AMBETTER FROM SUPERIOR HEALTHPLAN
WRITTEN DESCRIPTION OF COVERAGE

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

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

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

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

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

Covered Services and Benefits

The Ambetter from Superior HealthPlan Summary of Benefits and plan brochures for all plan options can be found at the links below. These documents will explain all covered services and benefits, including payment for services of a *preferred provider* and *non-preferred provider*, and *prescription drug* coverage, both generic and name brand after the *deductible* has been met. The summary of benefits will also provide an explanation of *your* financial responsibility for payment for any premiums, *deductibles*, *copayments*, *coinsurance* or other out-of-pocket expenses for non-covered or non-preferred services. Please note that we will pay the negotiated fee or usual and customary rate to *non-preferred* or *non-network providers*, as explained under the "*eligible service expense*" definition found in *your contract*.

Bronze/Essential Care Plans

Silver/ Balanced Care Plans

Gold/Secure Care Plans

Emergency Care Service and Benefits

Your health insurance policy provides coverage for medical emergencies wherever they occur. In an emergency, always call 911 or go to the nearest *hospital* emergency room (ER). Anything that could endanger *your* life (or *your* unborn child's life, if *you're* pregnant) without immediate medical attention is considered an emergency situation. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

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

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

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

Out-of-Area Service and Benefits

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

Insured's Financial Responsibility

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

Premium Payment

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

Each premium is to be paid to *us* on or before its due date. The initial premium must be paid prior to the coverage *effective date*, although an extension may be provided during the annual Open Enrollment period.

Grace Period

When an *enrollee* is receiving a premium subsidy:

> Grace Period: A grace period of 90 days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force.
>
> If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advanced premium tax credits* are received.
>
> *We* will continue to pay all appropriate claims for *covered services* rendered to the *enrollee* during the first and second month of the grace period, and may pend claims for *covered services* rendered to the *enrollee* in the third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *enrollee*, as well as *providers* of the possibility of denied claims when the *enrollee* is in the third month of the grace period. *We* will continue to collect *advanced premium tax credits* on behalf of the *enrollee* from the Department of the Treasury, and will return the *advanced premium tax credits* on behalf of the *enrollee* for the second and third month of the grace period if the *enrollee* exhausts their grace period as described above. An *enrollee* is not eligible to re-enroll once terminated, unless an *enrollee* have a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When an *enrollee* is not receiving a premium subsidy:

> Grace Period: A grace period of 30 days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force.
>
> Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *contract* will stay in force; however, claims may pend for *covered services* rendered to the *enrollee* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *enrollee*, as well as *providers* of the possibility of denied claims when the *enrollee* is in the grace period.

Deductibles

In addition to *your* premium, *your* health insurance policy requires *you* to pay the amount of the *deductible* from one of the available plan options for each covered person for each calendar year.

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

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

This *deductible*, unless otherwise indicated, will be applied to all categories of *eligible service expenses* before benefits are available under the 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 *deductible amounts* to the "family" *deductible amount*.

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

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

Coinsurance Stop-Loss Amount

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

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

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

Individual Coinsurance Stop-Loss Amount

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

Family Coinsurance Stop-Loss Amount

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

Coinsurance Percentage

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

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

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

The amount provided or payable will be subject to:

1. Any specific benefit limits stated in the *contract*;
2. A determination of *eligible service expenses*.

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

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

Changing the Deductible

You may increase the *deductible* to an amount currently available only if enrolled through a special enrollment period. A request for an increase in the *deductible* between the first and fifteenth day of the month will become effective on the first day of the following month. Requests between the sixteenth and last day of the month will become effective on the first day of the second following month. *Your* premium will then be adjusted to reflect this change.

Coverage Under Other Policy Provisions

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

Health Insurance Policy Limitations and Exclusions

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *enrollee* or *enrollee* in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on the *enrollee* or *enrollee* by a *provider* (including a *hospital*) but that are actually the responsibility of the *provider* to pay.
3. Any services performed by an *enrollee* or an *enrollee's immediate family*, including someone who is related to an *enrollee* by blood, marriage or adoption or who is normally a member of the *enrollee's* household.
4. Any services not identified and included as *covered service expenses* under the *contract*. *You* will be fully responsible for payment for any services that are not *covered service expenses*.

Even if not specifically excluded by the *contract*, no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *provider*; and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness*, or covered under the Preventive Care Services provision.

