

2027

InHealth

Major Medical Expense Coverage

This Policy provides benefits for Covered Services through a Health Maintenance Organization (HMO); services are generally available only when received from InHealth Network Providers.

Benefits are provided in-Network only. In order to obtain benefits, you must receive care from the Network Primary Care Physician (PCP) we designate. Your Network Primary Care Physician will be able to coordinate all Covered Health Care Services and submit electronic referrals online to InStil Health for services from Network Physicians. For children, you may designate a pediatrician as the PCP. No benefits are provided for services received out-of-Network unless the service is due to an Emergency Medical Condition and the services are provided at an Urgent Care Center or Hospital Emergency Room. You do not need Prior Authorization from InHealth or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the InHealth at 833-738-0978.

This contract is based on federal and state laws and regulations. If laws or regulations are updated during a contract year, the contract is revised to be consistent with the updated law or regulation.

This product is intended to be fully compliant with the Affordable Care Act and any later federal or state laws. When we receive your application, we will issue you this Policy and an ID card, but the Policy will not be in effect until we receive any payment due from you, including your portion of the first month's premium.

Guaranteed Renewable Except for Stated Reasons

This Policy renews each calendar year and you can continue coverage by paying the Premium required by the first of each calendar month or within the grace period. At the end of each year, if you do not change plans during an Open Enrollment period, this plan will automatically renew.

We can cancel this Policy if:

1. You fail to pay Premiums according to the terms of the Policy; or
2. We determine you have committed an act or practice that constitutes fraud or an intentional misrepresentation of a material fact under the terms of the Policy, we will provide 31 days notice to each person covered by the Policy; or
3. We decide to discontinue offering InHealth for everyone who has this Policy. If we discontinue the product, we must:
   a. Provide notice to each individual covered by this Policy of the discontinuance at least 90 days before the date the Policy is discontinued or within time frames as directed by a governmental agency;
   b. Offer each individual covered by this Policy the option to purchase other individual Health Insurance Coverage currently offered by us; and
   c. In exercising the option to discontinue the Policy or offering the option to purchase other individual coverage, we act uniformly without regard to any Health Status-related Factor.
4. If we decide to discontinue offering all products in the Individual market in South Carolina, we will provide 180 days notice to each person covered by the Policy.

At the time of renewal, we may modify this Policy for everyone who has it as long as the modification is consistent with federal and state law and effective on a uniform basis. However, we cannot cancel your Policy simply because of a change in your health.

Premiums

The benefits described are available if the required Premium is paid on time.

We base Premiums on coverage selected, tobacco use, age, where you live at the time this Policy is issued, and regulatory fees and taxes as required by the Affordable Care Act. The Member Schedule shows the Premium as of the Effective Date. Premiums may only be changed at the beginning of your Benefit Period. At least 31 days prior to your new Benefit Period, you will receive notice of your new Premium and any benefit changes for the new Benefit Period. If you receive a Special Enrollment Period and select a new benefit option, your premiums may also change as of the date your benefit option changes **If you receive an Advance Premium Tax credit, the amount you are billed each month is reduced by the tax credit you receive. If the tax credit changes at any time during the Benefit Period, your billed premium will change. This change will occur as directed by the Health Insurance Marketplace and may occur without notice to you.**

If the Member's age, tobacco use or residence has been misstated and if the amount of the Premiums is based on these factors, an adjustment in Premiums, coverage, or both, will be made based on the Member's true age, tobacco usage or residence.

Your Premiums are not affected by Health-Status Related Factors (except for tobacco use), race, color, national origin, disability, sex, expected length of life, degree of medical dependency or quality of life.

Right to Examine Policy for Thirty Days

If you aren't satisfied with this Policy, return it to us or your agent within 30 days after it is received. All Premiums will be refunded and may be reduced by any claims that have been paid. If the Policy is returned, it will be void from the beginning. The parties will be in the same position as if no Policy had been issued. Please note however: the return of this Policy is not considered reason for a Special Enrollment Period if your coverage is purchased through the Marketplace.

Important Notice Concerning Statements in Your Application for Insurance

The Application is a part of your Policy. If a statement on your Application or enrollment records is an intentional misrepresentation of material facts related to your eligibility for coverage, or you perform an act or practice that constitutes fraud, we may have grounds to rescind the Policy. A rescission does not include a retroactive cancellation or discontinuance of your coverage due to the failure to timely pay Premiums. If the Policy is rescinded, we will provide 30 days written notice and refund Premiums; your refund may be reduced by any claims that have been paid. After this Policy has been in force for two years, we cannot use any statement made in any Application (unless fraudulent) to void the Policy or deny any claim incurred after the two-year period.

This Policy contains a requirement for Preauthorization of certain services. See the Preauthorization Section for details.

The Policyholder hereby expressly acknowledges understanding this Policy is solely with InStil Health. The Policyholder further acknowledges and agrees to have not entered into this Policy based on representations by any person other than InStil Health. No person, entity or organization other than InStil Health shall be held accountable or liable to the Policyholder for any of InStil Health's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of InStil Health other than those obligations created under other provisions of this Policy.

InStil Health Insurance Company

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This Policy generally provides benefits for Covered Services only when received from in-Network Providers.

Introduction

This Policy is a Qualified Health Plan. If at any time this Policy is considered no longer "Qualified," coverage will end as specified in the Eligibility section.

Please take time to review this Policy carefully. You'll find a complete list of benefits, instructions on how to use your benefits wisely, tips on how to make the most of your coverage, how to file claims and who to call when you have a question. There also are important sections explaining your benefits and commonly used terms. The terms "we," "us" or "our" refer to InStil Health. The term "you" or "your" refers to the named insured person. No agent, employee or representative of InStil Health has the authority to waive or change any of the requirements within the Application or waive or change any of the provisions within this Policy.

There are no dollar limits on Essential Health Benefits. Except for Emergency Services for an Emergency Medical Condition, benefits generally are available in the InHealth Network only from Network Providers.

This InHealth product uses a Health Maintenance Organization (HMO), meaning it has a more limited, restricted provider network. This Policy only provides benefits for Covered Services received from InHealth Providers who specifically participate in the InHealth Network. This Policy does not cover services rendered by out-of-Network Providers (except for Emergency Services as defined in this Policy and other very limited situations). Services provided outside the InHealth Network are only available for air ambulance services as described herein; to treat an Emergency Medical Condition when those services are received in a Hospital Emergency Room or free-standing Emergency Room, for as long as your condition continues to be considered an Emergency (with the exception of certain covered post-stabilization services); or for non-Emergency treatment at certain in-Network facilities where you receive services from an out-of-Network Provider. Always ask to make sure your Provider is an InHealth Provider to ensure benefits are available. In addition, be sure the Provider's location is in the InHealth Network.

If you receive out-of-Network services in one of the scenarios described above, benefits are provided at the in-Network Coinsurance amount, based on the Recognized Amount. The Allowed Amount we pay for the out-of-Network Hospital or free-standing Emergency Room charges will be no less than the amount required under applicable law. Please see the section entitled "Special Out-of-Network Rules" below for more information.

InHealth encourages early identification and management of health problems to improve health outcomes and help reduce health care costs. We may offer wellness programs and other services to members in connection with this policy, to promote health and prevent disease. These programs and services are not insurance and are available to you at no additional cost. Rewards, discounts, and incentives may be available through participation in a wellness program. Participation in a wellness program is optional. If you have a medical condition that may prohibit you from participating in a wellness program, please contact our customer service area regarding your options. Wellness program terms and conditions may change at any time. When you purchase this product, you are agreeing to participate in disease management programs that may be offered to you based on your filed claims. Disease management may include fully responding to questions during appointments, responding to phone calls, or participating in a health questionnaire or other follow-up.

In addition, our process involves evaluation and Preauthorization of all Hospital Admissions (except for Emergency admissions or unless otherwise specified in this policy), whether a scheduled Admission or any continuation of a Hospital stay was longer than originally Preauthorized. Preauthorization is also required for certain services in order to receive maximum benefits available under this Policy. See the Preauthorization section for services that require Preauthorization.

InStil Health Insurance Company does not discriminate on the basis of race, color, national origin, age, disability, sex (consistent with the scope of sex discrimination under Section 1557 of the Patient Protection and Affordable Care Act),or health status in the administration of the plan, including enrollment and benefit determination. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. For questions about your coverage, please contact InStil Health as shown below.

How to Contact Us if You Have a Question

It is only natural to have questions about your coverage and we are committed to helping you understand your coverage so you can make the most of your benefits.

Your Fastest Place for Answers – https://instilhealth.com
If you have access to the Internet, you can find quick and easy answers to your health coverage questions any time day or night. When you go to our website, you will find useful tools that can help you better understand your coverage.

Here are some of the things you can do on our website:
- Learn more about our products and services.
- Find links to other health-related websites.
- Locate a Network Provider, including a Physician, Hospital or Pharmacy.
  Go to: https://instilhealth.com/links/2027/providers
- Use My Health Toolkit®.

My Health Toolkit
Visit https://instilhealth.com and access My Health Toolkit to:
- Check your eligibility.
- See how much has been applied toward your Deductible or Out-of-pocket Limit.
- Check on Authorizations.
- Check the status of your claims.
- Order a new ID card.
- See if our records show if you have other Health Insurance.
- Ask a Customer Advocate a question through secure email.
- View your Explanation of Benefits (EOB).
- Go paperless with our on-line bills and Explanations of Benefits.
- Pay your bill.
- Estimate cost for certain prescription drugs.
- Rate your doctor.
- View your contract/policy documents, including your Summary of Benefits and Coverage (SBC).

For Customer Service Inquiries
You can also contact InStil Health by telephone or mail.

CALL	833-738-0978 Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time
TTY	855-889-4325 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:30 a.m. to 5:30 p.m. Eastern Standard Time
FAX	803-870-9439
WRITE	InStil Health Post Office Box 100228 Columbia, SC 29260-6000
E-MAIL	Instil.membership@instilhealth.com for questions
WEBSITE	https://www.instilhealth.com

Your Rights and Responsibilities

As a Member, you have certain rights. You also have some responsibilities. As part of our ongoing efforts to keep you informed, we have listed your rights and responsibilities below.

You have the right to:

- Be treated with respect and recognition of your dignity and right to privacy.
- Get the information you need to make thoughtful decisions by using your PCP before choosing a treatment plan.
- Constructively share your opinion, concerns or complaints.
- Receive information from InStil Health regarding services provided or care received.

You have the responsibility to:

- Carefully read all health plan materials provided by InStil Health after we accept you as a Member.
- Notify us if any information on your enrollment is or was incorrect.
- Ask questions and make sure you understand the information given to you.
- Present your InStil Health ID card prior to receiving services or care.
- Inform InStil Health of any information that affects your coverage, including any other insurance you may have.
- Select a representative to act on your behalf in the event you are unable to represent yourself.
- Pay your cost share amounts, including your Premium.
- Tell us if you move.

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) gives an overview of the benefit options of your insurance plan. All insurance companies are required to provide you with an SBC, which is in a format required by the government. You can find your SBC by going to My Health Toolkit.

You may also contact a Customer Service Advocate and ask us to send you a copy of the SBC. We can send it to you electronically or mail a paper copy (free of charge). Please note: the format and content of an SBC is controlled by federal agencies. In the event of an inconsistency between the SBC and these Policy documents, these Policy documents are controlling.

Preauthorization

Preauthorization is also called prior authorization, prior approval or precertification. It is important to understand what Preauthorization means. It means the service has been determined to be medically appropriate for the patient's condition. **A Preauthorization does not guarantee that we will pay benefits.**

Preauthorization must be obtained for certain categories of benefits; a failure to get preauthorization may result in benefits being denied. We will make our final benefit determination when we process your claims. Even when a service is preauthorized, we review each claim to make sure:

- The patient is a Member under the Policy at the time service is provided; and
- The service is a Covered Service (Policy limitations or exclusions may apply); and
- The service provided was Medically Necessary as defined by your Policy, including appropriateness, health care setting, level of care, and effectiveness.

A Preauthorization may only be for a specific period of time or number of visits/treatments. If you have any questions about this, please contact InStil Health.
If your request for Preauthorization of services is denied, you can request further review; see the Appeal Procedures Section of this Policy. Preauthorization denials are considered denied claims for purposes of appeals and grievances.

Network Providers in South Carolina will be familiar with the requirement to obtain Preauthorization and will get the necessary approvals. If a Network Provider in South Carolina does not get Preauthorization, it cannot balance-bill you. Any services received outside the Network that are not for an Emergency Medical Condition or Urgent Care *must be preauthorized*.

For some services to be covered out-of-Network, you will be required to use a Provider we designate. If the Provider we designate is not an in-Network Provider, benefits may be provided in accordance with a Letter of Agreement or the Allowed Amount. These Providers may be permitted to bill you the difference between what we agreed to pay, and the full billed charges for a service.

For transplant services to be covered (in-Network or out-of-Network), you will be required to use the Provider we designate.

To use the InStil Health Preauthorization process, call the numbers listed in the table below to reach the appropriate medical services personnel. Below is the list of services that must be Preauthorized. For Preauthorization requirements for Prescription drugs, please see the Prescription Drug section of this Policy.

The following services or benefits require preauthorization. Your Network Provider should obtain any needed authorization; however, you remain responsible for any unauthorized charges or services and your in-Network Provider should not balance-bill you.

Types of services	Who to Call:
Non-Emergency Hospital Services (not required for maternity/newborns; see next page) Habilitation or Rehabilitation (including Inpatient Rehabilitation) Human Organ and/or Tissue Transplants Skilled Nursing Facility (SNF) Continuation of Inpatient or Skilled Nursing Facility admission (remaining as Inpatient longer than originally approved) Cardiac rehabilitation (Phase 1 and 2) Pulmonary rehabilitation	In Columbia 803-736-5990 In S.C. 800-327-3238 Outside S.C. 800-334-7287
Outpatient facility admissions for services Surgery (including pre-authorization for anesthesia) Dialysis (hemodialysis or peritoneal), including home dialysis (when required criteria are met)	
Home Health Care or Hospice Services	
Durable Medical Equipment; supplies used with the DME must be Preauthorized every 90 days.	
Treatment for hemophilia - care must be coordinated through a Center for Disease Control and Prevention (CDC) designated Hemophilia Treatment Center. You must see a Provider at the designated Hemophilia Treatment Center within 60 days of the beginning of your Benefit Period.	
Treatments for Varicose Veins and Venous Insufficiency	
Colonoscopies when not for screening/preventive purposes	
Virtual colonoscopies and capsule endoscopies	
Inter-Disciplinary Pain Management Program	
Ambulance Services for non-Emergency transport	
Inpatient admissions for Behavioral Health treatment Residential Treatment Center (RTC) Continuation of an Inpatient or RTC admission (remaining as Inpatient longer than originally approved) Outpatient/office diagnostic and therapeutic: Psychological testing, rTMS, ECT Outpatient facility admissions for services: Intensive outpatient and Partial Hospitalization Programs Applied Behavioral Analysis (ABA) Therapy related to Autism Spectrum Disorder	Companion Benefit Alternatives, Inc. (CBA) – In Columbia 803-699-7308 Outside Columbia 800-868-1032
Outpatient/office diagnostic MRI, MRA, PET scans and CT scans Radiation oncology Musculoskeletal/spine management (interventional pain management, lumbar and cervical spine surgery) services. Virtual colonoscopy or CT Colonography Diagnostic Cardiology Interventional Cardiology Physical Medicine Joint Program (select hip, knee, shoulder procedures)	Evolent 866-500-7664
Genetic Counseling and Testing, including Prenatal Screening and Mutation Analysis	Avalon Health Services, LLC 844-227-5769
Prescription Drugs, Specialty Pharmacy medications, Injections/ Injectable drugs; medications that require special handling or exceed allowed quantities (See Prescription Drug section for details.)	OptumRx Customer Service 855-823-0387

Evolent is an independent company that preauthorizes certain radiological procedures on behalf of InStil Health.

