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*.

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 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* 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

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 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*.
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).
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 *your*

Dental Benefit Rider, if applicable.

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. Court ordered care or testing, or required as a condition of parole or probation. Benefits will be allowed for services that would otherwise be covered under this policy;
    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 policy.
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. 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 fetal reduction *surgery*.
26. Except as specifically identified as a *covered service expense* under the *contract*, services or expenses for alternative treatments, including acupressure, acupuncture, 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.
27. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or Semi-professional sports; intercollegiate sports (not including intramural sports); racing or speed testing any non-motorized vehicle or conveyance (if the *enrollee* is paid to participate or to instruct); rodeo sports; horseback riding (if the *enrollee* is paid to participate or to instruct); rock or mountain climbing (if the *enrollee* is paid to participate or to instruct); or skiing (if the *enrollee* is paid to participate or to instruct).
28. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *enrollee* is a pilot, officer, or *enrollee* of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.
29. 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*;
30. Services of a private duty registered nurse rendered on an outpatient basis.
31. Diagnostic testing, laboratory procedures, screenings, or examinations performed for the purpose of obtaining, maintaining, or monitoring employment.
32. For any medicinal and recreational use of cannabis or marijuana.
33. 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.
34. Surrogacy Arrangement. Health care services, including supplies and medication, 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 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; or
j. Any other health care services, supplies and medication relating to a Surrogacy Arrangement.
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 insureds possessing an active policy with us and/ or the child possesses an active policy with us at the time of birth.

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.
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 injectable medication or biological product that is not expected to be self-administered by the *enrollee* at *enrollee's* place of residence unless listed on the formulary.
22. For any claim submitted by non lock-in pharmacy while *enrollee* is in lock-in status. To facilitate appropriate benefit use and prevent opioid overutilization, *enrollee's* participation in lock-in status will be determined by review of pharmacy claims.
23. For any prescription or over the counter version of vitamin(s) unless otherwise included on the formulary.
24. Medication refills where an *enrollee* has more than 15 days' supply of medication on hand.

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*.

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

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*.

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.

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: 1-866-683-5369

Expedited *Complaints*: If *your complaint* concerns an emergency or a situation in which *you* may be forced to leave the *hospital* prematurely, *we* will resolve it no later 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.

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 members shall have direct access to an OB/GYN (who is an exclusive provider) for female services.

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: Aransas, Armstrong, Atascosa, Austin, Bandera, Bastrop, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Brewster, Brooks, Brown, Burleson, Burnet, Caldwell, Calhoun, Cameron, Camp, Carson, Castro, Chambers, Cherokee, Coke, Coleman, Collin, Collingsworth, Comal, Comanche, Concho, Cooke, Dallam, Dallas, Deaf Smith, Delta, Denton, DeWitt, Donley, Ector, Edwards, El Paso, Ellis, Falls, Fannin, Fayette, Fisher, Fort Bend, Freestone, Frio, Galveston, Gillespie, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hartley, Hays, Henderson, Hidalgo, Hill, Hood, Houston, Hunt, Irion, Jack, Jackson, Jefferson, Johnson, Kendall, Kerr, Kimble, Kinney, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Llano, Madison, Mason, Matagorda, Maverick, McCulloch, McLennan, Medina, Menard, Milam, Mills, Mitchell, Montague, Montgomery, Nacogdoches, Navarro, Nueces, Oldham, Orange, Palo Pinto, Panola, Parker, Parmer, Potter, Rains, Randall, Real, Refugio, Robertson, Rockwall, Runnels, Rusk, San Jacinto, San Saba, Schleicher, Scurry, Sherman, Smith, Somervell, Starr, Sterling, Stonewall, Sutton, Tarrant, Tom Green, Travis, Trinity, Tyler, Val Verde, Van Zandt, Victoria, Waller, Webb, Wharton, Wheeler, Willacy, Williamson, Wise, Wood, and Zapata.

