



**AMBETTER FROM SUPERIOR HEALTHPLAN  
HEALTH MAINTENANCE ORGANIZATION  
WRITTEN DESCRIPTION OF COVERAGE**

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

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

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

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

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

All *enrollees* must select a *primary care provider*. *You* may select any *network primary care provider* who is accepting new patients, or *you* may select a *network provider* of which *you* are a current patient. 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 Member Services. Until a *primary care provider* is selected or assigned, benefits will be limited to coverage for *emergency care*.

*Your primary care provider* coordinates *your* medical care, as appropriate, either by providing treatment or by issuing *referrals* to direct *you* to *participating providers*. Except for *emergency care*, only those services which are provided by or referred by *your primary care provider* will be covered. It is *your* responsibility to consult with *your primary care provider* in all matters regarding *your* medical care. If *your primary care provider* performs, suggests, or recommends a course for treatment for *you* that includes services that are not *covered services*, the entire

cost of any such non-covered services will be *your* responsibility.

In addition to a *PCP*, female *enrollees* may also select a participating Obstetrician/Gynecologist (OB/GYN Care) for gynecological and obstetric conditions, including annual well-woman exams and maternity care, without first obtaining a *referral* from a *PCP* or contacting *us*. *Enrollees* who have been diagnosed with a chronic, disabling or life threatening illness may request approval to choose a participating *specialist* as a *PCP* using the process described in the Specialist as a Primary Care Provider provision.

### 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 *participating provider* and *non-participating 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-participating services. Please note that we will pay the negotiated fee or usual and customary rate to *non-participating* or *non-network providers*, as explained under the "*eligible service expense*" definition found in *your contract*.

[Bronze/Essential Care Plans](#)

[Silver/ Balanced Care Plans](#)

[Gold/Secure Care Plans](#)

### Acquired Brain Injury Services

Benefits for *eligible service expenses* incurred for *medically necessary* treatment of an *Acquired Brain Injury* will be determined on the same basis as treatment for any other physical condition. *Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation required for and related to treatment of an Acquired Brain Injury, 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*.

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

### Air Ambulance Service Benefits

Covered service expenses will include ambulance services for ground, water, fixed wing and rotary wing air transportation from home, scene of accident, or medical emergency:

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

### 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 healthcare practitioner:

1. who is licensed, certified, or registered by an appropriate agency of the state of Texas;
2. whose professional credential is recognized and accepted by an appropriate agency of the United States;
3. who is certified as a *provider* under the TRICARE military health system; or
4. who is acting under the supervision of a health care practitioner.

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

1. evaluation and assessment services;
2. *applied behavior analysis therapy*;
3. behavior training and behavior management;
4. speech therapy;
5. occupational therapy;
6. physical therapy;
7. psychiatric care such as counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker; and
8. medications or nutritional supplements used to address symptoms of *autism spectrum disorder*.

### Mental Health and Substance Use Disorder Benefits

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

Inpatient

1. *Inpatient* psychiatric hospitalization;
2. *Inpatient* detoxification treatment;
3. Observation;
4. Crisis stabilization;
5. *Inpatient rehabilitation*;
6. *Residential treatment facility* for mental health and substance use; and
7. Electroconvulsive Therapy (ECT).

## Outpatient

1. Individual and group therapy for mental health and substance use;
2. Partial Hospitalization Program (PHP);
3. Medication Management services;
4. Psychological and *neuropsychological testing* and assessment;
5. *Applied Behavior Analysis (ABA)* for treatment of *Autism spectrum disorders*;
6. *Telehealth services* and *telemedicine medical services*;
7. Electroconvulsive Therapy (ECT);
8. Intensive Outpatient Program (IOP);
9. Mental health day treatment;
10. Outpatient detoxification programs;
11. Evaluation and assessment for mental health and substance use; and
12. Medication Assisted Treatment – combines behavioral therapy and medications to treat *substance use disorders*;
13. Transcranial Magnetic Stimulation (TMS);
14. Assertive Community Treatment (ACT).

## Chiropractic Services

Chiropractic services are covered when a participating chiropractor finds that the services are *medically necessary* to treat or diagnose neuromusculoskeletal disorders on an outpatient basis.