Companion Benefit Alternatives, Inc. is a separate company that preauthorizes Mental Health and Substance Use Disorder services on behalf of InStil Health.

Avalon Health Services, LLC is an independent company that preauthorizes certain laboratory services and procedures on behalf of InStil Health.

OptumRx is an independent company that provides pharmacy benefit management services on behalf of InStil Health.

Hospital Admission for Maternity/Newborns – No Preauthorization is required for a mother's admission or hospitalization related to the delivery of a newborn child when the hospital stay is 48 hours or less for a vaginal birth or 96 hours or less for a cesarean section. The day of delivery, Surgery or birth is not counted in the 48 or 96 hours. If you or the newborn are not released within these timeframes, you or your Provider should contact InStil Health for authorization for a continued stay. If you are in a Network Hospital, the Hospital should contact us for this authorization.

You have 60 days to add a newborn child to your coverage or to obtain other coverage for the child; see the *Eligibility, Coverage and When your Coverage Ends* section. Coverage is not automatic and until the newborn is covered under this policy, we cannot process benefits or approve a Preauthorization if the child needs a continued stay in the Hospital. We recommend that you add the newborn to this coverage (or other coverage, if you prefer) as soon as possible after birth to ensure benefits for that child are processed timely.

Emergency Hospital Admissions — If you experience an emergency illness or injury, seek immediate medical assistance. An Emergency is an unexpected and usually dangerous situation that requires immediate medical attention at a Hospital Emergency Room. An Emergency Medical Condition is an illness, symptom or condition so serious that a reasonable person would seek medical care immediately to avoid serious harm, including illness or injury to an unborn child. If you are Admitted to a Hospital due to an Emergency Medical Condition, your Admission will be unexpected, so no pre-approval or preauthorization is required; however, we should be notified of the Admission as soon as possible. Our medical services personnel must be notified within 24 hours or by 5 p.m. of the next working day, or as soon as reasonably possible, if you are admitted to the Hospital. Otherwise, we will not provide benefits for the hospitalization. If an Emergency Admission approval is not obtained within this timeframe due to circumstances beyond your control, an appeal can be made and the Admission will be reviewed to determine if it was Medically Necessary to admit you to the Hospital for an Emergency Medical Condition.

A Provider may be considered an Authorized Representative without a specific designation by you only when the approval request is for Urgent Care Claims (medical conditions which require immediate treatment). For all other types of claims, a Provider can appeal an adverse determination only when you give the Provider a specific designation to act as your Authorized Representative.

Special Out-of-Network Rules

If you receive treatment from an out-of-Network Provider as described below, your treatment may be covered and your costs may be comparable to those received from an in-Network Provider, but only if one of the below exceptions applies. The Provider must be an out-of-Network Provider (physician or other clinician, or facility not in our Network) and, in these limited situations, we will treat the Provider as though it was in-Network for purposes of determining your cost share liability and will pay the Provider our portion of the claim directly. You will still be required to meet any in-Network cost share amounts under all other terms of this coverage, and those in-Network cost share amounts will be based on the Recognized Amount. These are the only circumstances in which InStil Health will allow for out-of-Network services without prior authorization and approval.

- You are treated in the emergency department of a hospital or a free-standing emergency department where the facility or a treating Provider is not in-Network. In emergency situations, no prior authorization is required. For services furnished after your condition has stabilized, as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the emergency department visit where emergency services were furnished, if the Provider or facility provides you (or your authorized representative) with an advance notice, and obtains your (or your authorized representative's) signed consent to be treated on a non-Network basis, these rules will not apply.
- You seek non-Emergency treatment at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center, but during your treatment, you receive services from a non-Network Provider. An example of this would be if you have surgery performed in a Network Hospital; your surgeon is in our Network, but the anesthesiologist is not in our Network. In some cases, if the Provider or facility provides you (or your authorized representative) with an advance notice and obtains your (or your authorized representative's) written consent to be treated on a non-Network basis, these rules will not apply.
- If it is Medically Necessary for you to be transported by an air ambulance company not in our Network.

If you need assistance because one of the above actions has occurred, please contact us using the information on the back of your ID card or as shown in the section above titled "How to Contact Us."

Eligibility, Coverage, and When Your Coverage Ends

Eligibility

Every Qualified Individual or Enrollee who applies for coverage during a Special or Open Enrollment Period will be accepted for coverage if the applicant is a South Carolina Resident and resides in the InHealth service area, which includes Chesterfield, Darlington, Florence, Spartanburg and York counties of South Carolina. Children are eligible to enroll for coverage as a Dependent through age 25. Gaining or losing a Dependent in your household may affect your eligibility for Premium Tax Credits and your eligibility for a Special Enrollment.

This product is considered to be a duplication of Medicare coverage. If you are entitled to or enrolled in Medicare coverage, you cannot lawfully purchase this product.

Effective Date of Coverage

The date on which coverage for a Member begins under this Policy is called the **Effective Date**. Your Effective Date is shown on your Member Schedule.

You may enroll in coverage every year during the annual Open Enrollment Period. You may enroll at other times during the year only if you qualify for a **Special Enrollment** such as one of the situations described below.

Special Enrollment

A **Special Enrollment** occurs when you fall into one of the situations described below. In all situations, you must be a Qualified Individual, an Enrollee or Dependent to enroll. If you believe you meet the requirements for a Special Enrollment, you can:

- Contact the Health Insurance Marketplace
- Enroll on www.Healthcare.gov
- Contact your agent
- Enroll on www.instilhealth.com

Note: Special Enrollment Periods (SEP) are defined and regulated by federal regulation. Changes to the regulations may override the information shown below. This is not an all-inclusive list. You are not entitled to an SEP if your prior coverage did not qualify as Minimum Essential Coverage or if you did not have such coverage within 60 days before the triggering event (if applicable).

Triggering Event	Details about qualifying for a Special Enrollment Period
1. If you lose qualifying health coverage, such as:	• Coverage through a job, or through another person's job. This also applies if you're now eligible for help paying for coverage because your employer stops offering coverage or the coverage isn't considered qualifying coverage. • Expiration of COBRA (if elected). • Medicaid or Children's Health Insurance Program (CHIP) coverage (including pregnancy-related coverage and medically needy coverage). • Medicare. • Individual or group health plan coverage where the benefit period ends during the year and you choose to move to Marketplace coverage; this also includes student health insurance if it was qualifying coverage. • Coverage under your parent's health plan (if you're on it), including when you turn 26 or the maximum dependent age allowed under the plan and lose coverage. **Note:** This Special Enrollment Period doesn't include loss of coverage because you didn't pay your premiums (except where you lose all employer contributions or government subsidies for COBRA coverage, described below), you voluntarily dropped coverage, your prior coverage did not qualify as Minimum Essential Coverage, or the issuer finds fraud or misrepresentation.
2. Change in household size, if you:	• Got married. One spouse must have had qualifying health coverage for at least one day in the 60 days prior to the marriage or have been living outside the United States, in a U.S. territory, or in a service area where no qualified health plan was available. • Had a baby, adopted a child, or placement for adoption or foster care. • Got divorced, legally separated, or had a death in the family and lost health coverage. • Gained or became a dependent due to a child support or other court order.
3. Change in primary place of living so that you now have access to new Marketplace plans, including: Y*ou must show qualifying health coverage for at least one day in the 60 days before your move, unless no QHP was available. Examples are moving from a foreign country, US territory, or service area where no QHP was sold.*	• Moving to a new home. • Moving from a service area where no qualified health plan was available to an area where one is available. • A student moving to or from the place he or she attends school. • A seasonal worker moving to or from the place he or she lives and works. • Moving to or from a shelter or other transitional housing. **Note:** Moving only for medical treatment or staying somewhere for vacation doesn't qualify you for a Special Enrollment Period.
4. Change in eligibility for Marketplace coverage or help paying for coverage, if you: .	Whether enrolled through the Marketplace or through a private (non-Marketplace) plan: • Become newly eligible or ineligible for advance premium tax credits (APTC). • Have a change in eligibility for Cost-Sharing Reductions (such as for out-of-pocket costs or copayments). If you become newly ineligible for Cost-Sharing Reductions and are enrolled in a silver-level plan in the Marketplace, you may change to a plan that is one metal level higher or lower (i.e., gold or bronze). • Become newly eligible for Marketplace coverage because you've become a U.S. citizen, U.S. national, or lawfully present individual or after being released from incarceration (detention, jail, or prison). • Gain or maintain status as a member of a federally recognized tribe or an Alaska Native Claim Settlement Act (ANCSA) Corporation shareholder; you can change plans once per month. • Become newly eligible for help paying for Marketplace coverage because you moved to a different state and you were previously both of these: o Ineligible for Medicaid coverage because you lived in a state that hasn't expanded Medicaid.

	• Are enrolled in COBRA for which you are receiving employer contributions or government subsidies, and the employer contributions or government subsidies completely cease.
5. Enrollment or plan problems, such as if you:	• Weren't enrolled in a plan or were enrolled in the wrong plan because of: o Misinformation, misrepresentation, misconduct, or inaction of someone working in an official capacity to help you enroll (like an insurance company, navigator, certified application counselor, agent, or broker). o A technical error or another Marketplace-related enrollment delay. o The wrong plan data (like benefit or cost-sharing information) was displayed on www.HealthCare.gov at the time that you selected your health plan.
6. Other qualifying changes	• You applied for Medicaid or Children's Health Insurance Program (CHIP) coverage during the Marketplace Open Enrollment Period, or after a qualifying life event, and your state Medicaid or CHIP agency determined you or they weren't eligible. • You are a victim of domestic abuse or spousal abandonment and want to enroll in a health plan separate from your abuser or abandoner. • You submitted documents to clear a data matching issue after your prior coverage was ended. • You are an AmeriCorps service member starting or ending AmeriCorps service. • You can show you had an exceptional circumstance that kept you from enrolling in coverage, like being incapacitated or a victim of a natural disaster. • You or a dependent has new access to an individual coverage HRA or is newly provided with a qualified small employer health reimbursement arrangement, whether or not the HRA was previously offered, or you were previously enrolled, so long as you are not enrolled on the day prior to the new enrollment. • You learn, or reasonably should have known, about an event that triggers your eligibility for an SEP where you previously did not receive timely notice and were otherwise unaware of the event.

A Special Enrollment must be requested within 60 calendar days of the triggering event. We may request documentation to confirm you had a qualifying event and that you are entitled to a Special Enrollment Period.

Situations that do not qualify for a Special Enrollment Period:

- Being terminated from other coverage for not paying premiums or for fraud
- Divorce or death of a family member without a resulting loss of coverage
- Moving solely for medical treatment or vacation
- Changing from one legally present status to another (e.g. consumer who becomes a U.S. citizen who was previously a lawfully present individual)

Effective Date for Special Enrollment

Most Special Enrollments are eligible to receive coverage beginning the 1st day of the month after the selection.

Some Special Enrollments are eligible for other or additional Effective Date options. Examples include:

- For birth, adoption, placement for adoption or foster care, or as a result of a court order, your coverage Effective Date will be the date of the event, unless you specifically choose to begin coverage on the first day of the month following the date of birth, adoption, placement, or court order.
- For marriage, your coverage Effective Date is the first of the month following your selection of a plan; for example, if you get married on January 31st and immediately request coverage, your coverage will be effective February 1st. If you wait to request coverage until February 1st, coverage will be effective March 1st.
- For a loss of Minimum Essential Coverage or a loss of subsidies for COBRA or state continuation coverage (employer or government contributions end), the Effective Date depends on when you request coverage and

the date the loss of coverage occurs. You have 60 days before and 60 days after the loss of Minimum Essential Coverage or a loss of subsidies to make a plan selection. The Effective Date, though, will always be the first day of the month after plan selection, or the date you lose coverage or subsidies, whichever comes last (unless otherwise specified by the Marketplace).
    - Example: You are told on April 3 that you will lose Minimum Essential Coverage on May 31. You can choose a plan at any time prior to May 31 and your new coverage will be effective on June 1. However, if you choose a new plan after you have lost Minimum Essential Coverage, your new plan will be effective on the first of the month following your plan selection.
    - If you lose a subsidy for COBRA or state continuation coverage, the date the government or employer ends its subsidy is the date on which you are eligible for an SEP. If you make a plan selection after this date, your new plan is effective the first of the following month. You have 60 days before and 60 days after this date to make a plan selection.
- If you gain access to an individual coverage HRA (ICHRA) or a qualified small employer HRA (QSEHRA), and your plan selection is made before the triggering event (*i.e.*, the first day that coverage under the ICHRA can take effect, or that coverage under the QSEHRA takes effect, as applicable), your coverage effective date will be the first day of the month following the triggering event, unless the triggering event occurs on the first of the month (in which case your coverage effective date will be the date of the triggering event). If your plan selection is made on or after the triggering event, your coverage effective date will be the first day of the month following plan selection. For example, if you gain access to an ICHRA or QSEHRA as of July 1 and you select a plan on or before July 1, coverage will begin July 1. If you select a plan on July 2, coverage will be effective August 1.
- If you learn, or reasonably should have known, about an event that triggers your eligibility for an SEP where you previously did not receive timely notice and were otherwise unaware of the event, you may elect to have your coverage take effect as of the earliest effective date that otherwise would have been available for that triggering event.

Adding your Spouse
You may add your new spouse during a Special or Open Enrollment Period by enrolling and paying the additional full Premium required. Your spouse will not be covered until we receive the enrollment and required Premium.

Adding a Child
If you or your spouse gives birth, adopts a child or a child is placed with you or your spouse for foster care or legal guardianship while this Policy is in force, or if you are ordered to provide coverage as the result of a court order, then the child is eligible to receive benefits for Medically Necessary covered services and supplies from the moment of birth, adoption, placement, or court order. This includes any necessary care and treatment of medically diagnosed birth defects, diseases and anomalies or complications arising from a premature birth. Coverage is not automatic; you must add the child within 60 days of the birth, adoption or placement along with payment of the appropriate Premium in order for the coverage to be effective from the moment of birth, adoption or placement. Claims for services or benefits cannot be processed until the child is added to the coverage and the applicable premium has been received.

Dependents added to your coverage during a special enrollment period will be covered on the same basis as any other dependent.

