and prescribed by a provider. *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 *cost-sharing percentage* provisions.
19. Tissue transplants.
20. *Orthotic devices*, *prosthetic devices*, and professional services related to the fitting and use of those devices that are medically necessary and prescribed by a provider if the services are preauthorized and provided by a network provider. The repair and replacement of a prosthetic device or orthotic device is a covered benefit under this chapter unless the repair or replacement is necessitated by misuse or loss by the enrollee.
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. Blood glucose monitors, including noninvasive glucose monitors designed to be used by or adapted for the legally blind;
b. Test strips specified for use with a corresponding glucose monitor;
c. Lancets and lancet devices;
d. Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
e. Insulin and insulin analog preparations;
f. Injection aids, including devices used to assist with insulin injection and needleless systems;
g. Insulin syringes;
h. Biohazard disposal containers;
i. 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;
j. 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;
k. Prescription medications and medications available without a prescription for controlling the blood sugar level;

l. Podiatric appliances, including up to two pairs of therapeutic footwear per calendar year, for the prevention of complications associated with diabetes;
m. routine foot care such as trimming of nails and corns
n. Glucagon emergency kits;
o. On approval of the United States Food and Drug Administration, any new or improved diabetes equipment or supplies if medically necessary and appropriate as determined by a provider or other health care practitioner.

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 cost-sharing percentage 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* provider, 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.

Second Medical Opinion

Enrollees are entitled to a second medical opinion under the following conditions:

1. Whenever a minor surgical procedure is recommended to confirm the need for the procedure;
2. Whenever a serious injury or illness exists; or
3. Whenever *you* find that *you* are not responding to the current treatment plan in a satisfactory manner.

If requested, the second opinion consultation is to be provided by a *physician* of the *enrollee's* choice. The *enrollee* may select a *network provider* listed in the Healthcare Provider Directory. If an *enrollee* chooses a *network provider*, he or she will only be responsible for the applicable co-payment for the consultation. Any lab tests and/or diagnostic and therapeutic services are subject to the additional co-payment. If a second medical opinion is obtained by a *non-network provider*, prior authorization must be obtained before

services are considered an *eligible service expense*. If prior authorization is not obtained for a second medical opinion from a *non-network provider*, you will be responsible for the related expenses.

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:

- 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
- The subscriber is enrolled in the clinical trial. This section shall not apply to subscribers 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 Superior HealthPlan 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.
3. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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.

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

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 you or your *medical practitioner's* request. To exercise this right, please get in touch with your *medical practitioner*. Your *medical practitioner* can utilize the usual prior authorization request process. See "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.

An issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

Prescription Drug Exception Process

Standard exception request

An *enrollee*, an *enrollee's* designee or an *enrollee's* prescribing *provider* may request a standard review of a decision that a drug is not covered by the plan. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *enrollee*, the *enrollee's* designee or the *enrollee's* prescribing *provider* 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 *provider* may request an expedited review based on exigent circumstances. Exigent circumstances exist when an *enrollee* is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the *enrollee*, the *enrollee's* designee or the *enrollee's* prescribing *provider* with our coverage determination. Should the expedited exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External Review by Independent Review Organization
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 *provider* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization (IRO). *We* will make our determination on the external exception request and notify the *enrollee*, the *enrollee's* designee or the *enrollee's* prescribing *provider* 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.

In circumstances involving a Life-threatening condition, the *enrollee* 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, the *enrollee*, the *enrollee*'s designee or the *enrollee*'s prescribing provider 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.

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, unless listed on the Formulary.
2. For immunization agents, blood, or blood plasma, except when used for preventive care and listed on the Formulary.
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 *provider'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 31-day supply when dispensed in any one prescription or refill (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, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 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, cost-sharing percentage or copayment requirements. Charges for other services rendered at the same time as immunizations are subject to deductible, cost-sharing percentage and copayment in accordance with regular contract 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.