The number of effectuated members in Ambetter's *service area* under the Celtic EPO license is currently 328,652. Please refer to the table below for a breakdown of effectuated members based on service area.

Service Area	Total Effectuated Members
Aransas	205
Armstrong	26
Atascosa	904
Austin	537
Bandera	546
Bastrop	1802
Bell	1265
Bexar	14890
Blanco	402
Bosque	176
Brazoria	7172
Brazos	1388
Brewster	106
Brooks	153
Brown	193
Burleson	278
Burnet	736
Caldwell	1022
Calhoun	172
Cameron	14728
Camp	218
Carson	38
Castro	62
Chambers	637
Cherokee	397
Coke	0
Coleman	36
Collin	10098
Collingsworth	9
Comal	1720
Comanche	99
Concho	40
Cooke	353
Dallam	53
Dallas	14974
Deaf Smith	118
Delta	61
Denton	10291
DeWitt	202
Donley	17

Ector	0
Edwards	61
El Paso	16856
Ellis	2566
Falls	352
Fannin	0
Fayette	397
Fisher	50
Fort Bend	32670
Freestone	206
Frio	171
Galveston	4182
Gillespie	2130
Goliad	62
Gonzales	133
Grayson	789
Gregg	1355
Grimes	459
Guadalupe	1258
Hamilton	104
Hardin	40
Harris	59937
Hartley	13
Hays	2788
Henderson	687
Hidalgo	24181
Hill	336
Hood	615
Houston	857
Hunt	1591
Irion	32
Jack	70
Jackson	81
Jefferson	89
Johnson	3194
Kendall	1015
Kerr	1743
Kimble	57
Kinney	28
Lampasas	38
Lavaca	127
Lee	228

Leon	171
Liberty	1695
Limestone	200
Llano	343
Madison	264
Mason	197
Matagorda	550
Maverick	0
McCulloch	140
McLennan	1596
Medina	1228
Menard	29
Milam	95
Mills	56
Mitchell	27
Montague	153
Montgomery	9755
Nacogdoches	786
Navarro	596
Nueces	2136
Oldham	10
Orange	425
Palo Pinto	248
Panola	317
Parker	2073
Parmer	56
Potter	985
Rains	110
Randall	780
Real	69
Refugio	40
Robertson	293
Rockwall	1717
Runnels	0
Rusk	527
San Jacinto	601
San Saba	31
Schleicher	21
Scurry	109
Sherman	14
Smith	1994
Somervell	118

Starr	343
Sterling	0
Stonewall	0
Sutton	31
Tarrant	25587
Tom Green	0
Travis	10800
Trinity	119
Tyler	187
Val Verde	1112
Van Zandt	469
Victoria	571
Waller	1133
Webb	1376
Wharton	550
Wheeler	30
Willacy	1155
Williamson	4882
Wise	944
Wood	293
Zapata	843

Network Demographics

	Provider Type					
Service Area	Primary Care	Pediatrics - Routine/Primary Care	Gynecology (OB/GYN)	Psychiatry	Surgery	Acute General Hospital
Aransas	5	1	0	1	2	0
Armstrong	0	0	0	0	0	0
Atascosa	21	1	1	0	4	2
Austin	6	0	0	0	0	1
Bandera	12	1	1	0	0	0
Bastrop	43	3	9	0	12	2
Bell	70	31	10	32	19	4
Bexar	1621	405	617	105	804	38
Blanco	2	0	0	0	0	0
Bosque	51	0	1	4	3	2
Brazoria	110	21	18	27	32	8
Brazos	272	26	45	16	87	5
Brewster	9	3	8	0	2	1
Brooks	6	3	0	0	0	0
Brown	15	2	0	0	1	1
Burleson	6	0	0	0	0	2
Burnet	52	4	2	4	5	1
Caldwell	65	5	13	1	3	4
Calhoun	11	0	15	0	6	1
Cameron	442	119	130	34	160	4
Camp	20	3	2	1	6	2
Carson	1	0	0	0	0	0
Castro	2	0	0	0	0	2
Chambers	28	0	0	0	0	4
Cherokee	15	6	3	1	7	1
Coke	0	0	0	0	0	0
Coleman	0	0	0	0	0	0
Collin	754	150	218	43	400	18
Collingsworth	0	0	0	0	0	0
Comal	73	7	35	4	11	1
Comanche	14	1	0	1	16	1
Concho	1	0	0	0	0	1
Cooke	23	1	4	0	6	2
Dallam	0	0	0	0	0	0
Dallas	1997	306	312	87	622	28
Deaf Smith	1	0	0	0	2	1
Delta	4	0	0	0	0	0
Denton	472	51	54	15	99	7
DeWitt	73	6	18	0	2	1
Donley	2	0	0	0	0	0
Ector	34	19	20	0	26	2