A child is considered “adopted” or as being under legal guardianship (foster care) on the date the child is placed in your home. The child is no longer considered “adopted” or under your legal guardianship on the date placement is disrupted and the child is removed from placement with you or your spouse. A dependent covered under a court order is no longer eligible for coverage if a later court order transfers responsibility for coverage to any other person. Terminations will be effective as outlined below.

Premium Payment

The Premium is the amount that must be paid for your health insurance or plan. The Premium for this Policy is due on the 1st of each month. If you are eligible for an Advance Premium Tax Credit, the amount you are billed each month may be reduced by the tax credit. If your tax credit changes during the Benefit Period, the amount you are billed will change to reflect the new tax credit.

You are responsible for all Premiums due for your coverage, including for dependents included on your coverage. ***We will not accept payment of your premiums from any health care provider, health agency, health entity, public or private institution or any other person or entity which does not have an insurable interest.*** We only accept premium payments and co-payments from you or

a. Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
b. Indian tribes, tribal organizations or urban Indian organizations; and
c. State and Federal Government programs.
d. An employer for an employee under an Individual Coverage Health Reimbursement Account (ICHRA) or Qualified Small Employer Health Reimbursement Account (QSEHRA) plan.

You may pay your Premiums electronically or we will bill you monthly. At any time, we may notify you that no premium is due for coverage for a certain period of time. The notification will include the reason for the waiver of premium and the length of time the waiver is in effect. This can occur when we need to refund money to you or in situations involving a medical loss ratio rebate (see the *Medical Loss Ratio* section). We are under no obligation to waive your premium and the fact that we may do so does not obligate us to waive premium in the future.

Grace periods and Reinstatement

This Policy has a grace period for Premium payments. This means if your Premium is not paid on or before the date it is due, it may be paid during the grace period. **If the Premium has not been paid by 12:01 a.m. of the day following the end of the grace period, your coverage will automatically terminate without further notice to you. Any claims paid after the last Premium paid date does not extend this coverage.**

Coverage obtained through the Health Insurance Marketplace with APTC – If you have paid at least one month's Premium and are receiving the APTC at the time of the Premium due date, your grace period is three months. Benefits will be provided according to your coverage during the first month of the grace period. Benefits are not allowed for services provided during the second and third month of the grace period until your Premium is paid in full. If premiums are not fully paid by the end of the grace period, this Policy will terminate effective on the first day of the second month of the three-month grace period. In order for your account to be considered out of the grace period, you must pay any Premium due in full to bring your account current and out of the delinquency grace period.

Example: You enroll in coverage on January 1. You miss your April Premium payment, but on May 15, you send in one month's Premium. You are not able to make another Premium payment. On July 1, your coverage will be cancelled back to May 1. You have a grace period of three months, but at the end of three months, your Premiums must be paid in full or coverage is cancelled. *If you are cancelled for non-payment of Premium and were receiving APTC, you cannot be reinstated.* You will not be eligible to purchase a Marketplace plan until the next Open Enrollment, unless you have a qualifying event that allows you a Special Enrollment Period, such as marriage, the birth of a child, or a similar event. During this uninsured period, you will be responsible for paying your medical bills.

Coverage purchased on the Health Insurance Marketplace without APTC – If you are not receiving APTC at the time of a Premium due date, the grace period is 31 days. Benefits will not be allowed during the grace period until Premiums are paid in full. Premiums not fully paid by the end of the 31-day grace period will cause this Policy to terminate without further notice, effective as of the Premium due date. If your Policy is cancelled, you cannot be reinstated. You will not be eligible to purchase a Marketplace plan until the next Open Enrollment, unless you have a qualifying event that allows

you a Special Enrollment Period, such as marriage, the birth of a child, or a similar event. During this uninsured period, you will be responsible for paying your medical bills.

Coverage purchased on the Private Marketplace/not through the Health Insurance Marketplace - If you did not purchase your Policy through the Health Insurance Marketplace, you have a grace period of 31 days. This Policy shall continue in force during the grace period. If Premiums are unpaid at the end of the grace period, your coverage will automatically terminate without further notice to you.

The Policy may be reinstated, if:

a. You request reinstatement; and
b. The unpaid Premium is not more than 60 days overdue; and
c. You pay all overdue and currently due Premiums; and
d. We approve your request for reinstatement.

The Policy will be reinstated on the date the Policy terminated, if requirements (a) through (d) above have been met. If your request is not approved, we will refund the Premium submitted. After the Policy is reinstated, both parties will have the same rights as existed just before the due date. Any claims you incurred during the period Premiums were unpaid may be submitted to us for processing under the benefits of this Policy. Any amendments to the Policy will still apply and remain effective after reinstatement.

Non-Discrimination

Receiving APTC does not affect your eligibility for this coverage or the amount of your Premiums, nor does this tax credit prevent you from taking any action to enforce your rights under applicable law.

Health Status-Related Factors, race, color, national origin, age, disability, sex expected length of life, degree of medical dependency or quality of life will not affect your eligibility for this coverage. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. If you have questions about your coverage, please contact InStil Health at the number shown in the "How to Contact Us" section for more information.

Premiums may not be increased, coverage cannot be denied and wellness incentives may not be reduced or withheld based on the lawful ownership, possession, use or storage of a firearm or ammunition.

Termination of Insurance

Coverage will end at 12:01 a.m. Eastern Standard Time:

a. Within 14 days after we receive your request for termination or on the specific date you request, if later; or
b. The last day of the month following the month you receive notice from the Health Insurance Marketplace you or a dependent is no longer eligible for coverage offered through the Health Insurance Marketplace;
c. On the date this Policy is no longer considered a Qualified Health Plan or is not renewed;
d. On the date the Policy terminates due to non-payment of Premiums;
e. On the Policy Effective Date if rescinded or otherwise terminated retroactively to such Effective Date;
f. If you are determined to be no longer eligible for coverage, the day following the last day of the month following the month in which you received notice of your ineligibility;
g. For your spouse's coverage, if you and your spouse divorce or are legally separated (if applicable), the Premium due date following the date of divorce or legal separation;
h. For a Dependent (other than a spouse) who reaches age 26, the end of the benefit period in which the Dependent reaches age 26. An Incapacitated child's coverage, however, will not end because he or she reaches age 26.
i. If we receive a termination from the Health Insurance Marketplace/FFM, as of the date specified by the Marketplace/FFM.
j. If you move out of the State of South Carolina, the end of the month following your move, unless you request an earlier termination.

For this coverage to be considered a Qualified Health Plan, InStil Health must be determined to be a Qualified Health Plan issuer and the plan must be certified that it meets all the requirements of the Health Insurance Marketplace regulations. If InStil Health receives notification either that it is no longer certified or the plan is no longer considered qualified, your coverage will not end until we have notified you and you have had the opportunity to enroll in other coverage. If we decide to not seek recertification of this Plan, we will give you 90-days written notice and coverage will not end until the end of your Benefit Period.

We will provide benefits to the end of the period for which we accepted Premiums or as required by the Health Insurance Marketplace.

We will not cancel this Policy retroactively and refund any Premium, whether or not you had any claims during that period of time except in case of death or when coverage is rescinded.

Continuation of Coverage for Your Former Spouse and non-Incapacitated Dependent Child
If your spouse covered under this Policy is no longer eligible because of a legal divorce, or if a non-Incapacitated child covered under this Policy is no longer eligible because of reaching the age limit, then he or she qualifies for a Special Enrollment and may apply for a new Policy under the Special Enrollment rights.

Extension of Benefits
If the Policy terminates during a period of confinement or continuous loss which began while the Policy was in force, your coverage under the Policy may remain in effect for the duration of one period of confinement or through such continuous loss, if and to the extent that you remain continuously disabled. In no event will your coverage extend beyond the duration of the Policy Period or exceed any Benefit Period Maximum. One period of confinement means consecutive days of inpatient services for a Member in a Hospital, Skilled Nursing Facility, or Residential Treatment Center that begins before the Termination Date of the Policy and continues past that date. The term continuously disabled means the Member is unable to perform the duties of his or her occupation and is under the ongoing care of a Physician. A child who is continuously disabled is receiving ongoing medical care by a Physician and unable to perform the normal activities of a child in good health of the same age and sex. We will provide extended benefits under this section only for Covered Services as listed in this Policy that are related to the treatment of the disabling medical condition.

Important Note: We recommend that you notify us if you wish to exercise the Extension of Benefits rights. We will then determine if you are eligible for benefits. In order for us to recognize Extension of Benefits and ensure proper processing, we must receive a Physician's statement of continuous disability.

Qualified Individual Redetermination

The Health Insurance Marketplace must periodically re-determine your eligibility for Advanced Premium Tax Credits and/or Cost-share Reductions during the benefit year if (1) updated information is reported to and verified by the Health Insurance Marketplace; or (2) the Health Insurance Marketplace identified updated information through its own data matching process. If a redetermination results in a change in eligibility, then the change will generally be effective for the first day of the month following the date of the eligibility redetermination notice. The Health Insurance Marketplace may establish a cut-off date for a redetermination notice (such as the 15th of the month). Any changes due to a redetermination received after this cut-off date will be effective the first day of the second month following the notice.

Medical Loss Ratio

Individual contracts must meet certain medical loss ratio requirements as required by federal law. If all individual coverage issued by InStil Health does not meet the medical loss ratio requirement, we will issue medical loss ratio rebates. These rebates may be in the form of a lump-sum check, credit or debit card reimbursement, pre-paid debit or credit cards or Premium credits. A Premium credit means you will not be required to pay your Premium or a portion of your Premium for a specified period of time. However, after the specified time, you must again pay your Premiums.

Each year, by a date determined by Health and Human Services, you will receive notice if you are due a Medical Loss Ratio rebate for the previous year. Every Member's rebate will be in the same form, unless the Member is no longer active. If the Member is no longer active, the rebate will be in the form of a lump-sum check.

Covered Services

We will provide benefits for Covered Services according to the provisions described in this Policy and as shown in your Member Schedule. We base benefits on a percentage of the Allowed Amount. Benefits may be subject to Deductibles, Copayments, Coinsurance, Benefit Period Maximums, exclusions and limitations. Preauthorization must be obtained on certain services to receive maximum benefits. See the *Preauthorization* section for details.

Benefits are provided in-Network only, except as expressly provided otherwise. Please note: Even at an in-Network Hospital or facility, you may be treated by an out-of-Network Provider; there is no Maximum out-of-pocket (no limit) on out-of-Network charges. See the Special Out-of-Network Rules section, for additional information.

All Covered Services must be Medically Necessary and include only the services specifically described in this section unless limited or excluded in other provisions of the Policy. The services must be prescribed by and performed by, or under the direction of, your InHealth Network PCP designated by us or by an InHealth Network Provider Authorized in advance by your PCP; however, a contract exclusion may apply even if a service is considered Medically Necessary.

There are no annual or lifetime dollar limits on Essential Health Benefits.

The following Essential Health Benefits are described in detail below:

- Ambulatory Patient Services
- Emergency Services
- Habilitation and Rehabilitation Services
- Hospital Services
- Laboratory Services
- Maternity and Newborn Care
- Mental Health & Substance Use Disorder Services
- Pediatric Services
- Prescription Drugs
- Preventive Services

Benefit Period Maximums for Covered Services (per Member per Benefit Period):

60 days for Skilled Nursing Facility/Residential Treatment Center
60 visits for Home Health Care
6 months per episode for Inpatient and Outpatient Hospice Care
30 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined
30 Habilitative (developmental) visits for Physical, Speech and Occupational Therapy Services combined
$500 for Chiropractic Care Services

The following are Covered Services:

Ambulatory Surgical Center – Medically Necessary services, supplies, and benefits provided at an Ambulatory Surgical Center. When you receive services at an Ambulatory Surgical Center, we may allow additional visits for rehabilitation; you should coordinate a request for increased benefits through our Case Management area.

Ambulance Service – Benefits are provided for professional ambulance services to the nearest Network Hospital in case of an accident or Emergency Medical Condition. The following requirements apply to all ground and air ambulance transports:

1. The transport is Medically Necessary and reasonable under the circumstances;
2. A InStil Health member is transported;
3. The destination is within the United States; and
4. The facility is medically appropriate to treat the Member's condition.

Non-Emergency Ground Ambulance Transportation: Benefits may be available for non-emergency ground transportation between Hospitals or for a preauthorized admission to another health care facility at a lower level of care, only when all of the following requirement requirements are met:

- Use of a medical transport is medically necessary because the member's condition makes other forms of transportation infeasible (e.g. mechanical ventilation, traction);
- The sending Hospital admission was as an inpatient and was preauthorized;
- The receiving Hospital or facility inpatient admission is preauthorized;
- Use of a medical transport is preauthorized; and
- The receiving Hospital or facility is the closest facility that can provide Covered Services appropriate to the Member's condition.

When all of the above requirements are met, ground transportation may be used in non-emergency transfers for a preauthorized admission for a lower level of care.

An out-of-Network Provider may Balance Bill you in most non-emergency situations unless prohibited by law. Repatriation is not covered; see the Exclusions section.

Air Ambulance Transportation: Preauthorization is required for transportation as an Inpatient from one Hospital to a second Hospital using an air ambulance. The following requirements must be met:

- The first Hospital does not have needed hospital or skilled nursing care for the member's illness or injury (such as burn care, cardiac care, trauma care, and critical care);
- The second Hospital is the nearest medically appropriate facility;
- A ground ambulance transport endangers the Member's medical condition; and
- The transport is not related to a hospitalization outside the United States.

Cost-Sharing for out-of-Network air ambulance services is at the in-Network level, applied toward the in-Network Deductible and Maximum out-of-pocket, and based on the Recognized Amount.

The Allowed Amount for air ambulance services provided by non-Network Providers will be no less than the minimum amount required by applicable law, and you generally may not be Balance Billed by the Provider unless prohibited by law. The Allowed Amount for ground ambulance services provided by non-Network Providers will be determined by InStil Health, in its discretion, using methods, including, but not limited to, governmental reimbursement rates such as Medicare, and/or comparable costs for the same or similar transportation services in the same geographic area, and/or other transportation services over comparable distances. See the Special Out-of-Network Rules section, for additional information.

Autism Spectrum Disorder – Applied Behavior Analysis and Developmental Relationship-Based Intervention services may be considered Medically Necessary when performed to meet the functional needs of a member with Autism Spectrum Disorder (ASD). The following requirements must be met:

- Services are rendered by a covered provider
- Diagnosis of Autism Spectrum Disorder
- Supporting clinical documentation including required testing and results, plan of care of with specified goals that do not duplicate services that directly support academic achievement goals that may be included in an Individualized Education Program/Individualized Services Plan (IEP/ISP), duplicate services that are provided or available by other medical or behavioral health professionals
- Treatment goals must be focused on active ASD core symptoms, substantial deficits that inhibit daily functioning, or clinical significantly aberrant behavioral

Benefit Period Maximum – The maximum number of day or visits that benefits will be provided for a Covered Service in a Benefit Period, as listed in the Schedule of Benefits or this Policy. If you have reached your Benefit Period Maximum on any Covered Service and have any further questions, please contact Customer Service.