Transplant Services

Covered Services For Transplant Service Expenses:
Transplants are a covered benefit when preauthorized in accordance with this contract. Transplant services must meet medical criteria as set by Medical Management Policy.

If *we* determine that an *enrollee* is an appropriate candidate for a *medically necessary* 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 approved as a *medically necessary* transplant.

Transplant Benefit expenses include services related to donor search, acceptability testing of potential live donors, and FDA-approved artificial devices.

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 transplant from any *physician*. However, if a transplant is performed in a *Center of Excellence:*

1. *Covered service expenses* for the 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 a prophylactic bone marrow harvest or peripheral blood stem cell collection when no transplant occurs.
2. For animal to human transplants.
3. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision.
4. To keep a donor alive for the transplant operation.
5. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ.
6. Related to transplants and transplant services which do not meet medical criteria as set by Medical Management Policy.
7. For a transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*"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 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 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 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.

Pediatric Oral Expense Benefits

Covered service expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is an *enrollee*:

1. Diagnostic, preventive and restorative care;

2. Oral surgery and reconstruction;
3. Endodontic and periodontic care;
4. Crown and fixed bridge;
5. Removable prosthetics; and
6. *Medically necessary* orthodontia.

Visit limitations are as follows:

1. One diagnostic exam every six months, beginning before age one;
2. Bitewing x-rays once every six months;
3. Panoramic x-rays once every sixty months;
4. Prophylaxis every six months beginning at age six months;
5. Fluoride two times in a twelve-month period; three times in a twelve-month period during orthodontic treatment; sealant once every three years for occlusal surfaces only; oral hygiene instruction two times in twelve months for ages eight and under if not billed on the same day as a prophylaxis treatment;
6. Palliative treatment of dental pain- minor procedure;
7. Frenulectomy or frenuloplasty covered for ages six and under without prior authorization, covered for seven and over with prior authorization;
8. Root canals on baby primary posterior teeth only; Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;
9. Periodontal scaling and root planing once per quadrant in a two-year period with prior authorization;
10. Periodontal maintenance once per quadrant in a twelve-month period, with prior authorization;
11. Stainless steel crowns for permanent posterior teeth once every sixty months;
12. Metal/porcelain crowns and porcelain crowns limited to one tooth every 60 months, with prior authorization;
13. Space maintainers and re-cementation of space maintainers;
14. One resin based partial denture, replaced once within a three-year period;
15. One complete denture upper and lower, and one replacement denture in a 36 month period after the initial installation ;
16. Prosthodontic services are limited to one every 60 months; and
17. Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seating date.

Telehealth Service and Telemedicine Medical Service

We will not exclude coverage for a telehealth service or a telemedicine medical service under this plan because the service is not provided through a face-to-face consultation. *You* are required to pay copayment amounts for telehealth service or telemedicine medical service as required for other medical benefits.

Wellness and Other Program Benefits

Benefits may be available from time to time 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 Ambetter.SuperiorHealthPlan.com or by contacting Customer Service 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 from time to time 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 $200 per calendar year

a. Get Started: $25
b. Wellbeing Survey: $50
c. Annual Well Visit: $50
d. Auto-Pay Sign Up: $25
e. On.Target: $50

Rewards will be loaded onto the *enrollee's* "My Health Pays" Rewards card. The card is similar to a Health Reimbursement Account (HRA). Dollars are notional and expire after upon termination of coverage. Reward dollars can be used in two ways: (a) *Enrollee* cost share: copays, deductibles, cost-sharing percentage 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.

Members will also have opportunities throughout the year to earn raffle entries for completing various wellness related activities. Examples that may result in raffle entries include certain preventive screenings, ongoing medication adherence, specific labs, and other activities. Members will be given the opportunity to decline participation in the raffles at any time or decline to accept prizes if selected as a winner.