## Dialysis Services

*Covered service expenses* and supplies include:

1. Services provided in an outpatient dialysis *facility* or when services are provided in the home by a preferred *provider*;
2. Processing and administration of blood or blood components;
3. Dialysis services provided in a *hospital*;
4. Dialysis treatment of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.

## Radiology, Imaging and Other Diagnostic Testing

*Medically necessary* radiology services, imaging and tests performed are a *covered service* (e.g., X-ray, MRI, CT scan, PET/SPECT, mammogram, ultrasound).

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

### Home Health Care Service Expense Benefits

Coverage is provided for Medically Necessary in-network care provided at the *enrollee's* home and are limited to the following charges:

1. *Home health aide services*, only if provided in conjunction with skilled registered nurse or licensed practical nursing services.
2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care*.
3. *Home infusion therapy*.
4. Hemodialysis, and for the processing and administration of blood or blood components.
5. Skilled services of a registered nurse or licensed practical nurse rendered on an outpatient basis.
6. *Necessary medical supplies*.
7. Rental of *medically necessary durable medical equipment*.
8. Sleep studies.

### Hospice Care Benefits

*Hospice care* benefits are allowable for a *terminally ill enrollee* receiving *medically necessary care* under a *hospice care program*. Covered services and supplies include:

1. Room and board in a *hospice* while the *enrollee* is an *inpatient*.
2. Occupational therapy.
3. Speech-language therapy.
4. Respiratory therapy.
5. The rental of medical equipment while the *terminally ill enrollee* is in a *hospice care program* to the extent that these items would have been covered under the *contract* if the *enrollee* had been confined in a *hospital*.
6. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.
7. Counseling the *enrollee* regarding his or her terminal *illness*.
8. *Terminal illness counseling* of the *enrollee's immediate family*.
9. *Bereavement counseling*.

### Respite Care Expense Benefits

*Respite care* is only for home and *inpatient* locations, and are not only subject to *deductible*.

### Hospital Benefits

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

1. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate.
2. Daily room and board and nursing services while confined in an *intensive care unit*.
3. *Inpatient* use of an operating, treatment, or recovery room.
4. Outpatient use of an operating, treatment, or recovery room for *surgery*.
5. Services and supplies, including drugs and medicines, which are routinely provided by the *hospital* to persons for use only while they are *inpatient*.
6. Emergency treatment of an *injury* or *illness*, even if confinement is not required. See *your Schedule of Benefits* for limitations.
7. Administration of whole blood and blood plasma. (Note: Whole blood, including the cost of blood, blood plasma, and blood expanders that are not replaced by or for the *enrollee*).
8. Meals and special diets when *medically necessary*.
9. Private Duty Nursing when *medically necessary*.
10. Short term rehabilitation therapy services when in an acute *hospital* setting.

### Infertility

Infertility treatment is a *covered service expense* when medical services are provided to the *enrollee* which are *medically necessary* for the diagnosis of infertility.

### Durable Medical Equipment

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

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

### Medical and Surgical Supplies

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

### Orthotic and Prosthetic Devices

*We* will cover the most appropriate model of *orthotic* and *prosthetic devices* that are determined *medically necessary* by *your* treating *physician*, podiatrist, prosthetist, or orthotist.

### Maternity Care

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

### Newborn Charges

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

### 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.

### Prescription Drug Benefits

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

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

For the most current Ambetter Formulary or preferred drug list or for more information about our pharmacy program, visit [Ambetter.SuperiorHealthPlan.com](http://Ambetter.SuperiorHealthPlan.com) (under "For Members", "Drug Coverage") or call Member Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

### 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.

### 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:

- 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.

Additional Preventive Care Services include:

- Preventive Care Services for Children
- Preventive Care Services for Women, including Pregnant Women
- Preventive Services for Adults
- Routine Exams and Immunizations
- Certain Tests for Detection of Human Papillomavirus, Ovarian and Cervical Cancer
- Mammography Screening and Diagnostic Imaging
- Detection and Prevention of Osteoporosis
- Certain Tests for Detection of Prostate Cancer
- Early Detection Tests for Cardiovascular Disease
- Screening Tests for Hearing Impairment
- Contraceptive Care
- Medically Necessary Vision Services

### Sleep Studies

Sleep studies are covered when determined to be *medically necessary*.