Covered service expenses will not include, and no benefits will be provided or paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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 cosmetic breast reduction or augmentation, except for the *medically necessary* treatment of Gender Dysphoria.
5. The reversal of sterilization and reversal of vasectomies.
6. For abortion (unless the life of the mother would be endangered if the fetus were carried to term).
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, except those meeting the definition of *telehealth services* or *telemedicine medical services*, or for failure to keep a scheduled appointment.
11. For stand-by availability of a medical practitioner when no treatment is rendered.
12. 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 and Surgical Benefits provision.
13. For *cosmetic treatment*, except for *reconstructive surgery* for mastectomy or that is incidental to or follows *surgery* or an *injury* from trauma, infection or diseases of the involved part that was covered under the *contract* or is performed to correct a birth

defect.

14. For mental health exams and services involving:
    a. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities;
    b. Marriage counseling;
    c. Pre-marital counseling;
    d. Testing of aptitude, ability, intelligence or interest; or
    e. Evaluation for the purpose of maintaining employment *inpatient* confinement or *inpatient* mental health services received in a *residential treatment facility* unless associated with chemical or alcohol dependency in a non-medical transitional residential recovery setting.
15. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Services provision.
16. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
17. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
18. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
19. 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.
20. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as expressly provided in this *contract*.
21. 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.
22. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days.
23. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *enrollee is* insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives an *enrollee's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for an *enrollee's* workers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency.
24. As a result of:
    a. An *injury* or *illness* caused by any act of declared or undeclared war.
    b. The *enrollee* taking part in a riot.
    c. The *enrollee's* commission of a felony, whether or not charged.
    d. 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 administer or prescribed by a physician, except as expressly provided under the Mental Health

and Substance Abuse Expense Benefit and excluding presence of mental health and substance abuse disorders.

25. For or related to surrogate parenting.
26. For or related to treatment of hyperhidrosis (excessive sweating).
27. For fetal reduction *surgery*.
28. 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.
29. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any non-motorized vehicle or conveyance (if the *enrollee* is paid to participate or to instruct); rodeo sports; horseback riding (if the *enrollee* is paid to participate or to instruct); rock or mountain climbing (if the *enrollee* is paid to participate or to instruct); or skiing (if the *enrollee* is paid to participate or to instruct).
30. 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.
31. As a result of any *injury* sustained while at a *residential treatment facility*.
32. For the following miscellaneous items: in vitro fertilization, artificial insemination (except where required by federal or state law); biofeedback; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods section; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*enrollee* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; *rehabilitation* services for the enhancement of job, athletic or recreational performance; routine or elective care outside the *service area*; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
33. Services of a private duty registered nurse rendered on an outpatient basis.
34. Diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.

Non-Covered Services and Exclusions:

No benefits will be paid under this benefit subsection for services provided or expenses incurred:

1. For *prescription drug* treatment of erectile dysfunction or any enhancement of sexual performance unless such treatment is listed on the formulary.
2. For weight loss prescription drugs unless otherwise listed on the formulary.
3. For immunization agents, blood, or blood plasma, except when used for preventative care and listed on the formulary.
4. For medication that is to be taken by the *member,* in whole or in part, at the place where it is dispensed.
5. For medication received while the *member* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.

7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are on the formulary.
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network.
12. Foreign Prescription Medications, except those associated with an Emergency Medical Condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
13. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *member's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
14. For medications used for cosmetic purposes.
15. For infertility drugs unless otherwise listed on the formulary.
16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
17. For drugs or dosage amounts determined by Ambetter to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether such drugs or dosage amounts have been approved by any governmental regulatory body for that use.
18. For any drug related to dental restorative treatment or treatment of chronic periodontitis, where drug administration occurs at dental practitioner's office.
19. For any drug dispensed from a non-lock-in pharmacy while member is in opioid lock-in program.
20. For any drug related to surrogate pregnancy.
21. For any drug used to treat hyperhidrosis.

Lock-in program

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

Prior Authorization Requirements for Services

Some *covered services* require *prior authorization*. In general, *network providers* must obtain *authorization* from Ambetter from Superior HealthPlan prior to providing a service or supply to an *enrollee*. However, there are some *covered services* for which *you* must obtain the *prior authorization*.

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

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

To obtain *prior authorization* or to confirm that a *network provider* has obtained *prior authorization*, contact Ambetter from Superior HealthPlan by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *enrollee*. Failure to comply with the prior authorization requirements may result in benefits being reduced or not covered. In cases of emergency, benefits will not be reduced for failure to comply with *prior authorization* requirements. However, *you* must contact *us* as soon as reasonably possible after the emergency occurs. Please see *your contract* and *Schedule of Benefits* for specific details.