Birth Control – Benefits are provided for the following oral contraceptives and contraceptive devices with no cost-share. Other, non-FDA-approved contraceptive methods may be available, but your deductible and coinsurance would be applied, unless otherwise required by law. InStil Health will cover at least one option in each of the following categories. See the searchable Covered Drug List to determine if a specific brand or item is covered at no cost-share.

- Cervical cap
- Condoms
- Diaphragms
- Emergency contraception
- Implantable rod
- Intrauterine device (IUD)
- Oral contraceptives (birth control pills)
- Patch
- Shot/injection
- Spermicide
- Vaginal contraceptive ring
- Sponge

Birth control includes female sterilization surgery and surgical sterilization implant for women, including follow-up care.

Breastfeeding Support, Supplies and Counseling – Benefits will be provided for breastfeeding support and counseling. Breastfeeding support includes benefits for breast pumps when purchased through a doctor's office, Pharmacy or DME supplier and is limited to one pump every 12 months or per pregnancy.

Cardiac Rehabilitation – Benefits are provided for Phase 1 and 2 cardiac rehabilitation when provided within 30 days of an acute cardiac event. Preauthorization is required.

Chiropractic Care – Benefits are provided for services or care used to detect and correct structural imbalance, distortion, or subluxation in your body for the purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in the spinal column.

Cleft Lip and Palate – Benefits will be provided for the care and treatment of a cleft lip and palate and any condition or illness that is related to or caused by a cleft lip and palate. Cleft lip and palate means a congenital cleft in the lip or palate or both. Care and treatment will include, but are not limited to:

1. Oral and facial Surgery, surgical management and follow-up care;
2. Prosthetic treatment such as obdurators, speech appliances and feeding appliances;
3. Orthodontic treatment and management;
4. Treatment and management for missing teeth (prosthodontics);

5. Ear, nose and throat (otolaryngology) treatment and management;
6. Hearing (audiological) assessment, treatment and management including surgically implanted hearing aids; and
7. Physical therapy assessment and treatment.

If a Member with a cleft lip and palate is also covered by a dental policy, then teeth capping, prosthodontics and orthodontics will be covered by the dental policy to the limit of coverage provided and any excess after that will be provided by this Policy.

Clinical Trials – Benefits are provided for routine Member costs for items and services related to clinical trials when:
1. The Member has cancer or another life-threatening disease or condition;
2. The referring Provider is a Network Provider that has concluded that the Member's participation in such trial would be appropriate;
3. The Member provides medical and scientific information establishing that the Member's participation in such trial would be Medically Necessary; and
4. The services are furnished in connection with an Approved Clinical Trial, defined below.

An Approved Clinical Trial is one that is approved or funded through the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHRQ), or the Centers for Medicare & Medicaid Services (CMS); the Department of Defense (DOD), the Department of Veterans Affairs (VA), or the Department of Education (DOE), if the study or investigation has been peer reviewed and approved by U.S. Department of Health and Human Services (HHS); a cooperative group or center of any of these entities (except the DOE); a qualified non-governmental research entity identified in the guidelines issued by the NIH or is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).

Dental Services to Sound Natural Teeth Related to Accidental Injury – Benefits are provided for treatment, Surgery or appliances as a result of an accidental bodily injury but are limited to care completed within six months of an accident and while the patient is still covered under this Policy. Dental injuries occurring through the natural act of chewing are not considered accidental. If Preauthorization is not obtained and/or you don't use the Provider we designate, no benefits will be provided.

Diabetes Management – Benefits are provided for equipment, supplies, Outpatient self-management training and education including nutritional counseling for the treatment of Members with diabetes. A health care professional must follow minimal standards of care for diabetes as adopted and published by the Diabetes Initiative of South Carolina.

If Member meets certain criteria there is coverage allowance for a continuous glucose monitor and insulin pump if needed. Prior Authorization is needed.

Diabetes self-management training and education will be provided on an Outpatient basis when done by a registered or licensed health care professional certified in diabetes education.

Durable Medical Equipment (DME) – Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME is subject to all contract exclusions, whether or not Medically Necessary and Preauthorization is required.

Emergency Services – Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition. See the Definitions section of this Policy for Emergency, Emergency Medical Condition, and Emergency Services for more details.

Benefits are available to treat an Emergency Medical Condition at a Hospital Emergency Room or at an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency. If you receive care

for an Emergency Medical Condition and are treated in the Emergency Room at a Hospital, the charges for Emergency Services are paid as follows:

1. **Emergency Services provided by an in-Network Provider**
   When Emergency Services are received from an in-Network Provider, benefits are provided as any other in-Network service under this Policy.

2. **Emergency Services by an out-of-Network Provider**
   When Emergency Services are received from an out-of-Network Provider or Hospital, benefits will be provided for the Emergency Services, and you will be subject to in-Network Cost-Sharing based on the Recognized Amount. The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when provided by an out-of-Network Provider will be no less than the amount required under applicable law. See the Special Out-of-Network Rules section, for additional information.

Non-Emergency care outside the InHealth Network, including any follow-up to Emergency Care, is not covered.

Genetic Counseling – Benefits are provided for Genetic Counseling when Preauthorization is obtained. If Preauthorization is not obtained, no benefits will be provided.

Habilitation Services – Benefits include Physical, Occupational and Speech Therapy for the purpose of assisting a Member with achieving developmental skills, including as a result of a developmental speech delay, developmental communication disorder, or a developmental coordination disorder. Benefits are provided when a Physician prescribes therapy and it is performed by a licensed, professional physical, occupational or speech therapist. Preauthorization is required; you must use a Provider we designate, if applicable. If Preauthorization is not obtained and/or you don't use the Provider we designate, no benefits will be provided. No coverage after Benefit Period maximum allowance.

Home Health Care Services – A variety of services and benefits provided to a homebound Member in a personal residence. Homebound refers to a patient's inability to leave their home without significant difficulty or assistance. Home health care must be provided by or through a community home health agency on a part-time visiting basis and according to a Physician-prescribed course of treatment. We must Preauthorize the care based on an established home health care treatment plan before you are eligible for benefits. If Preauthorization is not obtained, no benefits will be provided. No coverage after Benefit Period maximum allowance. Home health care includes:

1. Services by a registered nurse (RN) or licensed practical nurse (LPN);
2. Services provided by a medical social worker;
3. Nutritional guidance;
4. Diagnostic services;
5. Administration of Prescription Drugs;
6. Medical and surgical supplies;
7. Oxygen and its use; and
8. Durable Medical Equipment (A separate Preauthorization is not needed when the entire Home Health Care plan is approved).

Hospice Services – Benefits are provided for palliative hospice services. You must obtain Preauthorization for hospice services before you are eligible for this care, and services, which must be provided according to a Physician prescribed treatment plan. If Preauthorization is not obtained, no benefits will be provided. Hospice services include:

1. Services provided by a registered nurse (RN) or licensed practical nurse (LPN);
2. Physical, speech and occupational therapy (Benefit Period Maximum applies)
3. Services provided by a home health aide or medical social worker;

4. Nutritional guidance;
5. Diagnostic services;
6. Administration of Prescription Drugs;
7. Medical and surgical supplies;
8. Oxygen and its use;
9. Durable Medical Equipment (separate Preauthorization not required when we approve entire Hospice Service plan);
10. Family counseling concerning the patient's terminal condition.

Hospital Services – Includes Inpatient Admissions, Outpatient care and ancillary services. Preauthorization is required. If Preauthorization is not obtained, no benefits will be provided. Please note: Even at an In-Network Hospital, Ambulatory Surgical Center, or certain other facilities, you may be treated by an Out-of-Network Provider and the provider generally may Balance Bill you unless prohibited by law. There is no Maximum Out-of-Pocket (no limit) on Out-of-Network billed charges. For Emergency Care and services furnished by an Out-of-Network provider at an In-Network Hospital, Ambulatory Surgical Center, or certain other facilities, you generally will be subject to In-Network Cost-Sharing and the In-Network Deductible and Maximum Out-of-Pocket, and the provider generally may not Balance Bill you. See the Special Out-of-Network Rules section for additional information.

Room and board benefits are provided at the most prevalent semi-private room rate. When all rooms in a Hospital are private, the semi-private room rate will be considered the private room allowance.

College or School Infirmary – When you receive care in a college or school infirmary that bills students for its services, benefits will be provided if the infirmary is a Network Provider in the InHealth Network, and are limited to the average semi-private room rate for South Carolina Hospitals.

The day you leave a Hospital, with or without permission, is treated as the day of discharge and will not be counted as an Inpatient care day, unless you return to the Hospital and are admitted by midnight of the same day. Please note that services provided on the day of discharge are provided according to the Policy terms and conditions. The day you return to the Hospital and are admitted, if applicable, is treated as the day of Admission and **is counted** as an Inpatient care day. The days during which you aren't physically present for Inpatient care **are not counted** as Inpatient days.

Immunizations – Benefits will be provided for immunizations as recommended by the Centers for Disease Control (CDC). The recommendations may include age and/or frequency restrictions. The CDC is an independent organization that offers health information and recommendations; they are not affiliated with InStil Health.

Laboratory and Diagnostic Services – Benefits will be provided for procedures to identify the nature and/or extent of a condition or disease. We will reduce benefits for Inpatient diagnostic services to the level of benefits for Outpatient services when services could have been safely done on an Outpatient basis. Diagnostic services include, but are not limited to:
1. Radiology, ultrasound and nuclear medicine;
2. Laboratory and pathology;
3. ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing;
4. Surgical pathology — pathological examination of tissue removed surgically, by resection or biopsy. This does not include smear techniques;
5. High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans and CT scans; and
6. Gastrointestinal endoscopies.

Mastectomy and Reconstruction – Benefits include Hospitalization for at least 48 hours following mastectomy. If you are released early, then we will provide benefits for at least one home care visit if the attending Physician orders it.

We will also provide benefits for Prosthetic Devices, reconstruction of the breast on which the mastectomy was performed and physical complications for all stages of mastectomy including lymphedemas. This includes Surgery and

reconstruction of the non-diseased breast to produce a symmetrical appearance as determined in consultation with the attending Physician and the patient.

Maternity Care – Benefits are available for all covered female members and are provided for pre- and postnatal care, including the hospitalization and related professional services for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The day of delivery or Surgery is not counted in the 48 hours after vaginal delivery (96 hours for Caesarean Section). Maternity care does not include: payment for a surrogate; artificial insemination and in-vitro fertilization. Benefits may include services of a midwife and/or provided at a birthing facility. All Providers must be in-Network, licensed or certified as appropriate, and performing services within the license or certification. Coverage is available under this Policy for a Newborn; see the Eligibility section for how to add your child, and see Newborn Child Coverage under Covered Services for the services and benefits available.

Mental Health and Substance Use Disorder Services (Behavioral Health Services) – Benefits are available for the treatment of conditions defined, described or classified as psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, including the continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with that use.

Benefits are provided as shown in the Member Schedule for Behavioral Services/Mental Health and/or Substance Use Disorders.

Newborn Child Coverage – When you purchase this Policy for your newborn, or add your newborn to your Policy within 60 days of his or her birth, and pay the appropriate Premium, coverage will be effective on the date of birth and benefits will be provided for the hospitalization and related professional services for the newborn for at least 48 hours after a vaginal delivery (96 hours following a Cesarean section) or the date of discharge from the Hospital — whichever occurs first. The day of birth is not counted in the 48 hours after vaginal delivery (96 hours for Caesarean Section). You may also choose to make coverage effective the first day of the month following the birth, but must give us notice of your choice; if we do not receive specific instructions, the Effective Date of Coverage for the Newborn will be the date of birth. Please Note: although you have 60 days to enroll the child, we cannot process claims until the Newborn Child is enrolled for coverage.

Pediatric Preventive Services – Benefits will be provided, subject to age and/or condition guidelines/ recommendations, as follows:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B services.
- Screenings recommended for children by Health Resources and Services and Administration.
- Pediatric vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B services and Health Resources and Services Administration (HRSA).

The USPSTF and HRSA are independent organizations that provide health information and recommendations; they are not affiliated with InStil Health.

Physician Services (Primary Care Physician, Specialist, or other Clinician) – Benefits are provided as outlined below. Please note that Preauthorization is required for all Inpatient admissions and for other services as described in the Preauthorization section. While the benefits described below are Covered Services, care that is in excess of Medically Necessary treatment criteria is not covered.

1. Office/Outpatient Services – Care and consultation by a Physician or other Clinician in an Outpatient setting for the examination, diagnosis or treatment of an injury, illness, or Behavioral Services treatment.

2. Inpatient Services – Care and consultation provided in an Inpatient setting for the examination, diagnosis or treatment of an injury, illness, or Behavioral Services treatment.
   a. Inpatient and Intensive Care Visits; may also include diagnostic services and therapy services done concurrently with medical or Behavioral Services care.
   b. Consultation – Limited to one consultation per consulting Physician.
3. Surgery – Benefits include pre- and post-operative care as well as daily care by the Physician who performed the Surgery if you are Inpatient. Benefits are provided at a lower reimbursement percentage if two or more surgical procedures are performed during one operation.

   a. Surgical Assistant – Services of a Physician or other Clinician who actively assists the operating Physician during an eligible Surgery in a Hospital are only available if all of the following conditions are met:
      - The complexity of the procedure or the patient's condition warrants an assistant surgeon
      - An intern, resident or house physician is not available to assist
        - Non-Physicians (e.g., physician assistants, first assistants, certified surgical assistants and nurse practitioners) may not serve as an assistant surgeon or Surgical Assistant, unless the non-Physician has separate surgical privileges at the Facility or Hospital.

      Benefits are not available when the service or procedure does not require an assistant at surgery (when an assistant is not Medically Necessary).

   b. Anesthesia – Services provided by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant. See the Special Out-of-Network Rules section, for additional information.
4. Chemotherapy – The treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the FDA.
5. Dialysis Treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency to include hemodialysis or peritoneal dialysis. Dialysis treatment may include home dialysis, when required criteria are met. NOTE: this service requires preauthorization.
6. Radiation Therapy – The treatment of disease by X-ray, radium or radioactive isotopes.

Prescription Drugs – Benefits are provided for Prescription Drugs under the pharmacy and medical portions of your benefit. More detailed information is noted in the *Prescription Drug* section. Prescription Drugs and pharmaceuticals that are provided under the Prescription Drug benefit are not provided as a medical benefit. NOTE: When prescription drugs are infused, we may require administration be performed at a specific site of care.

Preventive Services – A limited number of services are provided as preventive care with no cost share, as follows:
- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B services.
- Screenings recommended for children and women by Health Resources and Services and Administration.
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines.
- Pediatric vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B services and Health Resources and Services Administration (HRSA).

Preventive care (except Preventive Pap Smear) must meet the age and/or condition guidelines/recommendations of the USPSTF, CDC, HRSA or ACS to be covered at no cost to the Member. These organizations and agencies are independent bodies that offer health information and recommendations; they are not affiliated with InStil Health.

Virtual colonoscopies and capsule endoscopies may be covered but are subject to medical management guidelines and are subject to preauthorization. Any services not performed as screening/preventive measures are covered at regular contract terms.