Edwards	0	0	0	0	0	0
El Paso	601	222	259	99	286	15
Ellis	226	53	3	0	29	2
Falls	7	0	0	0	1	4
Fannin	5	1	0	0	1	1
Fayette	24	3	3	2	14	1
Fisher	1	0	0	0	0	1
Fort Bend	331	48	55	21	95	9
Freestone	0	0	0	0	0	1
Frio	17	0	4	1	1	2
Galveston	88	6	2	28	11	2
Gillespie	52	8	7	1	22	1
Goliad	1	0	0	0	0	0
Gonzales	26	3	1	0	4	1
Grayson	76	13	5	18	30	4
Gregg	77	13	34	15	19	1
Grimes	14	0	0	0	0	1
Guadalupe	22	12	30	0	10	1
Hamilton	39	0	0	0	2	4
Hardin	8	0	0	0	0	0
Harris	2719	766	554	412	885	39
Hartley	0	0	0	0	2	4
Hays	150	42	57	2	59	1
Henderson	25	3	10	0	5	3
Hidalgo	952	300	198	51	257	16
Hill	38	1	0	0	7	1
Hood	29	4	2	0	14	2
Houston	5	0	0	0	3	1
Hunt	72	13	4	24	14	12
Irion	0	0	0	0	0	0
Jack	10	0	0	0	0	2
Jackson	8	3	0	0	1	1
Jefferson	98	15	9	20	14	4
Johnson	48	5	13	3	2	0
Kendall	67	5	15	4	43	0
Kerr	81	5	14	0	24	2
Kimble	6	0	0	0	0	0
Kinney	0	0	0	0	0	0
Lampasas	24	2	1	0	2	1
Lavaca	64	0	0	1	4	5
Lee	4	1	0	2	3	0
Leon	2	0	0	0	0	0
Liberty	23	4	0	2	1	1
Limestone	25	0	0	0	2	8
Llano	13	0	0	0	0	0
Madison	9	0	0	0	0	2
Mason	5	1	0	0	0	0

Matagorda	15	4	12	0	8	2
Maverick	20	3	9	0	4	1
McCulloch	8	0	0	0	3	2
McLennan	135	19	11	17	64	4
Medina	52	0	16	0	5	2
Menard	6	0	0	0	0	0
Milam	13	4	0	0	0	0
Mills	12	0	0	0	0	0
Mitchell	2	0	0	0	0	2
Montague	7	0	0	0	1	0
Montgomery	460	44	71	28	112	13
Nacogdoches	35	12	22	3	12	3
Navarro	31	7	10	0	9	2
Nueces	186	156	65	36	191	18
Oldham	0	0	0	0	0	0
Orange	3	1	0	3	1	1
Palo Pinto	25	2	1	0	2	1
Panola	11	3	8	0	2	6
Parker	37	8	25	4	6	1
Parmer	8	0	0	0	0	0
Potter	227	145	52	23	93	4
Rains	4	0	0	0	0	0
Randall	31	5	2	1	11	0
Real	0	0	0	0	0	0
Refugio	0	0	0	0	2	4
Robertson	2	0	0	0	0	0
Rockwall	80	13	28	1	63	3
Runnels	0	0	0	0	0	1
Rusk	34	4	10	0	10	1
San Jacinto	2	0	0	0	0	0
San Saba	0	0	0	0	0	0
Schleicher	0	0	0	0	0	0
Scurry	16	0	2	0	2	4
Sherman	2	0	0	0	0	0
Smith	153	12	15	10	42	9
Somervell	10	0	0	0	2	2
Starr	80	9	0	0	11	1
Sterling	0	0	0	0	0	0
Stonewall	4	0	0	0	0	2
Sutton	3	0	0	0	0	1
Tarrant	1546	222	340	105	451	25
Tom Green	216	45	49	17	45	4
Travis	1267	642	422	166	740	29
Trinity	9	1	0	0	0	0
Tyler	1	0	0	0	0	1
Val Verde	27	10	18	4	20	2
Van Zandt	4	1	0	0	0	0