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

In the event *you* are 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, Ambetter from Superior HealthPlan 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* who is a patient. Examples of an *enrollee* who has a special circumstance include an *enrollee* with a disability, acute condition, life-threatening *illness*, or who is past the 24th week of *pregnancy*.

Special circumstances shall be identified by the treating *physician* or healthcare *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*. A request for special circumstances are not available when a provider has been terminated for medical competence or professional behavior..

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. If an *enrollee* is past the 24th week 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 after delivery.

Complaint Procedures

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

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

You should send *your* written *complaint* to:
Ambetter from Superior HealthPlan Complaint Department
5900 E. Ben White Blvd.
Austin, TX 78741
Fax: 1-800-310-0943

Expedited *Complaints*: If *your complaint* concerns an emergency or a situation in which *you* may be forced to leave the *hospital* prematurely, *we* will resolve it no later than one business day from the time that *we* receive it. Within three business days, *you* will get a letter with the resolution to *your complaint*.

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

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

Retaliation Prohibited

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

Network Information

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

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

- Provider specialty
- ZIP code
- Gender
- Languages spoken
- Whether or not he/she is currently accepting new patients

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

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Board certification status

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

Ambetter from Superior HealthPlan Service Area and Number of Enrollees

Service area is any place that is within the counties in the state of Texas that Ambetter has designated as the *service area* for this plan. Ambetter from Superior HealthPlan's service area includes the following counties: Bandera, Bastrop, Bell, Bexar, Blanco, Brazoria, Brazos, Brooks, Burleson, Burnet, Caldwell, Cameron, Collin, Comal, Concho, Dallas, Denton, El Paso, Fayette, Fort Bend, Gillespie, Grimes, Harris, Hays, Hidalgo, Hunt, Kendall, Kerr, Lee, Llano, Madison, Mason, McCulloch, McLennan, Medina, Menard, Montgomery, Nueces, Parker, Potter, Randall, Rockwall, Starr, Tarrant, Travis, Webb, Willacy, and Williamson.

The number of effectuated members in Ambetter's *service area* under the Celtic EPO license is currently 319,726. Please refer to the table below for a breakdown of effectuated members based on service area.

Service Area	Total Effectuated Members 2020
Bandera	493
Bastrop	1,095
Bell	2,114
Bexar	23,442
Blanco	435
Brazoria	3,216
Brazos	2,024

Brooks	80
Burleson	219
Burnet	1,072
Caldwell	566
Cameron	10,356
Collin	12,430
Comal	1,305
Concho	35
Dallas	30,096
Denton	14,530
El Paso	22,343
Fayette	463
Fort Bend	19,557
Gillespie	1,916
Grimes	459
Harris	55,169
Hays	1,995
Hidalgo	28,180
Hunt	1,146
Kendall	792
Kerr	1,637
Lee	267
Llano	555
Madison	192
Mason	187
McCulloch	139
McLennan	2,545
Medina	919
Menard	38
Montgomery	6,235
Parker	1,520
Rockwall	1,352
Starr	2,398
Tarrant	45,125
Travis	14,507
Willacy	929
Williamson	5,653

Network Demographics

Provider Type	Internal Medicine	Family Medicine	General Practice	Pediatrics	Obstetrics	Anesthesiology	Psychiatry	Surgery	Acute General Hospital
Bandera	9	2		1	1				
Bastrop	13	24	2	6	3		1		1
Bell	15	23	9	24	10	50	23	2	1
Bexar	641	297	93	437	202	598	83	158	20
Blanco	1	3						1	
Brazoria	60	31	1	22	16	14	11	10	4
Brazos	30	98	9	15	15	23	7	16	1
Brooks		2		1					
Burleson		2							1
Burnet	20	19		6	2			7	1
Caldwell	12	17		5	4			2	1
Cameron	132	95		86	36	23		33	5
Collin	289	219		122	63	55	23	69	11
Comal	19	16		5	5	11		2	1
Concho		2	1						1
Dallas	822	570	102	260	169	91		134	17
Denton	104	164	11	41	28	43		23	6
El Paso	210	152	36	128	85	103		64	9
Fayette	6	9	3	2	1			4	1
Fort Bend	106	63	16	22	32	28		34	7
Gillespie	18	30	2	6	7	4		6	1
Grimes	2	10	1	1					1
Harris	965	514	60	255	226	185	181	193	23
Hays	37	31	2	32	15	6	7	14	2
Hidalgo	294	323	61	220	89	20	27	58	8
Hunt	13	20	10	10			20	1	3
Kendall	12	18		5	2		3	3	
Kerr	42	33	1	2	12	12		11	1
Lee	1	3							
Llano		3							
Madison		5							1
Mason		3							
McCulloch	1	4	1	1				1	1
McLennan	39	54	10	12	8	33	5	17	1
Medina	15	12	2	1	3			1	1
Menard									
Montgomery	146	127	9	27	24	31	7	20	4
Nueces	60	28	10	45	15	10	23	27	4