### Transplant Services

Transplants are a covered benefit when an *enrollee* is accepted as a transplant candidate and pre-authorized in accordance with the *contract*.

### Pediatric Vision Expense Benefits

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

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

### Emergency Care Service and Benefits

*Your Evidence of Coverage* provides coverage for medical emergencies wherever they occur.

In an emergency, always call 911 or go to the nearest *hospital* emergency room (ER).

Anything that could endanger *your* life (or *your* unborn child's life, if *you're* pregnant) without immediate medical attention is considered an emergency situation. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

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

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

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

#### Out-of-Area Service and Benefits

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

#### Non-Emergency Services

If *you* are traveling outside of the Texas service area *you* may be able to access *providers* in another state if there is an Ambetter plan located in that state. *You* can locate Ambetter *providers* outside of Texas by searching the relevant state in *our provider* directory at <https://guide.ambetterhealth.com>. Not all states have Ambetter plans. If *you* intend to seek care from an Ambetter *provider* outside of the service area, *you* may be required to obtain *prior authorization* from the originating Ambetter state for non-emergency services. Contact Member Services at the phone number on *your ID* card for further information.



### Hospital Based Providers

When receiving care on or after 1/1/2020, at a *network hospital* or other *facility*, it is possible that some *hospital-based providers* (for example, anesthesiologists, emergency room *providers*, radiologists, pathologists) may not be under contract with Ambetter as *network providers*. If appropriate notice is provided to and acknowledged by you before rendering services, these *providers* cannot bill *you* for the difference between Ambetter's *eligible service expense* and the *provider's billed charge* – this is known as “*balance billing*”, unless a notice and disclosure statement was signed ten days prior to receiving care. *We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their network status with Ambetter. You may not be balance billed for non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, diagnostic imaging, laboratory services, and neonatology, as well as diagnostic services (including radiology and laboratory services)) received from a non-network provider at a network hospital or network ambulatory facility. If you are ever balance billed contact Member Services immediately at the number listed on the back of your ID card.*

Although healthcare services may be or have been provided to *you* at a healthcare *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 medical practitioners who are not members of that *network*.

If *you* receive a bill for emergent, *covered services* prior to 1/1/2020, rendered at a non-*network facility* or by a *non-network provider*, *you* must submit that bill and all related documentation to the Texas Department of Insurance to initiate a request for *balance billing mediation*. A copy of the request form may be obtained by calling 1-800-252-3439.

### Enrollee's Financial Responsibility

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

### Premium Payment

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

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

### Grace Period

When an *enrollee* is receiving a premium subsidy:

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

If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if *advanced*

*premium tax credits* are received.

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

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

Grace Period: A grace period of 60 days will be granted for the payment of each premium due after the first premium. During the grace period, the contract continues in force.

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first 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 Evidence of Coverage* 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 *contract* benefits will pay for covered expenses at the *coinsurance* percentage level for covered *inpatient* and outpatient expenses each calendar year. *Your Evidence of Coverage* payments may be limited by *contract* exclusions and limitations. You will be responsible for any charge that is left unpaid after Ambetter from Superior HealthPlan has paid up to its *contract* limits and obligations.

#### Coinsurance Percentage

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

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

When the annual 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 Contract Provisions

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

## Evidence of Coverage Limitations and Exclusions

No benefits will be provided or paid for:

1. Any service or supply that would be provided without cost to the *enrollee* or *enrollee* in the absence of insurance covering the charge.
2. Expenses, fees, taxes, or surcharges imposed on the *enrollee* or *enrollee* by a *provider* (including a *hospital*) but that are actually the responsibility of the *provider* to pay.
3. Any services performed by 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*.
5. Any services where other coverage is primary to Ambetter must be first paid by the primary payor prior to consideration for coverage under Ambetter.
6. For any non-*medically* necessary court ordered care for a medical/surgical or mental health/substance use disorder diagnosis, unless required by state law.