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 an *enrollee* by 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 *provider;* 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 *contract'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. The reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term, or in cases of rape or incest).
7. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses*.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations or for failure to keep a scheduled appointment.
11. 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.
12. For stand-by availability of a *medical practitioner* when no treatment is rendered.
13. For *dental service expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery,* except as expressly provided for under Medical Service Expense Benefits.
14. For *cosmetic treatment*, except for *reconstructive surgery* 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.
15. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Service Expense Benefits.

17. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT,* except as specifically provided under the Transplant Service Expense Benefits.
18. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
19. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services (unless expressly provided for in this *contract)*.
20. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
21. 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.
22. 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,*.
23. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition.
24. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first 90 days.
25. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *Enrollee* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable 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 w*orkers' 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.
26. 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.
27. 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.
28. For or related to surrogate parenting.
29. For or related to treatment of hyperhidrosis (excessive sweating).
30. For fetal reduction surgery.
31. 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.

32. 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).
33. 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.
34. As a result of any *injury* sustained while at a *residential treatment facility.*
35. 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.
36. 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, except for what is indicated in the Medical And Surgical Benefits section; 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*;
37. Services of a private duty registered nurse rendered on an outpatient basis.

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*; or
2. The date you are no longer eligible for coverage; or
   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.

Refund upon Cancellation

We will refund any premium paid and not earned due to *contract* termination. After the contract has been continued beyond its original term, *you* may cancel the contract at any time by written notice, delivered or mailed to the Marketplace, or if an off-exchange *member* by written notice, delivered or mailed to *us*. Such cancellation shall become effective upon receipt, or on such later date specified in the notice. If *you* cancel, *we* shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.

Discontinuance

90-Day Notice: If *we* discontinue offering 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.

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, benefits are not provided if this *contract* is terminated because of:

1. A request by *you*; or
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

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 within 30 days prior to the settlement.
8. To reimburse *us* from any money received from any *third party*, to the extent permitted by Texas law for benefits *we* paid for the *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 BENEFITS

The Coordination of Benefits (COB) applies when an *enrollee* 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 contracted 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.

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.

Plan includes:

1. group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage;
2. individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies;
3. individual and group preferred provider benefit plans and exclusive provider benefit plans;
4. 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;
5. limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage;
6. the medical benefits coverage in automobile insurance contracts; and
7. Medicare or other governmental benefits, as permitted by law.

Plan does not include:

1. disability income protection coverage;
2. the Texas Health Insurance Pool;
3. workers' compensation insurance coverage;
4. hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage;
5. supplemental benefit coverage; accident only coverage;
6. specified accident coverage;
7. 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;
8. Medicare supplement policies;
9. a state plan under Medicaid;
10. a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or
11. other nongovernmental plan; or an individual accident and health insurance contract that is designed to fully integrate with other policies through a variable deductible.

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

"This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other 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 enrollee 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.

Allowable expense is a health care expense, including deductibles, cost-sharing percentage, and copayments, that is covered at least in part by any plan covering the enrollee. 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 enrollee 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 an *enrollee* 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 an enrollee 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 an enrollee 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 an enrollee 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 an enrollee has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

"Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a non-preferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or cost-sharing percentage amounts for which the subscriber is responsible.

"Closed panel plan" is a plan that provides health care benefits to enrollees 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.

"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 an enrollee is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
2. Except if, a plan that does not contain a COB provision that is consistent with this contract is always primary unless the provisions of both plans state that the complying plan is primary.
3. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
4. 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.
5. If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when an enrollee uses a non-contracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.
6. When multiple contracts providing coordinated coverage are treated as a single plan. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.
7. If an enrollee is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.
8. Each plan determines its order of benefits using the first of the following rules that apply.
    A. **Nondependent or Dependent**. The plan that covers the enrollee other than as a dependent, for example as an employee, member, covered enrollee, subscriber, or retiree, is the primary plan, and the plan that covers the enrollee as a dependent is the secondary plan. However, if the enrollee is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the enrollee as a dependent and primary to the plan covering the enrollee as other than a dependent, then the order of benefits between

the two plans is reversed so that the plan covering the enrollee as an employee, member, covered enrollee, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