Parker	15	16	2	4	10	33	3	3	1
Potter	24	11	6	9	14	12	9	3	2
Randall	1	8	1	1	1	1			
Rockwall	12	22	2	5	8	1	3	9	1
Starr	11	24	5	5	1	2		12	2
Tarrant	516	641	50	153	197	86	54	125	12
Webb	14	30	4	10	8		7	6	2
Travis	391	369	68	340	238	221	98	107	10
Willacy		6		1					
Williamson	70	111	20	97	40	80	19	20	5
Totals	**5,188**	**4,264**	**610**	**2,425**	**1,590**	**1,776**	**614**	**1,196**	**174**

Waivers and Local Market Access Plan

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

Provider Type	Internal Medicine	Family Medicine	General Practice	Pediatrics	Obstetrics	Anesthesiology	Psychiatry	Surgery	Acute General Hospital
Bandera									
Bastrop									
Bell									
Bexar									
Blanco									
Brazoria									
Brazos									
Brooks									X
Burleson									
Burnet									
Caldwell									
Cameron									
Collin									
Comal									
Concho					X	X			
Dallas									
Denton									
El Paso									
Fayette									
Fort Bend									
Gillespie									
Grimes									
Harris									
Hays									
Hidalgo									
Hunt									
Kendall									
Kerr									
Lee									
Llano									
Madison									
Mason									
McCulloch						X			
McLennan									
Medina									
Menard					X	X			
Montgomery									
Nueces									
Potter									
Parker									
Randall									
Rockwall									
Starr									
Tarrant									
Travis									
Webb						X			
Willacy									
Williamson									

Provider Type	Internal Medicine	Family Medicine	General Practice	Pediatrics	Obstetrics	Anesthesiology	Psychiatry	Surgery	Acute General Hospital
Bandera									
Bastrop									
Bell									
Bexar									
Blanco									
Brazoria									
Brazos									
Brooks									X
Burleson									
Burnet									
Caldwell									
Cameron									
Collin									
Comal									
Concho					X	X			
Dallas									
Denton									
El Paso									
Fayette									
Fort Bend									
Gillespie									
Grimes									
Harris									
Hays									
Hidalgo									
Hunt									
Kendall									
Kerr									
Lee									
Llano									
Madison									
Mason									
McCulloch						X			
McLennan									
Medina									
Menard					X	X			
Montgomery									
Nueces									
Parker									
Potter									
Randall									
Rockwall									
Starr									
Tarrant									
Travis									
Webb						X			
Willacy									
Williamson									

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

Texas Department of Insurance Notice

- An *exclusive provider benefit plan* provides no benefits for services *you* receive from out-of-network *providers*, with specific exceptions as described in *your* policy and below.
- *You* have the right to an adequate *network* of *preferred providers* (known as "*network providers*").
    - If *you* believe that the *network* is inadequate, *you* may file a *complaint* with the Texas Department of Insurance.
- If *your* insurer *approves* a referral for out-of-network services because no *preferred provider* is available, or if *you* have received out-of-network *emergency care*, *your* insurer must, in most cases, resolve the *non-preferred provider's* bill so that *you* only have to pay any applicable *coinsurance*, *copay*, and *deductible amounts*.
- *You* may obtain a current directory of *preferred providers* at the following website: Ambetter from Superior HealthPlan or by calling 1-877-687-1196 (Relay Texas/ TTY 1-800-735-2989 for assistance in finding available *preferred providers*. If *you* relied on materially inaccurate directory information, *you* may be entitled to have an out-of-network claim paid at the in-network level of benefits.

Guaranteed Renewable

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

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

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

Annually, *we* may change the rate table used for this policy form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of covered *enrollees*, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. *We* have the right to change premiums.

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

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

In addition to the above, this guarantee for continuity of coverage shall not prevent *us* from cancelling or non-renewing this *contract* in the following events: (1) non-payment of premium; (2) an *enrollee* fails to pay premiums or contributions in accordance with the terms of this *contract*, including any timeliness requirements; (3) an *enrollee* has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact relating to this *contract*; or (4) a change in federal or state law, no longer permits the continued offering of such coverage, such as CMS guidance related to individuals who are Medicare eligible.