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

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

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

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *contract*, 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 or where a woman is at serious risk of substantial impairment of a major bodily function unless the abortion is performed).
7. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered service expenses*.
8. For expenses for television, telephone, or expenses for other persons.
9. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions.
10. For telephone consultations, except those meeting the definition of *telehealth services* or *telemedicine medical services*, or for failure to keep a scheduled appointment.
11. For services provided outside of a *primary care provider* visit, when a *referral* is not obtained through *your primary care provider*, except in an emergency, or as specified elsewhere in this *contract*.

12. For stand-by availability of a medical practitioner when no treatment is rendered.
13. For *dental service* expenses, including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under *your* Dental Benefit Rider, if applicable.
14. For *cosmetic treatment*, except for *reconstructive surgery* for mastectomy or that is incidental to or follows *surgery* or an *injury* from trauma, infection or diseases of the involved part that was covered under the *contract* or is performed to correct a birth defect.
15. For mental health 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. Court ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that are *medically necessary* and would otherwise be covered under this *contract*;
  - e. Testing of aptitude, ability, intelligence or interest; or
  - f. Evaluation for the purpose of maintaining employment. Benefits will be allowed for services that would otherwise be covered under this *contract*.
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Services provision.
17. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
18. While confined primarily to receive *rehabilitation*, *custodial care*, educational care, or nursing services (unless expressly provided for in this *contract*).
19. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *contract*.
20. 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.
21. 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*.
22. For treatment received outside the United States, except for a medical emergency while traveling.
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. 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 under the Mental Health and Substance Abuse Expense Benefit and excluding presence of mental health

and substance abuse disorders.

25. For or related to treatment of hyperhidrosis (excessive sweating).
26. For fetal reduction *surgery*.
27. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, 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.
28. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any non-motorized vehicle or conveyance (if the *enrollee* is paid to participate or to instruct); rodeo sports; horseback riding (if the *enrollee* is paid to participate or to instruct); rock or mountain climbing (if the *enrollee* is paid to participate or to instruct); or skiing (if the *enrollee* is paid to participate or to instruct).
29. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *enrollee* is a pilot, officer, or *enrollee* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
30. As a result of any *injury* sustained while at a *residential treatment facility*.
31. For the following miscellaneous items: in vitro fertilization, artificial insemination (except where required by federal or state law); biofeedback; care or complications resulting from non-*covered services*; chelating agents; domiciliary care; food and food supplements, except for what is indicated in the Medical Foods 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*; treatment of spider veins; transportation expenses, unless specifically described in this *contract*;
32. Services of a private duty registered nurse rendered on an outpatient basis.
33. Diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
34. For any medicinal and recreational use of cannabis or marijuana.
35. Surrogacy Arrangement. Health care services, including supplies and medication relating to a Surrogacy Agreement, to a Surrogate, including an *enrollee* acting as a Surrogate or utilizing the services of a Surrogate who may or may not be an *enrollee*, and any child born as a result of a Surrogacy Arrangement. This exclusion applies to all health care services, supplies and medication relating to a Surrogacy Agreement, to a Surrogate including, but not limited to:
  - a. Prenatal care;
  - b. Intrapartum care (or care provided during delivery and childbirth);
  - c. Postpartum care (or care for the Surrogate following childbirth);
  - d. Mental Health Services related to the Surrogacy Arrangement;
  - e. Expenses relating to donor semen, including collection and preparation for implantation;
  - f. Donor gamete or embryos or storage of same relating to a Surrogacy Arrangement;
  - g. Use of frozen gamete or embryos to achieve future conception in a Surrogacy Arrangement;
  - h. Preimplantation genetic diagnosis relating to a Surrogacy Arrangement;

- i. Any complications of the child or Surrogate resulting from the pregnancy;
  - j. Any other health care services, supplies and medication relating to a Surrogacy Arrangement; or
  - k. Any and all health care services, supplies or medication provided to any child birthed by a *Surrogate* as a result of a *Surrogacy Arrangement* are also excluded, except where the child is the adoptive child of *enrollee's* possessing an active *contract* with us and/ or the child possesses an active *contract* with us at the time of birth.
36. Vehicle installations (modifications) which may include, but are not limited to: adapted seat devices, door handle replacements, lifting devices, roof extensions and wheelchair securing devices.
37. For all health care services obtained at an Urgent Care Facility that is a *non-network provider*