Victoria	148	36	20	1	54	6
Waller	2	1	0	0	0	0
Webb	142	45	25	17	36	3
Wharton	43	3	2	0	5	2
Wheeler	0	0	0	0	0	1
Willacy	19	4	5	1	0	0
Williamson	430	200	88	52	230	9
Wise	81	2	3	1	15	8
Wood	27	1	0	0	7	1
Zapata	7	8	4	0	0	0

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					
Service Area	**Primary Care**	**Pediatrics - Routine/Primary Care**	**Gynecology (OB/GYN)**	**Psychiatry**	**Surgery**	**Acute General Hospital**
Aransas						X
Armstrong						
Atascosa						
Austin						
Bandera						
Bastrop						
Bell						
Bexar						
Blanco						
Bosque						
Brazoria						
Brazos						
Brewster		X		X	X	X
Brooks						X
Brown					X	
Burleson						
Burnet						
Caldwell						
Calhoun						
Cameron						
Camp						
Carson						
Castro						
Chambers		X				
Cherokee						
Coke						
Coleman						
Collin						
Collingsworth		X	X	X	X	
Comal						
Comanche					X	
Concho						
Cooke						
Dallam		X	X	X	X	
Dallas						
Deaf Smith						
Delta						

Denton						
DeWitt						
Donley					X	
Ector						
Edwards		X			X	
El Paso						
Ellis						
Falls						
Fannin						
Fayette						
Fisher					X	
Fort Bend						
Freestone						
Frio						
Galveston						
Gillespie						
Goliad						
Gonzales						
Grayson						
Gregg						
Grimes						
Guadalupe						
Hamilton						
Hardin						
Harris						
Hartley		X				
Hays						
Henderson						
Hidalgo						
Hill						
Hood						
Houston						
Hunt						
Irion						
Jack						
Jackson						
Jefferson					X	
Johnson						
Kendall						
Kerr						
Kimble					X	
Kinney					X	
Lampasas						
Lavaca						
Lee						

Leon						
Liberty						
Limestone						
Llano						
Madison						
Mason					X	
Matagorda						
Maverick					X	
McCulloch						
McLennan						
Medina						
Menard						
Milam						
Mills					X	
Mitchell					X	
Montague						
Montgomery						
Nacogdoches						
Navarro						
Nueces						
Oldham						
Orange					X	
Palo Pinto						
Panola						
Parker						
Parmer					X	
Potter						
Rains						
Randall						
Real					X	X
Refugio						
Robertson						
Rockwall						
Runnels						
Rusk						
San Jacinto						
San Saba					X	
Schleicher						
Scurry					X	
Sherman			X	X	X	
Smith						
Somervell						
Starr						
Sterling						

Stonewall		X			X	
Sutton						
Tarrant						
Tom Green						
Travis						
Trinity						
Tyler						
Val Verde					X	
Van Zandt						
Victoria					X	
Waller						
Webb					X	
Wharton						
Wheeler				X	X	
Willacy						
Williamson						
Wise						
Wood						
Zapata					X	

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

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.