B. **Dependent Child Covered Under More Than One Plan**. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply. For a dependent child whose parents are married or are living together, whether or not they have ever been married: The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
   a) 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:
         - the plan covering the custodial parent;
         - the plan covering the spouse of the custodial parent;
         - the plan covering the noncustodial parent; then
         - the plan covering the spouse of the noncustodial parent.
   b) For a dependent child covered under more than one plan of individuals who are not the parents of the child, must determine the order of benefits as if those individuals were the parents of the child.
   c) 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, applies.
   d) 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 to the dependent child's parent(s) and the dependent's spouse.

C. **Active, Retired, or Laid-off Employee**. The plan that covers an enrollee 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 enrollee as a retired or laid-off employee is the secondary plan. The same would hold true if an enrollee is a dependent of an active employee and that same enrollee is a dependent of a retired or laid-off employee. If the plan that covers the same enrollee 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.

D. **COBRA or State Continuation Coverage**. If an enrollee 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 enrollee as an employee, member, subscriber, or

retiree or covering the enrollee 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.

E. **Longer or Shorter Length of Coverage.** The plan that has covered the enrollee as an employee, member, covered enrollee, subscriber, or retiree longer is the primary plan, and the plan that has covered the enrollee the shorter period is the secondary plan.
F. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the Benefits of this Plan

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.

If an enrollee is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

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.

Time For Payment Of Claims
We will review your request for reimbursement, and if eligible, will be processed for payment within 45 days of receipt of your claim.

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 180 days from the date of the incident to file an appeal in Texas. Complaints are considered standard unless they concern an emergency or denial of continued stay for hospitalization, in which case they will be considered expedited.

If *you* notify US orally or in writing of a Complaint, *we* will, not later than the fifth business day after the date of the receipt of the Complaint, send to *you* a letter acknowledging the date *we* received *your* Complaint. If the Complaint was received orally, *we* will enclose a one-page Complaint form 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 a standard Complaint will not exceed thirty (30) calendar days after the date *we* receive *your* Complaint.

An expedited 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 and we will send you a letter with our resolution within three business days.

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

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 members to the Complaint appeal panel, which shall advise *us* on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of our staff, Physicians or other Providers, and enrollees. A member of the appeal panel may not have been previously involved in the disputed decision. The Physicians or other Providers on the appeal panel must have experience in the area of care that is in dispute and must be independent of any Physician or Provider who made any previous determination. If specialty care is in dispute, the appeal panel must include a person who is a specialist in the field of care to which the appeal relates.
4. Not later than the fifth business day before the scheduled meeting of the panel, unless *you* agree otherwise, *we* shall provide to *you* or *your* designated representative:
   a. any documentation to be presented to the panel by our staff;
   b. the specialization of any Providers consulted during the investigation; and
   c. the name and affiliation of each of our representatives on the panel.
5. *You*, or *your* designated representative if *you* are a minor or disabled, are entitled to:

a. appear in person before the Complaint appeal panel;
b. present alternative expert testimony; and
c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

6. Investigation and resolution of 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 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* 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* 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, denials of continued stays in a Hospital, or denial of prescription drugs or intravenous infusions, 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.

In circumstances involving denial of the provision of prescription drugs or intravenous infusions for which *you* are receiving benefits under this evidence of coverage, *you*, *your* designated representative, or *your* provider is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In these situation, *you*, *your* designated representative, or *your* 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 electronically at www.tdi.texas.gov.

You may also send a printed copy of your complaint to the Texas Department of Insurance:

- **By mail:** Texas Department of Insurance, Consumer Protection (111-1A), P.O. Box 149104, Austin, Texas 78714-9091
- **In person or by delivery service:** Texas Department of Insurance, Consumer Protection (111-1A), 333 Guadalupe St., Austin, Texas 78701
- **By fax:** (512) 490-1007
- **By email:** ConsumerProtection@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 provider* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.