**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 *enrollee*, in whole or in part, at the place where it is dispensed.
5. For medication received while the *enrollee* is a patient at an institution that has a facility for dispensing pharmaceuticals.
6. For a refill dispensed more than 12 months from the date of a *physician's* order.
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs.
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are on the formulary. This exclusion does not apply to prescribed FDA approved contraceptive methods
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs.
10. For any drug that we identify as therapeutic duplication through the Drug Utilization Review program.
11. For more than a 30-day supply when dispensed in any one prescription or refill or for maintenance drugs up to a 90-day supply when dispensed by mail order or a pharmacy that participates in extended day supply network. Specialty drugs and other select drug categories are limited to 30-day supply when dispensed by retail or mail order. Please note that only the 90 day supply is subject to the discounted *cost sharing*. Mail orders less than 90 days are subject to the standard *cost sharing* amount.
12. Foreign Prescription Medications, except those associated with an Emergency Medical Condition while you are traveling outside the United States. These exceptions apply only to medications with an equivalent FDA-approved Prescription Medication that would be covered under this document if obtained in the United States.
13. For prevention of any diseases that are not endemic to the United States, such as malaria, and where preventative treatment is related to *enrollee's* vacation during out of country travel. This section does not prohibit coverage of treatment for aforementioned diseases.
14. For medications used for cosmetic purposes.
15. For infertility drugs unless otherwise listed on the formulary.

16. For any controlled substance that exceeds state established maximum morphine equivalents in a particular time period, as established by state laws and regulations.
17. For drugs or dosage amounts determined by Ambetter 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 *enrollee* is in opioid lock-in program.
20. For any drug related to surrogate pregnancy.
21. For any drug used to treat hyperhidrosis.
22. For any injectable medication or biological product that is not expected to be self-administered by the *enrollee* at *enrollee's* place of residence unless listed on the formulary.
23. For any claim submitted by non lock-in pharmacy while *enrollee* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *enrollee's* participation in lock-in status will be determined by review of pharmacy claims.
24. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
25. Medication refills where an *enrollee* has more than 15 days' supply of medication on hand.

### **Lock-in program**

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

### Prior Authorization Requirements for Services

Some medical, pharmaceutical and behavioral health *covered services* require *prior authorization*. In general, *network providers* do not need to obtain *authorization* from Ambetter from Superior HealthPlan prior to providing a service or supply to an *enrollee*. However, there are some *covered services* for which *you* must obtain the *prior authorization*.

*Enrollees* are required to obtain a *referral* from their *PCP* for in-network *specialists* or other providers for additional healthcare services deemed *medically necessary*. A *referral* is required prior to a non-emergent visit with a practitioner outside of your *PCP* care services (excluding emergencies, urgent care, behavioral/mental health care services, and ob/gyn services). This includes, but is not limited to, in-person office visits, specialist consultations, and diagnostic testing, as well as visits to an in-network facility. Emergency Room services do not require a *referral*. *You* do not need a referral from *your network primary care physician* for in-network mental or *behavioral health* services, obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

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* 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.

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

1. For services that require *prior authorization*, within 3 calendar days of receipt.
2. For concurrent review, within 24 hours of receipt of the request.
3. For post-stabilization treatment or life-threatening condition, within the timeframe appropriate to the circumstances and condition of the *enrollee*, but not to exceed one hour of receipt of the request.
4. For post-service requests, within 30 calendar days of receipt of the request.