Prosthetics – Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Duplicates and services related to the repair or replacement of a prosthetic are only considered Medically Necessary when due to routine wear and tear or a change in the Member's medical condition, and with prior authorization from us.

Pulmonary Rehabilitation – Benefits are provided when medically necessary for specific pulmonary conditions and circumstances This benefit requires Preauthorization.

Rehabilitation Services – Health care services that help a person improve skills and functioning that have been lost or impaired due to an illness or injury. Preauthorization is required; you must use a Provider we designate, if applicable. If Preauthorization is not obtained and/or you don't use the Provider we designate, no benefits will be provided. No coverage after Benefit Period maximum allowance.

Residential Treatment Center (RTC) – Benefits include room and board, general nursing service, therapy services and other ancillary services. Preauthorization is required. If Preauthorization is not obtained, benefits will be denied. No coverage after Benefit Period maximum allowance.

Benefits for a Residential Treatment Center are provided at the semi-private room rate. When you are admitted to a Residential Treatment Center in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room rate.

The day you go to the Residential Treatment Center is the Admission day. The day you leave the Residential Treatment Center, with or without permission, is the discharge day. Please note that services provided on the day of discharge are provided according to the policy terms and conditions.

Benefits are not provided for days in which you are not physically present in the Residential Treatment Center.

Skilled Nursing Facility – Benefits include room and board, special diets, general nursing services, therapy services and other ancillary services. You must be admitted within 14 days after being discharged from a Hospital following an authorized hospitalization. Preauthorization is required. If Preauthorization is not obtained, benefits will be denied. No coverage after Benefit Period maximum allowance.
Benefits for a Skilled Nursing Facility are provided at the semi-private room rate. When you are admitted to a Skilled Nursing Facility in which all rooms are private, the most prevalent semi-private room rate, as determined by us, will be considered the private room rate.

The day you go to the Skilled Nursing Facility is the Admission day. The day you leave the Skilled Nursing Facility, with or without permission, is the discharge day. Please note that services provided on the day of discharge are provided according to the policy terms and conditions.

Benefits are not provided for days in which you are not physically present in the Skilled Nursing Facility.

Telehealth – The exchange of Member information during which a Member can have a telephone, video or web-based appointment with a licensed Provider. Telehealth does not require two-way audio or video consultations between a Referring Provider and/or Specialist.

Telemedicine – Benefits will be provided for Telemedicine services such as: consultation, diagnosis and treatment where the services would otherwise be covered if you were "in person." Office and outpatient visits that are conducted via Telemedicine are counted towards any applicable Benefit limits for these services. Consulting and referring Providers must be Network Providers who have been credentialed as eligible Telemedicine Providers.

Telemedicine services will be covered when the services performed are Covered Services under this Policy and under the following circumstances:

1. The medical care is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the Member's need; and,
2. The medical care can be safely furnished, and there is no equally effective, more conservative and less costly treatment available.

The following are examples of services that are not Telemedicine services and are not covered:

1. E-mail messages;
2. Facsimile transmissions

Therapy – Benefits are provided for physical, occupational and speech Therapy when prescribed by a Physician and performed by a licensed, professional physical, occupational or speech therapist. No coverage after Benefit Period maximum allowance.

Transplants (Human Organ and/or Tissue) – We provide benefits for covered transplants only when Preauthorized and a Provider we designate performs the transplant at a location we designate.

Organ transplant coverage includes all expenses for medical and surgical services a Member receives for human organ and/or tissue transplants while the Member is covered under this Policy. Organ transplants don't include transplants involving mechanical or animal organs.

1. We provide benefits for certain living donor transplants covered under this Policy, including but not limited to kidney transplants, liver transplants, and specific tissue transplants as pre-authorized. Benefits will be subject to the following conditions:
   a. When both the transplant recipient and the donor are Members, benefits will be provided for both.
   b. When the transplant recipient is a Member and the donor is not, benefits will be provided for both.
   c. When the transplant recipient is not a Member and the donor is, no benefits will be provided to either the donor or the recipient.
   d. We will also provide benefits to transport the donor organ or tissue to the location where the transplant will be performed, if the transplant is a covered benefit under this Policy.

2. The following transplants are not Covered Services:

- Uses of allogeneic bone marrow transplantation (between two related or unrelated people), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high

doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;
- Adrenal tissue to brain transplants;
- Procedures that involve the transplantation of fetal tissues into a living recipient;
- Services and supplies related to transplants involving mechanical or animal organs.

Urgent Care – Benefits are provided when you seek treatment at an in-Network Urgent Treatment Center during and after normal business hours.

Varicose Vein and Venous Insufficiency Treatment – When medically necessary, benefits will be paid for services, supplies or treatment for varicose veins and/or venous insufficiency, including but not limited to endovenous ablation, vein stripping or the injection of sclerosing solutions. Preauthorization is required.

Pediatric Vision Services

We provide Pediatric Vision Services as shown in the Member Schedule. Pediatric Vision Services are available from birth through end of the Benefit Period in which the member turns age 19. Vision Services are provided through EyeMed. EyeMed is a separate company that provides Vision Services on behalf of InStil Health. To find a EyeMed Provider, go to www.eyemed.com , chose “Find an eye doctor”, select the Insight Network and enter your ZIP code. (This link leads to a third-party site. That company is solely responsible for the contents and privacy policies on its site.)

Any copayment made for Vision Services will be applied to your Maximum Out-of-pocket.

Prescription Drug Coverage

InStil Health works with a team of health care Providers to choose drugs that provide quality treatment. The prescription drugs that BlueCross covers are listed on the Covered Drug List (formulary), and are covered as a benefit under this policy as long as:

- The drug is Medically Necessary and prescribed by one of our Network providers and
- The prescription is filled at one of our Network pharmacies and
- Other Plan rules are followed where applicable, including but not limited to: Prior Authorization, Quantity Limits and Step Therapy.

The Covered Drug List gives information about Prescription Drugs covered under this Plan which has five coverage levels, called Tiers. Benefits are limited to a 90-day supply at a retail pharmacy or a 90-day supply by mail. A 90-day supply at Retail will result in 3 times the copayment amount listed on your Schedule of Benefits. A 90-day supply is not available for Specialty Drugs or for any controlled substances. More information about the Covered Drug List and Network Pharmacies can be found under the Prescription Drug Information section at: https://www.instilhealth.com/links/2027/pharmacy.

How your Drug Benefits are paid

To receive benefits for Prescription Drugs, you must obtain your prescriptions from our Network providers and fill them through our Network Pharmacies; simply show the pharmacist your InStil Health ID card.

If a Physician or other Clinician prescribes a Brand-name Drug and there is an equivalent Generic Drug available (whether or not the Physician allows substitution of the Brand-name Drug), then the Member must pay any difference between the cost of the Generic Drug and the higher cost of the Brand-name Drug. The difference you must pay between the cost of the Generic Drug and the higher cost of the Brand-name Drug does not apply to your Deductible or your Maximum Out-of-pocket.

Pharmacy benefits are only available when provided by a Network Pharmacy. Not all pharmacies are part of the OPTUM Network. Exceptions may be made in case of an Emergency Medical Condition. Please contact a Customer Advocate, if you need to file a Prescription Drug claim for an Emergency Medical Condition.

We will provide benefits for off-label use of Prescription Drugs that haven't been approved by the FDA for the treatment of a specific type of cancer for which the drug was prescribed, provided the drug is recognized for treatment of that specific cancer in at least one standard reference compendium or the drug is found to be safe and effective in formal clinical studies. These results must have been published in peer-reviewed professional medical journals.

Until your Maximum out-of-pocket Limit is met, you will pay one or more of the following for each Prescription Drug, depending upon your Plan type: Prescription Drug Deductible, Copayment, Deductible and/or Coinsurance. Once you have met your Maximum out-of-pocket, you will no longer have to pay out-of-pocket for covered benefits until a new Benefit Period begins. Please refer to your Member Schedule for specific Plan costs for each Tier referenced below. No tier is restricted to a specific class of prescription drugs. Any tier may contain a mix of generic, brand or non-brand name drugs or specialty medications, including infusible or injectable drugs.

- **Tier 0:** Drugs on this tier are considered **preventive** medications under the Affordable Care Act (ACA) and are covered at no cost to you.
- **Tier 1:** Drugs on this tier are usually **generic** drugs. They will typically cost less than brand drugs.
- **Tier 2:** Drugs on this tier are usually **preferred** drugs. They typically cost less than other brand drugs.
- **Tier 3:** Drugs on this tier are usually **non-preferred** drugs. They typically cost more than other brand drugs and may have generic equivalents.
- **Tier 4:** Drugs on this tier are usually **specialty drugs** that are used to treat complex conditions. They are typically the most expensive drugs available.

How to file a Prescription Drug Claim
Network Pharmacies will file all claims for you. No benefits are available from non-Network Pharmacies. If you receive Prescription Drugs from a non-Network Pharmacy due to an Emergency Medical Condition, please refer to *How to Contact Us if You Have a Question* section.

If you fill a Prescription Drug before the effective date of your coverage or before you pay the premium for your coverage, you will have to pay the full retail price of the Prescription Drug. The charge will not be refunded and will not apply to your Deductible or Maximum Out-of-pocket.

Mail-order Pharmacy
We have contracted with a pharmacy that will provide up to a 90-day supply of Prescription Drugs straight to your door when you set up this service. Our Mail-order Pharmacy order form may be used to set up Mail-order service and is located on our website at https://instilhealth.com/links/2027/pharmacy

Specialty Pharmacy
Drugs that are designated to be specialty medications will be filled by In-Network Specialty Pharmacies when using your pharmacy benefits. If a covered specialty drug is not available from In-Network Specialty Pharmacies, we will arrange to have the prescription filled from another Specialty Pharmacy. The list of drugs that must be filled by our Specialty Pharmacy is included as part of the Covered Drug List. Our In-Network Specialty Pharmacies have also agreed to accept our allowance as payment in full for Covered Services except for any Deductibles, Copayments or Coinsurance you owe. Specialty medications are limited to a 31-day supply. Specialty pharmacy services are available through pharmacies participating in the InStil Health specialty pharmacy network. Network specialty pharmacies are independent companies that provide pharmacy services on behalf of InStil Health. Specialty drugs administered under the medical benefit may not be available from our Specialty Pharmacy. Certain specialty drugs can be billed and administered in the providers office, in network infusion centers or home.

Over-The-Counter (OTC) Drug
These are drugs that do not require a prescription. We do not generally pay benefits for over-the-counter drugs but may designate specific classes of over-the-counter Drugs to be covered as Prescription Drugs. A prescription for an included drug must be presented at the Pharmacy or the drug will not be covered.

Additional Requirements/Limits
There may be additional requirements or limits on some medications on the Covered Drug List. These requirements and/or limits may include:

- **Prior Authorization (PA):** If your drug needs prior authorization, your doctor will have to get approval before we will cover your drug. Your doctor should contact our prior authorization center for drugs filled under the pharmacy benefit. There are different reasons a drug might require prior authorization. One is to make sure it's being used for the condition(s) it was approved for by the United States Food and Drug Administration (FDA). Another is because there

are covered drugs that usually work just as well but cost less. If your Provider does not obtain prior authorization, no benefits will be provided.

- **Quantity Limits (QL):** If your drug has a quantity limit, we will only cover a certain amount of the drug in a specified period of time; unless your Provider requests a quantity in excess of this amount and gives evidence supporting this request which is approved prior to the prescription being filled. This is to make sure you are using the drug safely and based on the FDA guidelines. If we determine a member has used multiple doctors or pharmacies to obtain quantities of prescription medication in excess of what is allowed or recommended, we reserve the right to require the use of a designated provider for prescribing the medication and/or a specific pharmacy to fill prescriptions of that medication.

- **Step Therapy (ST):** If your drug has a step therapy requirement, we will only cover second choice drugs if you have already tried a first-choice drug and it didn't work for you. The reason for a particular step therapy requirement may be because there are covered drugs that usually work just as well but will cost you less. It may also be because some drugs are approved by the FDA specifically as second-choice drugs or as add-ons to other medication.

Pharmacy Appeals:
If a member requests a prescription drug that is on the formulary (covered drug), but the request is denied, the member can file an appeal. Appeal information will be included on the notice of denial. If the first appeal is denied, you can request a second-level appeal. If the second appeal is denied, the member can request an external review using information included in the appeal denial notice.

Formulary Exception Request (standard or expedited):
If a drug is not on the formulary (not covered), it may be helpful to discuss other covered alternatives with your Physician; or, if not medically viable, you may request a formulary exception. An exception request may be made by the Member, the Member's designee, or the Member's prescribing Provider (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan (i.e. non formulary) by contacting us at 855-404-6752. We will work with the prescribing physician to obtain any medical records or other necessary information to process the request. We must act on a standard request within 72 hours and on an expedited request within 24 hours after we receive your request for a formulary exception. Expedited requests are available only when you have exigent circumstances: a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. For a standard formulary exception, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription, including refills. For an expedited formulary exception, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigent circumstances.
If your formulary exception request is denied, you can ask for an appeal or an external exception review. The request can be made by you, your designee, or your prescribing Provider. You can ask for an exception review by contacting us to begin the process at:

Attention: Pharmacy Management
I-20 East at Alpine Road, AX-740
Columbia, SC 29219

Fax: 1-803-741-5350External exception reviews are available. The external exception review will be assigned to an independent review organization that will make a determination on your exception review. We will notify you or your designee, along with the prescribing Provider, of the coverage determination. If the original request was a standard formulary exception request, we will notify you no later than 72 hours following receipt of the request, and if approved, will provide coverage of the approved non-formulary drug for the duration of the prescription. If the original formulary

exception request was an expedited request, the determination will be made no later than 24 hours following receipt of the request and, if approved, will provide coverage of the non-formulary drug only for the duration of the exigency.

Pharmacy Exclusions: What's Not Covered?

We will not provide benefits for the following Prescription Drugs:

a. That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction (unless indicated for confirmed diagnosis of Benign Prostatic Hypertrophy), cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal.
b. That are used for infertility.
c. More than the number of days' supply allowed as shown in your Member Schedule.
d. Refills in excess of the number specified on your Physician's prescription order.
e. More than the recommended daily dosage defined by InStil Health, unless prior authorization is sought and approved.
f. When administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.
g. That are available over-the-counter or when there is an over-the-counter equivalent containing the same active ingredients as the prescription/Rx version including any over-the-counter supplies, devices or supplements.
h. When not consistent with diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
i. Some medications classified as self-administered drugs; when obtained, purchased, and/or administered at a doctor's office or in an outpatient setting.
j. That require Prior Authorization, and the Prior Authorization is not received.
k. That requires step therapy when the Step Therapy Program is not followed.
l. That are prescribed and/or received Out-of-network, unless due to an Emergency Medical Condition.
m. That are not on the Covered Drug List (certain drugs administered under the medical benefit are exempt).
n. Any medication or drugs for which some or all of the cost sharing is paid by a drug manufacturer in any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) that reduces or eliminates immediate out-of-pocket costs for a specific prescription brand drug. Although the drug remains a covered prescription drug, cost sharing amounts provided by the drug manufacturer will not be counted toward the member's annual limitation on cost sharing.
o. Food or nutritional substances, such as orthomolecular therapy, infant formula, nutrients, vitamins, food supplements, and enteral feedings, whether or not obtained with a prescription.
p. Prescription Drugs that are new to the market and under clinical review by InStil Health or its pharmacy benefit manager shall be listed on the Prescription Drug List as excluded until the clinical review has been completed and a final determination has been made as to whether the Drug should be included.
q. Prescription Drugs and pharmaceuticals under the medical portion of this Policy when benefits are available under the Prescription Drug benefit.