You have the right to:

1. Participate with *your provider* 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 *providers* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your provider* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care provider* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care provider* 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 provider* 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 contract.
9. Voice complaints about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. File an appeal if you disagree with certain decisions we have made.
11. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your provider*(s) of the medical consequences.
12. See *your* medical records.
13. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care provider* 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.

14. A current list of *network providers*. *You* can also get information on *your network providers'* education, training, and practice.
15. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
16. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
17. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
18. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
19. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care provider*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care provider*. *Your primary care provider* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
20. Select *your primary care provider* within the *network*. *You* also have the right to change your *primary care provider* or request information on *network providers* close to your home or work.
21. Know the name and job title of people giving you care. *You* also have the right to know which *provider* is your *primary care physician*.
22. An interpreter when *you* do not speak or understand the language of the area.
23. A second opinion by a *network provider*, 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.
24. 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 provider* 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 *provider* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of

covered services.

5. Show *your* I.D. card and keep scheduled appointments with *your provider*, and call the *provider*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care provider*. *You* should establish a relationship with *your provider*. You may change your *primary care provider* verbally or in writing by contacting *our* Customer Service 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 *providers* 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 *providers* 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 *provider*.
11. Tell *your* health care professional and *provider* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care provider* 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 provider*.
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 *cost-sharing 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*.

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 coverage eligibility will be used to void/rescind the coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application signed by an *enrollee;*
2. A copy of the application 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 after not less than fifteen (15) days' written notice 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*.

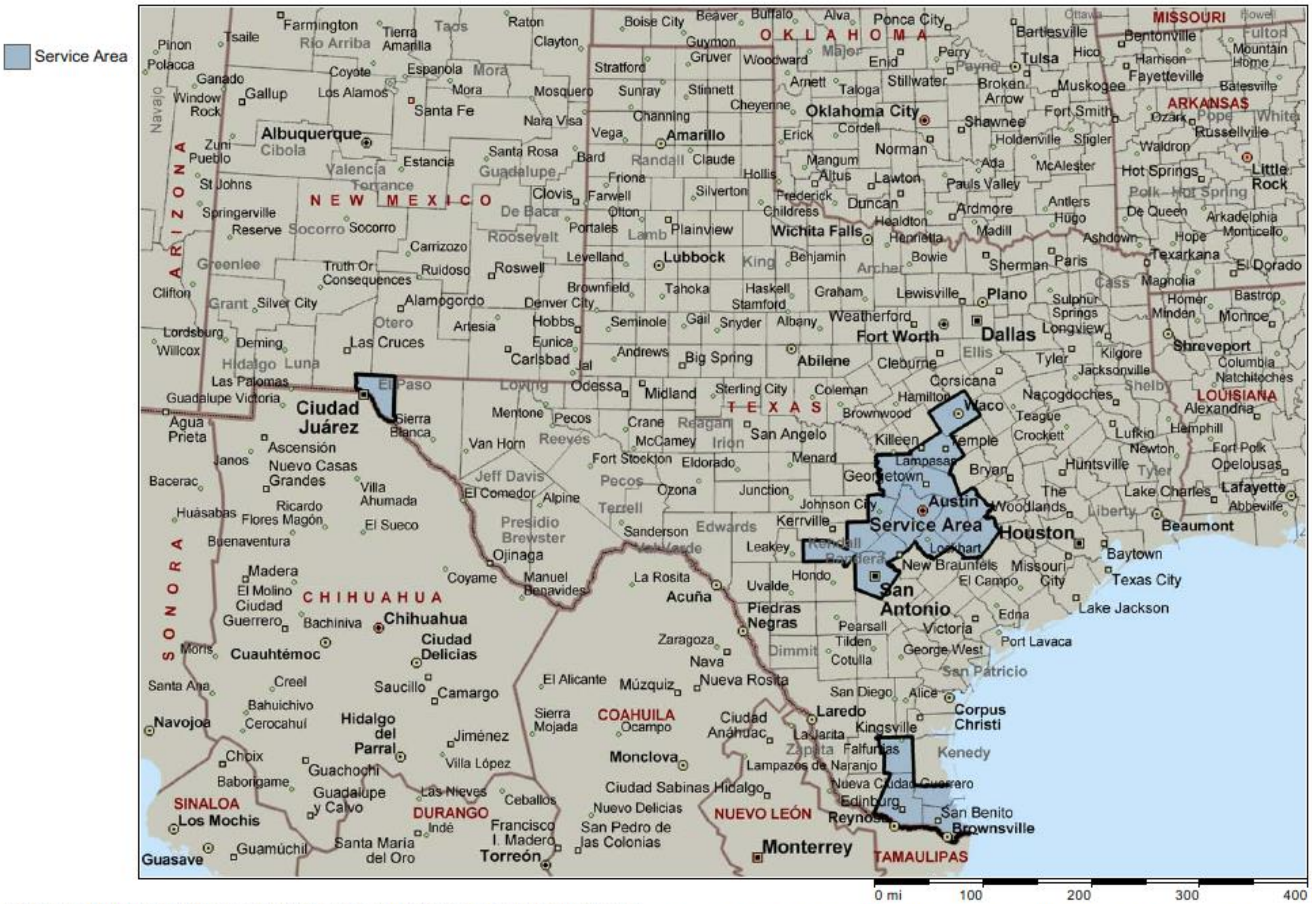
Conformity with State Laws
Any part of this *contract* in conflict with the laws of the state in which your *contract* was issued on this *contract's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Conditions Prior To Legal Action
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*.