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

Under the No Surprises Act, if an *enrollee* is receiving a *covered service* with respect to an *network provider* or *facility* and: (1) the contractual relationship with the *provider* or *facility* is terminated, such that the *provider* or *facility* is no longer in network; or (2) benefits are terminated because of a change in the terms of the participation of the *provider* or *facility*, as it pertains to the benefit the member is receiving, then *we* will: (1) notify each enrollee who is a *continuing care patient* on a timely basis of the termination and their right to elect continued transitional care from the provider or facility; (2) provide the individual with an opportunity to notify the health plan of the individual's need for transitional care; and (3) permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual's status as a continuing care patient during the period beginning on the date on which the above notice is provided and ending on the earlier of (i) the 90-day period beginning on such date; or the (ii) date on which such individual is no longer a continuing care patient with respect to their *provider* or *facility*.

## Complaint Procedures

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

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

You should send your written *complaint* to:  
Ambetter from Superior HealthPlan 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 72 hours from the time that we receive it. Within 72 hours, 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.

Expedited *appeals* of *adverse determinations* involving ongoing emergencies or denials of continued stays in a *hospital*, denials of *prescription drugs*, intravenous infusions, or a denied step therapy protocol exception will be resolved no later than one (1) business day after the request is received.

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

### Retaliation Prohibited

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

#### Access to OB/GYN Services

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

### 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](http://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).

### Texas Department of Insurance Notice

- A health maintenance organization (HMO) plan provides for services *you* receive from out-of-network *physicians* or *providers*, with specific exceptions as described in *your* evidence of coverage and below.
- *You* have the right to an adequate *network of participating providers* (known as "*network physicians and providers*").
  - If *you* believe that the *network* is inadequate, *you* may file a *complaint* with the Texas Department of Insurance at [www.tdi.texas.gov/consumer.complfrm.html](http://www.tdi.texas.gov/consumer.complfrm.html).
- If *your* HMO *approves* a referral for out-of-network services because no *participating provider* is available, or if *you* have received out-of-network *emergency care*, *your* HMO must, in most cases, resolve the *non-participating provider's* bill so that *you* only have to pay any applicable *coinsurance*, *copay*, and *deductible amounts*.
- *You* may obtain a current directory of *participating providers* at the following website: [Ambetter from Superior HealthPlan](http://Ambetter from Superior HealthPlan) or by calling 1-877-687-1196 (Relay Texas/ TTY 1-800-735-2989 for assistance in finding available *participating 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, if *you* present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before *you* received the service.

### Ambetter from Superior HealthPlan Service Area and Number of Enrollees

*Service area* is any place that is within the counties in the state of Texas that Ambetter has designated as the *service area* for this plan. Ambetter from Superior HealthPlan's service area includes the following counties: Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery,

Rockwall, Tarrant, Travis, and Williamson.

The number of effectuated members in Ambetter's *service area* under the Superior HealthPlan HMO license is currently unknown. Please refer to the table below for a breakdown of effectuated members based on service area.

<b>Service Area</b>	<b>Total Effectuated Members</b>
<b>Bexar</b>	
<b>Collin</b>	
<b>Dallas</b>	
<b>Denton</b>	
<b>Fort Bend</b>	
<b>Harris</b>	
<b>Montgomery</b>	
<b>Rockwall</b>	
<b>Tarrant</b>	
<b>Travis</b>	
<b>Williamson</b>	

Network Demographics

Service Area	Provider Type					
	Primary Care	Pediatrics - Routine/Primary Care	Gynecology (OB/GYN)	Psychiatry	Surgery	Acute General Hospital
Bexar	139	24	7	14	46	7
Collin	96	22	23	4	37	3
Dallas	409	61	44	13	145	8
Denton	131	29	21	3	92	5
Fort Bend	117	20	28	1	48	5
Harris	903	117	121	51	322	14
Montgomery	236	22	19	2	47	4
Rockwall	16	1	1	0	6	0
Tarrant	365	30	47	6	72	7
Travis	414	133	93	26	208	9
Williamson	105	41	20	10	37	3

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."

Service Area	Provider Type					
	Primary Care	Pediatrics - Routine/Primary Care	Gynecology (OB/GYN)	Psychiatry	Surgery	Acute General Hospital
Bexar						
Collin						
Dallas						
Denton						
Fort Bend						
Harris						
Montgomery						
Rockwall						
Tarrant						
Travis						
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).

## Guaranteed Renewable

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

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

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

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

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

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

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