We contract with a pharmacy benefit manager to manage the pharmacy Network, and/or Specialty Drug Network Providers, and to perform other administrative services, including negotiating prices with the pharmacies in this Network. OptumRx® is an independent company that offers a pharmacy network on behalf of InStil Health.

We receive financial credits directly from drug manufacturers and through this pharmacy benefits manager. These credits are used to help stabilize overall rates and to offset costs. Reimbursements to pharmacies and Specialty Drug Network Providers or discounted prices charged by pharmacies and Specialty Drug Network Providers are not affected by these credits. Any cost-sharing that you must pay for Prescription Drugs is based on the Allowed Amount at the pharmacy or Specialty Drug Network Provider. Copayments are flat amounts and likewise don't change due to receipt of drug manufacturer credits.

Exclusions and Limitations

All Exclusions apply even if the service is deemed Medically Necessary. Notwithstanding any provision of the policy to the contrary, if the policy generally provides benefits for any type of injury or illness, then we will not apply an exclusion to an otherwise covered service in any case where the illness or injury results from a medical, physical or mental health condition or an act of domestic violence, whether or not the condition was diagnosed prior to the Policy Effective Date.

1. General Exclusions

a. Services and supplies that are:
   - not Medically Necessary
   - not needed for the diagnoses or treatment of an illness or injury; or
   - not specifically listed in Covered Services.

b. Services and supplies you received before you had coverage under this Certificate or after you no longer have this coverage except as described in Extension of Benefits under the Eligibility, Coverage and When Your Coverage Ends section of this Certificate.

c. Services or benefits received from any Provider not in the Network, unless we have directed you to receive care at the Provider, or if the care results from an Emergency Medical Condition and was received in the emergency department of a Hospital or free-standing Emergency Room. See the Special Out-of-Network Rules section, for additional information.

d. Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); participation in a riot or insurrection; service in the armed forces or an auxiliary unit.

e. Any loss that results from you committing, or attempting to commit a crime, felony or misdemeanor or from engaging in an illegal occupation.

f. Any service, supply or treatment for complications resulting from any non-covered service, procedure, condition or drug.

2. Abortion Services

a. Services or supplies related to an abortion, except:
   - For an abortion performed when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused or arising from the pregnancy; or
   - When the pregnancy is the result of rape or incest.

3. Administrative Charges

a. Services for which no charge is normally made in the absence of insurance.

b. Any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.

c. Separate charges for services or supplies from an employee of a Hospital, laboratory or other institution; or an independent health care professional whose services are normally included in facility charges.

4. Alternative Treatments, Pain Management, Wellness Programs

Charges for acupuncture, massage therapy, hypnotism and TENS unit, or services for chronic pain management programs.

5. Ambulance Charges

a. Ambulance services that meet the following criteria are excluded:
   1. That do not meet coverage guidelines as outlined under Ambulance Services in Covered Services; or
   2. That are not Medically Necessary and reasonable; or
   3. Transport to a more distant Hospital solely for the member's convenience, regardless of the reason, or to allow the Member to use the services of a specific Physician or Specialist. InStil Health will pay the base

rate and mileage for a Medically Necessary ambulance transport to the nearest medically appropriate facility. If the transport is to a facility that is not the nearest medically appropriate facility, the member is responsible for additional cost incurred to go to the Member's preferred facility; or

4. If the member is medically stable and the situation does not involve an Emergency; or
5. Transport from a Hospital in connection with a hospitalization outside the United States.

b. Any and all travel expenses such as, but not limited to: transportation, lodging and repatriation. For persons travelling outside the InHealth network area, and particularly if you travel outside the United States, we recommend you purchase travel insurance that covers medical expenses and, where possible, the cost of repatriation.

6. Behavioral, Educational, or Alternate Therapy Programs

Any behavioral, educational or alternative therapy techniques such as:

a. ABA therapy unless Medically Necessary for the treatment of Autism Spectrum Disorder;
b. Teaching, Expanding, Appreciating, Collaborating and Holistic (TEACCH) programs;
c. Higashi schools/daily life;
d. Facilitated communication;
e. Holding therapy;
f. Movement therapies;
g. Primal therapy
h. Group socialization
i. Art therapy
j. Music therapy; and,
k. Animal assisted therapy.

7. Benefits Available from other Sources

a. Services for which no charge is normally made in the absence of insurance.
b. Services or supplies for which you are entitled to benefits under a governmental program (except Medicaid).
c. Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.
d. Treatment provided in a government Hospital for which you are not legally responsible.
e. Charges by the Department of Veterans Affairs (VA) for a service-related disability.
f. Services or supplies you or a member of your immediate family provides; a member of your family means spouse, parents, grandparents, brothers, sisters, aunts, uncles, children or in-laws.
g. Separate charges for services or supplies from an employee of a Hospital, laboratory or other institution; or an independent health care professional whose services are normally included in facility charges.
h. Services provided when there is a site of care or location that is more appropriate and cost-effective for the condition of the Member or the care required.

8. Clinical Trials

a. Services that are not covered routine patient care costs or services, including the following:
   1. The investigational drug, device item or service that is provided solely to satisfy data collection and analysis needs;
   2. An item or service that is not used in the direct clinical management of the Member; and
   3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
b. An item or service provided by the research sponsors free of charge for any person enrolled in the Clinical Trial
c. Travel and transportation expenses unless otherwise covered under the Policy, including, but not limited to:
   1. Fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline or train;
   2. Mileage reimbursement for driving a personal vehicle;
   3. Lodging; and

4. Meals

9. Cosmetic Services (These services are excluded even if deemed medically necessary.)

a. Cosmetic Surgery: any plastic or reconstructive Surgery done mainly to improve the appearance or shape of any body part and for which no improvement in physiological or body function is reasonably expected. Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from unexpected or unforeseen physical trauma, infection or other diseases of the involved part, or reconstructive Surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. Complications arising from Cosmetic Surgery are also not covered.
b. Breast augmentation except after treatment for breast cancer.
c. Reduction mammoplasty for macromastia unless your Body Mass Index (BMI) is less than or equal to 30.
d. Any treatment or Surgery for obesity (even if morbid obesity is present), weight reduction or weight control, such as gastric by-pass, insertion of stomach (gastric) banding, intestinal bypass, wiring mouth shut, liposuction or complications from it. This includes any reversal or reconstructive procedures from such treatments.
e. Adjustable cranial orthosis (band or helmet) for positional plagiocephaly or craniosynostoses in the absence of cranial vault remodeling Surgery.

10. Dental Care, Oral Surgery

a. Physician services directly related to the care, filling, removal or replacement of teeth; the removal of impacted teeth; and the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. This includes but is not limited to: apicoectomy (dental root resection), root canal treatment, alveolectomy (Surgery for fitting dentures) and treatment of gum disease.
b. Services for or related to dental care except as follows:
    1. Within six months of an accident, a member may receive benefits for medically necessary, non-cosmetic dental treatment to teeth that were damaged in the accident;
    2. When a Member requires dental anesthesia because the Member is unable to cooperate for dental treatment, and the service or benefit is approved by us prior to any dental procedure; and
    3. For Medically Necessary Cleft Lip and Palate services.
c. Any service or supply related to dysfunctional conditions of the chewing muscles, wrong position or deformities of the jaw bone(s), jaw muscles, orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness) caused by jaw problems usually known as TMJ, regardless of cause.

11. Durable Medical Equipment

a. Durable medical equipment or Prosthetic Devices when preauthorization is not obtained.
b. Equipment available over the counter such as, but not limited to, air conditioners, air filters, whirlpool baths, spas, (de)humidifiers, wigs, fitness supplies, vacuum cleaners or common first aid supplies.
c. Items purchased that exceed the minimum specifications for your needs; we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.
d. Duplicates and services related to the repair or replacement of a prosthetic are only considered Medically Necessary when due to routine wear and tear or a change in the Member's medical condition, and with prior authorization from us.
e. A penile prosthesis will be considered as a benefit under Durable Medical Equipment only after Medically Necessary prostate Surgery.

12. Excessive sweating

Any services, supplies or treatment for excessive sweating.

13. Family Planning

a. Any services or supplies for the diagnosis or treatment of infertility.
b. Pre-conception testing or pre-conception genetic testing; limited testing is available but must be pre-authorized by Avalon Health Services. See Preauthorization section.

14. Food or Nutrition
Orthomolecular therapy including infant formula, nutrients, vitamins and food supplements, and enteral feedings.

15. Foot Care
Services and supplies related to non-surgical treatment of the feet, except when related to diabetes

16. Genetic testing or counseling
Limited services are available for genetic testing or counseling, and must be preauthorized by Avalon Health Services. See Preauthorization section.

17. Hearing Assistance
Hearing aids and exams for the prescription or fitting of them.

18. Infertility
a. Any services, supplies, or prescription drugs for the diagnosis or treatment of infertility. This includes, but is not limited to: fertility drugs, lab and X-ray tests, reversals of sterilization, surrogate parenting, artificial insemination and in-vitro fertilization.
b. Pre-conception testing or pre-conception genetic testing (limited testing is available but only when pre-authorized; see Preauthorization section).

19. Investigational or Experimental Services
Investigational or Experimental Services, as determined by us, including but not limited to the following:
a. Relating to transplants:
    1. Uses of allogeneic bone marrow transplantation (between two related or unrelated people), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;
    2. Adrenal tissue to brain transplants;
    3. Procedures that involve the transplantation of fetal tissues into a living recipient;
b. Biofeedback, except when used for migraines and tension headaches, unless preauthorized under InStil Health medical management guidelines;
c. Vagal Nerve Stimulation (VGS);
d. Rapid opiate detoxification.

Other services and supplies may be determined to be Investigational and/or Experimental when the service or supply does not meet medical management criteria under the definition of Investigation or Experimental in this Policy.

20. Long Term Care
Admissions or portions thereof for long-term care, including:
a. Rest care;
b. Care to assist a Member in the performance of activities of daily living (including, but not limited to, walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
c. Custodial or long-term care; or,
d. Psychiatric or Substance Use Disorder treatment, including, but not limited to, therapeutic schools, wilderness /boot camps, therapeutic boarding homes, half-way houses and therapeutic group homes.
e. Admissions or portions thereof for long-term or chronic care for medical or psychiatric conditions.

21. Maternity and Newborn Care

a. Limited pre-conception testing or pre-conception genetic testing is available and only as Pre-Authorized. See Pre-Authorization section.
b. Newborn care as an Inpatient, Outpatient, or Office Visit, unless the Newborn is added to the Policy within 60 days, and the appropriate Premium paid.

22. Out-of-Network Charges

Out-of-Network benefits are not available unless specifically described under Emergency Services, Urgent Care Services, or under Out-of-Area Services, which also provide benefits only for Emergency Services or Urgent Care Services. Even when coverage is available for out-of-Network services, benefits are limited to the in-Network Allowed Amount, and the Member remains liable for all amounts above the Allowed Amount; however, see the Special Out-of-Network Rules section, for additional information.

23. Physician Charges

a. Any type of fee or charge for handling medical records, filing a claim or missing a scheduled appointment.
b. Physician charges for drugs, appliances, supplies, blood and blood products.
c. Surgical assistant when not medically necessary

24. Preauthorization Required

a. Benefits will be denied for procedures, services or pharmaceuticals when you don't get the required Preauthorization.
b. Hospital or Skilled Nursing Facility charges when Preauthorization is not obtained. Please refer to the *Preauthorization* section of this Policy.
c. All Non-emergent Admissions to Hospitals or freestanding Rehabilitation Facilities for physical Rehabilitation when the services are not done at a Provider we designate and/or you don't receive the required Preauthorization.
d. Any medical social services, visual therapy or private duty nursing, except when part of a Preauthorized home health care or hospice services program.

25. Prescription Drugs and Medications

a. That are used for or related to Non-Covered Services or conditions, such as, but not limited to, weight control, obesity, erectile dysfunction (unless indicated for confirmed diagnosis of Benign Prostatic Hypertrophy), cosmetic purposes (such as Tretinoin or Retin-A, Kybella for chin fat), hair growth and hair removal.
b. That are used for infertility.
c. More than the number of days' supply allowed as shown in your Member Schedule.
d. Refills in excess of the number specified on your Physician's prescription order.
e. More than the recommended daily dosage defined by InStil Health, unless prior authorization is sought and approved.
f. When administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not licensed to dispense drugs.
g. That are available over-the-counter or when there is an over-the-counter equivalent containing the same active ingredients as the prescription/Rx version including any over-the-counter supplies, devices or supplements.
h. When not consistent with diagnosis and treatment of an illness, injury or condition or that is excessive in terms of the scope, duration or intensity of drug therapy that is needed to provide safe, adequate and appropriate care.
i. Some medications classified as self-administered drugs; when obtained, purchased, and/or administered at a doctor's office or in an outpatient setting.
j. That require Prior Authorization, and the Prior Authorization is not received.

k. That requires step therapy when the Step Therapy Program is not followed.
l. That are prescribed and/or received Out-of-network, unless due to an Emergency Medical Condition.
m. That are not on the Covered Drug List (certain drugs administered under the medical benefit are exempt).
n. Any medication or drugs for which some or all of the cost sharing is paid by a drug manufacturer in any form of direct support (cash, reimbursement, coupon, voucher, debit card, etc.) that reduces or eliminates immediate out-of-pocket costs for a specific prescription brand drug. Although the drug remains a covered prescription drug, cost sharing amounts provided by the drug manufacturer will not be counted toward the member's annual limitation on cost sharing.
o. Food or nutritional substances, such as orthomolecular therapy, infant formula, nutrients, vitamins, food supplements, and enteral feedings, whether or not obtained with a prescription.
p. Prescription Drugs that are new to the market and under clinical review by InHealth or its pharmacy benefit manager shall be listed on the Prescription Drug List as excluded until the clinical review has been completed and a final determination has been made as to whether the Drug should be included.
q. Prescription Drugs and pharmaceuticals under the medical portion of this Policy when benefits are available under the Prescription Drug benefit.

26. Preventive services
Preventive Services other than those specifically described under Covered Services or otherwise required by law to be covered. Some tests may be used for screening (preventive) purposes or for diagnostic purposes; when filed by the Provider for a diagnostic purpose, the claim will not be paid under the Preventive Care provisions. Normal contract terms will apply.

27. Psychological and Educational Testing
Psychological or educational diagnostic testing to determine job or occupational placement, school placement or for other educational purposes or to determine if a learning disability exists.