SERVICE AREA MAP



Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Superior HealthPlan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Superior HealthPlan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Superior HealthPlan 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Superior HealthPlan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) 로 전화하십시오.
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Superior HealthPlan، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب- 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Urdu:	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، Ambetter from Superior HealthPlan کے بارے میں سوالات ہیں تو آپ کو بغیر کسی قیمت کے اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لئے، 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) پر کال کریں۔
Tagalog:	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Superior HealthPlan, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Superior HealthPlan, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter from Superior HealthPlan के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) पर कॉल करें।
Persian:	اگر شما، یا کسی که شما به او کمک می کنید سؤالی در مورد Ambetter from Superior HealthPlan دارید، از این حق برخوردار هستید که کمک و اطلاعات را به صورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با یک مترجم شفاهی با شماره 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) تماس بگیرید.
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Superior HealthPlan hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) an.
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter from Superior HealthPlan વિશે કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વિના તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) ઉપર કૉલ કરો.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Superior HealthPlan вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).
Japanese:	Ambetter from Superior HealthPlanについて何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) までお電話ください。
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ ມີຄໍາຖາມກ່ຽວກັບ Ambetter from Superior HealthPlan, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

Statement of Non-Discrimination

Superior HealthPlan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Superior HealthPlan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Superior HealthPlan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Superior HealthPlan at 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989).

If you believe that Superior HealthPlan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Superior HealthPlan Appeal Department, 2100 South Interstate 35, Ste. 200, Austin, TX 78704, 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989), Fax 1-800-310-0943. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Superior HealthPlan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Declaración de no discriminación

Superior HealthPlan cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. Superior HealthPlan no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

Superior HealthPlan:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
    - Intérpretes calificados de lenguaje por señas
    - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
- Intérpretes calificados
- Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con Superior HealthPlan a 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989).

Si considera que Superior HealthPlan no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: Superior HealthPlan Appeal Department, 2100 South Interstate 35, Ste. 200, Austin, TX 78704, 1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989), Fax 1-800-310-0943. Usted puede presentar una queja en persona, por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, Superior HealthPlan está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de queja están disponibles en *http://www.hhs.gov/ocr/office/file/index.html*.