28. Services for Certain Diagnoses or Disorders
Medical Supplies, services or charges for the diagnosis or treatment of learning disorders, communication disorders, motor skills disorders, relational problems, intellectual disabilities, vocational rehabilitation, except as specified on the Schedule of Benefits.

29. Sexual Dysfunction
a. Any services or supplies for the diagnosis or treatment of sexual dysfunction due to any medical condition or organic disease. This includes, but is not limited to: drugs, lab and X-ray tests, counseling, procedures to correct sexual dysfunction, or penile prostheses, except after Medically Necessary prostate Surgery.
b. Testing, counseling, therapy for sexual function disorder.

30. Telehealth Services
a. Telehealth services which are initiated by either a Member or Provider (including, but not limited to a medical doctor) in which the method of web-based or video communication is not secure, does not occur in real-time and/or is not provided by Network Providers who have been credentialed as eligible Telehealth Providers.
b. Telemedicine services which do not comply with all requirements specified in the Covered Services section of this Policy.

31. Telemonitoring
Telemonitoring services are not Covered Services.

32. Transplants

a. Human organ and tissue transplants when a Preauthorization is not obtained or when you do not use the Provider we designate.
b. Transplants involving:
    1. The use of allogeneic bone marrow transplantation (between two related or unrelated people), syngeneic bone marrow transplantation (from one identical twin to the other), or other forms of stem cell transplant (with or without high doses of chemotherapy or radiation) where use of the transplant is not consistent with evidence-based guidance or standard medical practice;
    2. Adrenal tissue to brain transplants;
    3. Procedures that involve the transplantation of fetal tissues into a living recipient.
    4. Services and supplies related to transplants involving mechanical or animal organs,
c. Travel or transportation to obtain a Transplant.

33. Travel

Any and all travel expenses including, but not limited to, those related to a transplant, CAR-T therapy, gene therapy; and transportation, lodging and repatriation, unless specifically included in Covered Services. For persons travelling outside the InHealth network area, and particularly if you travel outside the United States, we recommend you purchase travel insurance that covers medical expenses and, where possible, the cost of repatriation.

34. Vision Care

a. Eyeglasses, contact lenses (except after cataract Surgery), and exams for the prescription or fitting of them except as shown in the Pediatric Vision section and the Additional Covered Services section.
b. Any Hospital or Physician charges related to refractive care such as radial keratotomy (Surgery to correct nearsightedness), or keratomileusis (laser eye Surgery or LASIK), lamellar keratoplasty (corneal grafting) or any such procedures that are designed to alter the refractive properties of the cornea.

Other Coverage

If you are enrolled in another insurance coverage, such as Medicare, that offers medical coverage for any of the benefits under this Policy, InHealth may reduce benefits under this Policy to avoid paying benefits between the two plans that are greater than the cost of the health care service. If you and/or your dependents become eligible for Medicare, you should apply and enroll in Medicare Part A and B and use Providers who accept Medicare in order to ensure that you receive full benefit coverage.

The coordination of benefits (COB) process ensures that claims are paid correctly by identifying the health benefits available to a beneficiary, such as Medicare, by coordinating the payment process and ensuring that the primary payer pays first. It also ensures that the amount paid by plans in dual coverage situations does not exceed 100% of the total claim, to avoid duplicate payment.

If you have Medicare Part A (hospital insurance), Medicare Part B (medical insurance), or Medicare Part C (combined hospital and medical), your Marketplace coverage duplicates your Medicare coverage. This may affect your eligibility for this Policy and any APTC you receive. Contact www.Healthcare.gov or call 800-318-2596 (TTY: 855-889-4325) to discuss how your Medicare eligibility affects this coverage.

If the Member resides in a state where automobile no-fault, personal injury protection or medical payments coverage is mandatory or if the Member is involved in an accident in a state where such coverage is mandatory and the Member's automobile insurance carrier provides the state mandated coverage, the Member's automobile coverage is primary and this Policy secondary.

Providers

This Policy generally provides benefits for Covered Services only when received from in-Network Providers.

This Policy generally requires you to use our Network Providers in the InHealth Network. Except for Emergency Services, benefits are covered in-Network only. The InHealth Network includes Physicians and Clinicians, Hospitals, Skilled Nursing Facilities, home health agencies, hospices and other Providers who have agreed to provide health care services to our Members at a discounted rate.
To find a Network Provider, go to https://www.instilhealth.com

To ensure you receive all the benefits to which you are entitled, be sure to show your ID card whenever you visit your Provider. This way your Provider will know you have this coverage.

It's important to use an InHealth Network Provider because these Providers have agreed to:
- Bill you no more than the InHealth Network allowance for Covered Services.
- File all claims for you when this Policy is your primary insurance.
- Ask you to pay only the required Deductibles, Copayments and Coinsurance for covered amounts.
- Obtain necessary Preauthorization.

Providers not in the InHealth Network:
- In many cases are not limited in the amount they can charge you.
- May require you to file claims.
- May require payment in full before you receive services.
- With the exception of Emergency Services, and certain out-of-Network Providers furnishing services at an in-Network Hospital, Ambulatory Surgical Center, or certain other facilities, generally can Balance-Bill you for any amount InStil Health does not pay unless prohibited by law. This may be true even when InStil Health agrees that you can receive services from an out-of-Network Provider. See the Special Out-of-Network Rules section, for additional information.

For some services to be covered, you will be required to use a Provider we designate. If the Provider is not an in-Network provider, benefits may be provided in accordance with a Letter of Agreement or the Allowed Amount. These Providers may be permitted to bill you the difference between what we agreed to pay, and the full billed charges for a service.

It is always a good idea to ask if your Provider is an InHealth Network Provider before you receive care. To find out if your Physician or Hospital is an InHealth Network Provider, see the *How to Contact Us if You Have a Question* section to request a directory or visit our website. The InHealth Provider Network may change.

We make every effort to contract with Physicians and Clinicians who practice at InHealth Network Hospitals. Some Physicians, however, choose not to be InHealth Network Providers even though they may practice at InHealth Network Hospitals. It's important to understand that while you can use these Physicians, you may be subject to greater Cost-Sharing requirements, or you may have no coverage at all under this Policy.

InStil Health has no financial incentives for providers that are intended to limit services provided, limit access to care or influence treatment or referral options.

Please note that you may be seen in a teaching facility or by a Provider who has a teaching program. This means that a medical student, intern or resident participating in a teaching program may see you. Please ask your Provider if you have questions about your care.

Continuation of Care

If benefits under this Policy are no longer covered due to a change in a Provider's terms of participation in the Network, such as a Network Provider's contract is modified, ends, or is not renewed for any reason other than fraud or failure to meet specified quality standards, including suspension or revocation of the Provider's license, and you are a Continuing Care Patient of the Provider at the time, you may be eligible to continue to receive Network benefits for that Provider's services for a limited period of time. We will attempt to notify you if and when these situations arise with your providers, and explain your right to elect continued Network coverage, but such continued Network coverage is not automatic; please contact us or have your provider contact us in order to receive this continued Network coverage.

We recommend you use a form for this request; this form can be found on our website or by calling 833-738-0978. Your treating Provider should include a statement confirming that you have a Serious and Complex Condition. Upon receipt of your request, we will confirm the last date the Provider is part of the InHealth Network and a summary of continuation of care requirements. If additional information is necessary, we may contact you or the Provider.

If you qualify for continued Network status, we will provide in-Network benefits for you from that Provider, for the course of treatment relating to your status as a Continuing Care Patient, for 90 days or until the date you are no longer a Continuing Care Patient with respect to the Provider, whichever occurs earlier. During this time, the Provider will accept the InHealth Network Provider allowance as payment in full. Such continued Network status is subject to all other terms and conditions of this Policy, including regular benefit limits.

Services Outside the InHealth Network

Services outside the InHealth Network include only those services necessary to treat an Emergency Medical Condition when those services are received as an Outpatient in a Hospital Emergency Room or in an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency when obtained outside the geographic area we serve.

How to File a Claim

By accepting this Policy, you authorize release to InStil Health or its representatives of all past and future medical records and other information deemed necessary by InStil Health to review, process or investigate your claims. This authorization for release of past, present and future information includes Medicare Part A and B claims.

Claims filed by Network Providers:
If you receive health care services or supplies from an InHealth Network Provider, the Provider will file your claims for you.

Claims for Services received from out-of-Network Providers:
The InHealth product uses a Health Maintenance Organization (HMO), and services provided by out-of-Network Providers are not covered under this policy, with the exception of care for an Emergency Medical Condition when provided in the Emergency Room in a Hospital or free-standing Emergency Room, and only as long as your condition is considered an "Emergency Medical Condition." See the Special Out-of-Network Rules section, for additional information.

Claims for Emergency Services received from Out-of-Network Providers:
If you receive health care services or supplies for an Emergency Medical Condition from an out-of-Network Provider, some Providers will file your claims for you. However, if you need to file your own claims, you can find filing forms on our web site at https://instilhealth/links/providers. Click on Members > Find Forms and Documents > File a Claim.

Please follow the instructions below when you have claims for expenses other than Prescription Drugs. When filing your own claims, here are some things you will need:

1. Comprehensive Benefits Claim Form for each patient. You can get these forms from the Claims Service Center or from our website.
2. Itemized Bills From the Providers.

Complete the front of each claim form and attach the itemized bills from the Provider to it. If the patient has other insurance that has already processed the claim, be sure to attach a copy of the other plan's Explanation of Benefits (EOB) notice. This will speed up our claims processing.

Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we cannot return them to you. Please be sure your Provider includes procedure and diagnosis codes. Send your claims to the Claims Service Center at the address found in the *How to Contact Us if You Have a Question* section.

Prescription Drug Claims:
Please refer to the Prescription Drug Coverage section if you need to file a claim for Prescription Drugs.

How Long You Have to File a Claim
We must receive your claim no later than 12 months from the date of service. Exceptions may be made if you show you were not legally competent to file the claim. Claims will be processed in the order we receive them.

How Long We Have to Process a Claim
The time frames we are allowed to provide a determination for each of these claims are listed below:
1. Pre-service Claim – We must give you our decision, based on Medical Necessity, in writing or in electronic form within 15 calendar days of receipt. A **Pre-service Claim** is any claim or request for a benefit where Preauthorization must be obtained from us before receiving the medical care, service or supply.

An extension of 15 calendar days may be provided if we determine that, for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 15-day time period that an extension is necessary. When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination after the additional information is received from you or the Provider.

We will let you know within five calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to send us required information. If we don't receive the required information within the 60-day time period, we may deny the claim.
2. Urgent Care Claim – We must provide you a determination, based on Medical Necessity, in writing or in electronic form within 72 hours of receipt of the original Urgent Care Claim. An **Urgent Care Claim** is any claim, where, if the normal Preauthorization review time frames were used, your life, health or ability to regain maximum function could be seriously jeopardized; or you would be subject to severe pain that cannot be adequately managed without the care or treatment. We will defer to the attending Provider with respect to the decision as to whether a claim constitutes "urgent care." A Provider may be considered an authorized representative without a specific designation by you when the Preauthorization request is for Urgent Care Claims (medical conditions which require immediate treatment).

We will notify you or your authorized representative within 24 hours from receipt of the original Urgent Care Claim if we don't have enough information to make a decision. An extension of 48 hours may be required if we don't receive complete information in which to make a Medical Necessity decision. If we don't receive the required information from you within 48 hours after notifying you, we may deny the claim.

3. Post-service Claim – We must give you our decision in writing or in electronic form within 30 calendar days if the decision is adverse to you. A **Post-service Claim** is any claim for which you are not required to obtain Preauthorization

before obtaining the medical care, service or supply. An adverse decision includes any rescission of coverage or any amount due that you may be held responsible for other than Copayment amounts previously paid to the Provider.

An extension of 15 calendar days may be provided if we determine that for reasons beyond our control, an extension is necessary. If an extension is required, we will notify you within the initial 30-day time period that an extension is necessary.

We will let you know within 30 calendar days if we receive incomplete information from you and additional information is required to make a determination. You have 60 calendar days to provide the required information. If we don't receive the required information within the 60-day time period, we may deny the claim.

When we require an extension due to incomplete information, we are entitled to the rest of the initial determination period to reach a benefit determination once we get the additional information from you or the Provider.

4. Concurrent Care Decision – If we make a decision to reduce or stop benefits for Concurrent Care that had previously been approved, you must be notified sufficiently in advance of the reduction or termination of benefits to allow you time to appeal the decision before the benefits are reduced or terminated. **Concurrent Care** is an approved ongoing course of treatment to be provided over a period of time or number of treatments.

If you request that Concurrent Care benefits be extended and the request involves Urgent Care, the request to extend a course of treatment beyond the initially approved period of time or number of treatments must be made at least 24 hours prior to the expiration of the initially approved period. We must make a decision within 24 hours.

Denial of Claims
If we deny any part or all of a claim, you will receive an Explanation of Benefits (EOB) explaining the reason(s).

If you don't understand why we denied your claim, you can:
•Read the information in this Policy. It outlines the terms and conditions of your health coverage.
•Contact InStil Health for help.

Right of Recovery
We have the right to recover any overpayments or mistakes made in payment. The recovery can be from any person to or for with respect to which such payments were made. Recovery will be by check, wire transfer or as an offset against existing or future benefits payable under this Policy, and from any other insurance companies or any other organizations.

Time Limit to Question a Claim or File a Lawsuit (Legal Actions)
You have only 180 days to question or appeal our decision regarding a claim. After that date, we will consider disposition of the claim to be final. You cannot bring any legal action against us until 60 days after we receive a claim (proof of loss) and you have exhausted the appeal process as described in the *Appeal Procedures* section of this Policy. You cannot bring any action against us more than six years after a claim (proof of loss) has been received.

Appeal Procedures

Please direct any complaints or disagreements you have regarding claims for services or benefits to us at 833-738-0978. You can also send us a secure email through the Ask Customer Service feature of My Health Toolkit on our website at https://instilhealth.com.

A Preauthorization denial will be considered a denied claim for purposes of this provision. You can direct any complaints or disagreements you have regarding a Preauthorization to us at 803-736-5990 from Columbia, or 800-327-3238 from anywhere else.

Appeals
An appeal is a request for us to review a claim denial. A member can appeal a claim denial or the appeal can be requested by a member's Authorized Representative. Except in an Urgent Care situation, no person can act as a member's Authorized Representative unless the member has designated that person as the Authorized Representative in writing. If your Provider appeals a claim denial for a Prescription Drug or any medical service, but you have not expressly authorized the Provider to serve as your Authorized Representative, the Provider's actions cannot be used to deny you an Appeal.

How to File an Appeal
If you wish to file a formal **appeal**, you must write to InStil Health Insurance Company, Member Services Center, P.O. Box 100300, Columbia, SC 29202. The appeal must state that you are requesting a formal appeal and include all pertinent information regarding the claim in question that you wish to be considered in the appeal.

Claims and appeals for services and supplies which are specifically excluded in the Policy are not eligible for external review. The following guidelines apply for each type of claim (including the appropriate claim with regard to a Concurrent Care decision), unless both parties agree to an extension:

1. Pre-service or Concurrent Care Claim – You have 180 days to appeal our decision on a Pre-service Claim or a Concurrent Care decision. We must complete the appeal process within 30 calendar days after receiving the appeal.

2. Urgent Care Claim – You have 180 days to appeal our decision on an Urgent Care Claim. You may request an expedited review for an Urgent Care Claim either orally or in writing, and all necessary information pertaining to the appeal must be transmitted by telephone, facsimile, or other expeditious method. We must complete the appeal process within 72 hours after receiving the appeal.

3. Post-service Claim – You have 180 days to appeal our decision on a Post-service Claim. We must complete the appeal process within 60 calendar days after receiving the appeal.

You will have the opportunity to submit written comments, documents or other information in support of the appeal and you will have access to all documents that are relevant to the claim. If we consider or present additional evidence in connection with the appeal or use new or additional reasons as the basis of the appeal decision, you will be notified of the new evidence or rationale in the appeal decision and have an opportunity to respond. The appeal will be conducted by someone other than the person who made the initial decision, or his or her subordinate. No deference will be afforded to the initial determination. Individuals involved in the decision-making for claims and appeals are not compensated or rewarded based on the outcome of an appeal.

You will be considered to have exhausted the internal appeal process if we fail to strictly adhere to the internal appeal process, unless the error was:

1. De minimis;
2. Non-prejudicial;
3. Attributable to good cause or matters beyond our control;
4. In the context of an ongoing good-faith exchange of information; and

5. Not reflective of a pattern or practice of non-compliance.

You may write to us and request an explanation of our basis for stating we meet the above standard.

External Reviews

Requests to cover services, benefits, or supplies which are specifically excluded in the Policy are not eligible for external review. You will be notified in writing of your right to request an external review. You should file a request for external review within four months of receiving that notice; your request for external review must be in writing. You will be required to authorize the release of any medical records that may be needed for the external review. If you need assistance during the external review process, you can contact the South Carolina Department of Insurance at the following address and telephone number:

South Carolina Department of Insurance
Post Office Box 100105
Columbia, SC 29202-3105
800-768-3467

Standard External Review

You can request an external review if we deny your claim, either in whole or in part, and the request relates to a decision involving medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or administration of this Policy's provisions under the section entitled "Special Out-of-Network Rules." You may be held financially responsible for the covered benefits. You can request an external review without completing the appeal process above if:

1. Your Physician has certified in writing that you have a Serious Medical or Behavioral Health Condition, a condition that requires immediate medical attention to avoid serious impairment to body functions, serious harm to an organ or body part, or that would place your health in serious jeopardy or jeopardize your ability to regain maximum function. This may include cancer, acute myocardial infarction, pregnancy, and Behavioral Health conditions.
; or
2. The denial of coverage was based on our determination that the service is Investigational or Experimental and your Physician certifies:
    a. Your condition is a serious disability or you have a life-threatening disease; and
        i. Standard health care services or treatments have not been effective in improving your condition; or
        ii. Standard health care services or treatments are not medically appropriate; or
        iii. The recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by us; and
    b. Medical and scientific evidence shows that treatment that was denied is more beneficial to you than available standard health services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

We will respond within five business days of your request for an external review, by either notifying the South Carolina Department of Insurance of a request for external review and requesting the South Carolina Department of Insurance to assign the review to an independent review organization (IRO) and forwarding your records to it or telling you in writing that your situation doesn't meet the requirements for an external review and explaining the reasons. The South Carolina Department of Insurance assigns an IRO on a rotational system. InStil Health does not assign the IRO and is obligated to notify the Department of Insurance if a conflict of interest exists so a different IRO can be assigned.

You have five business days from the date you receive our response to submit additional information to the IRO in writing. The IRO must consider this additional information when conducting its review. The IRO will also forward this information to us within one business day of its receipt.

If your request is assigned to an IRO, the IRO will determine within five business days after receiving your request whether all the information, certifications and forms required to process an external review have been provided. If the IRO needs additional information, you will be allowed to submit additional information in writing to them within seven business days.

If your request is not accepted for external review, the IRO will inform you and us in writing of the reason(s) your request was not accepted.

The IRO will provide written notice of its decision within 45 days after it receives the request.

If the IRO's decision is to allow benefits, we must process the claim subject to applicable Policy exclusions, limitations and other provisions within five business days of our receipt of the notification.

Expedited External Reviews
You can request an expedited external review at the same time as requesting an expedited internal review and there is no deadline on when you can make this request. When we receive your request for an expedited external review, the South Carolina Department of Insurance will assign your review to an IRO and we will forward our records by overnight delivery, or tell you in writing that your situation doesn't meet the requirements for an expedited external review and explain the reasons.

The IRO must make its decision as fast as possible but within no more than 72 hours after it receives the request for expedited review. If the IRO's decision is to allow benefits, we must approve the benefit as covered, but it remains subject to applicable Policy exclusions, limitations and other provisions.

All requests for external review and the subsequent review will be at our expense.

If your Physician certifies that you have a "Serious Medical or Behavioral Health Condition" as described above, you are entitled to an expedited external review.

Subrogation and Reimbursement

A. SUBROGATION
The Member agrees, as a condition of receiving Benefits, to transfer to the Corporation all rights to recover for the amount paid for such Benefits when the need for Benefits results from an injury occurring through the act or omission of a third party (including another person, firm, corporation, organization or business entity). The Corporation shall be subrogated, at its expense, to the rights of recovery of such Member against any third party who is liable, responsible or otherwise makes a payment for the injury.

B. REIMBURSEMENT
The Member agrees, as a condition of receiving Benefits, to reimburse the Corporation for the amount paid for Benefits which are related to an injury caused by an act or omission of a liable third party when the Member receives a settlement, judgment or other payment relating to the injury from another person, firm, corporation, organization or business entity. However, under no circumstances will the amount of reimbursement exceed the amount of the Member's recovery.

For purposes of this Article, a liable third party and/or liable insurance coverage include parties and coverages that are responsible or otherwise make a payment for the Member's injury even though liability or other culpability may be denied.

C. GENERAL PROVISIONS

The Corporation's subrogation/reimbursement rights apply to any judgment and/or settlement proceeds received by the Member from or on behalf of the liable third party.

The Corporation's subrogation/reimbursement interest extends to all Benefits paid or payable relating to the injury even if claims for those Benefits were not submitted to the Corporation for payment at the time the Member received the settlement, judgment or payment.

The Corporation's right of recovery may be from any available source, including the liable third party, any liability or other insurance covering the liable third party, malpractice insurance, the Member's own uninsured motorist insurance and/or underinsured motorist insurance.

As a condition of being entitled to Benefits, the Member must:

1. Immediately notify the Corporation of an injury for which another party may be liable, legally responsible or otherwise makes a payment in connection with the injuries;

2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

3. Deliver to the Corporation a copy of the police report, incident or accident report or any other reports issued as a result of the injuries within ninety (90) days of being requested to do so;

4. Authorize the Corporation to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries under the Plan and the expenses incurred by the Corporation in collecting this amount and assign to the Corporation the Member's rights to recovery when this provision applies;

5. Include the amount paid for Benefits as a part of the damages sought against a liable third party and/or liability insurance company;

6. Immediately reimburse the Corporation, out of any recovery made from a liable third party, the amount of medical Benefits paid for the injuries by the Corporation up to the amount of the recovery;

7. Immediately notify the Corporation in writing of any proposed settlement and obtain the Corporation's written consent before signing any release or agreeing to any settlement; and,

8. Cooperate fully with the Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Corporation.

The Corporation will pay reasonable attorney's fees and costs from the amount recovered.

If the Director of Insurance, or his or her designee, upon being petitioned by the Member, determines that the exercise of subrogation and/or reimbursement by the Corporation is inequitable and commits an injustice to the Member, subrogation and/or reimbursement will not be allowed. This determination by the director or his or her designee may be appealed to the Administrative Law Judge Division as provided by law.

General Provisions

1. **Claim Forms:** When we receive notice of a claim, we will send you forms for filing proof of loss. If these forms are not given to you within 15 days, you can meet the proof of loss by giving us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss section.

2. **Conformity with State Statutes:** Any provision of this Policy which, at any relevant time, is in conflict with the laws of the state in which it is delivered or in conflict with Federal law on that date is amended to conform to the minimum requirements of such laws. Notwithstanding anything herein to the contrary, no provision of this Policy shall be interpreted as prohibiting any provision, access, use, or disclosure of information to the extent required by applicable law.

3. **Entire Policy; Changes:** This Policy, together with the Application and any attached papers, is the entire Policy between you and InStil Health. No agent can change it in any way. Only an officer of ours can approve a change. That change must be shown on your Policy.

4. **Fees:** We may charge you a fee to Reinstate your Policy and a fee if your Premium payment is returned for non-sufficient funds (NSF). The Reinstatement fee is $10. The NSF fee is $25.

5. **Governing Law:** This Policy and all endorsements and amendments issued hereunder will be construed according to and controlled by the applicable laws and regulations of the State of South Carolina and Federal laws and regulations.

6. **Illegal Occupation:** We are not liable for any loss that results from the Covered Person committing, or attempting to commit a felony or from a Covered Person engaging in an illegal occupation, unless otherwise specified herein.

7. **Legal Action**: No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No such action may be brought after six years from the time written proof of loss is required to be given.

8. **Non-assessable:** This is a Non-assessable Policy. You are not subject to any assessment for any contingent liability. This means that if, for any reason, we owe money, you are not responsible for paying it.

9. **Notice of Claim:** Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice may be given to us at our home office or to our agent. Notice should include the name of the Covered Person and the Policy number.

10. **Other Valid Coverage: Proration:** This Policy is not meant to duplicate other valid coverage you have with other Health Insurance policies, not including Medicare; see the Medicare Coverage Provision above, on page 37.

If you have Other Valid Coverage, we will "prorate" benefit payments when your claim is received. We will carefully consider all of the valid Health Insurance that covers your claim. We will determine our responsibility for your loss in proportion to the responsibility that should be accepted by other insurance companies, and we will pay the portion of your claim we are responsible for.

If your claim is prorated, the portion of the Premiums you paid for coverage that we did not accept as our responsibility will also be prorated. This will be based on Premiums paid during the time both policies were in effect and the treatment was being provided.

11. **Payment of Claims:** Subject to Member Cost-Sharing, we will pay benefits as follows:

- Where a Member has received benefits from a Network Provider, we will pay benefits directly to the Network Provider.

- If a Member receives services from a non-Network Provider, we may pay benefits directly to the Member upon receipt of claims, where permitted under applicable law; in those cases, the Member is responsible for any payment to the Provider. No assignment of benefits is allowed to a non-Network Provider.
- Payment of benefits related to Emergency Services will be made to the Provider, whether Network or non-Network.
- Any payment of benefits or refund due after death will be paid to the Member's estate.

12. **Physical Examinations and Autopsy:** We have the right to have a Physician examine any person as often as reasonably necessary while a claim is pending or after our Medical Services staff has been contacted for review of medical services. We will pay for the cost of these examinations. We may also have an autopsy done during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

13. **Proofs of Loss:** Written proof of loss must be furnished to us at our office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event, except in the absence of legal capacity, will written proofs of loss be furnished later than one year from the time the proof is otherwise required.

14. **Right to Transfer:** Any person purchasing an individual accident, health or accident and Health Insurance policy, will have the right to transfer to any individual policy of equal or lesser benefits offered for sale by InHealth at the time transfer is sought. Members who purchase this coverage through the Health Insurance Marketplace may be restricted from exercising this right except at the times permitted by the Health Insurance Marketplace (Exchange).

15. **Time Limit On Certain Defenses:** After two years from the issue date only fraudulent misstatements in the Application may be used to void the Policy or deny any claim for loss incurred or disability that starts after the two year period.

16. **Time of Payment of Claim:** We will pay completed claims received via paper within forty business days and completed electronic claims within twenty business days following the later of 1) date the claim is received; or 2) the date on which the insurer receives all of the information needed in the format required for the claim to constitute a "clean" claim as defined in the South Carolina Health Care Financial Recovery and Protection Act.

Definitions

As you refer to this Policy, please note that the words beginning with **capital letters** have special definitions. We have included the definitions of these terms under this section to help you understand your coverage. More definitions are shown in other parts of this Policy.

Accidental Injury: An injury directly and independently caused by a specific accidental contact with another body or object. All injuries you receive in one accident, including all related conditions and recurrent symptoms of these injuries, will be considered one injury. Accidental Injury does not include indirect or direct loss that results in whole or in part from a disease or other illness.

Admission: The period of time between your entry as a registered bed-patient in a Hospital or Skilled Nursing Facility or long-term acute care Hospital and the time you leave or are discharged from the Hospital or Skilled Nursing Facility. The Admission may be on an Inpatient or Outpatient basis as determined by the Provider.

Advanced Premium Tax Credit (APTC): A tax credit provided on an advance basis on behalf of a qualified individual purchasing a qualified health plan through the Health Insurance Marketplace (or FFM).

Allowed Amount: The amount we agree to pay a Network Provider, Participating Provider, out-of Network Provider or Non-Participating Provider as payment for a service, procedure, supply or equipment. For an out-of-Network Provider, (i) the Allowed Amount shall not exceed the Maximum Payment and (ii) in addition to the Member's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Member may be Balance-Billed unless prohibited by law by the out-of-Network Provider, except as otherwise provided herein, for any difference between the Allowed Amount we pay and the billed charges.

Ambulatory Surgical Center: A free-standing facility not affiliated with a health system that is licensed for Outpatient Services only and doesn't provide overnight accommodations or around-the-clock care. The care must be provided under the supervision of a Physician. It also must provide nursing services by or under the supervision of an on-duty registered nurse (RN). The facility must not be an office or clinic for the private practice of a Physician.

Application: The electronic or paper form to transmit the necessary information from the Member to us when applying for this Policy. The Application is a part of this Policy.

Authorized Representative: A person you designate in writing to act on your behalf to appeal a particular adverse determination or claim denial. A Provider may act as your Authorized Representative without written permission only when seeking an approval request for Urgent Care Claims (medical conditions which require immediate treatment). In all other situations, a person, including a Provider, must have your written permission to act as your Authorized Representative.

Autism Spectrum Disorder – Autistic Disorder, Asperger's Syndrome and Pervasive Developmental Disorder.

Balance-Bill(ing): The process when a Provider bills you for the difference between the Provider's billed charge and the Allowed Amount we pay or for the penalties for not obtaining Preauthorization. For example, if the Provider's billed charge is $100 and the Allowed Amount we pay is $70, in many cases the Provider may bill you for the remaining $30. A Network Provider may ***not*** Balance-Bill you for Covered Services, except as noted in the *Preauthorization* Section.

Behavioral Health: The comprehensive medical term to include Mental Health and Substance Use Disorder services.

Benefit Period: A period beginning January 1st and continuing through December 31st. Your first Benefit Period begins on your Effective Date of coverage and lasts until December 31st.

Benefit Period Maximum: The maximum number of days, items or visits that benefits will be provided for a Covered service in a Benefit Period.

Coinsurance: A percentage of the Allowed Amount that you pay. This percentage applies to the negotiated rate or lesser billed charge when we have negotiated rates with that Provider. For example, you pay 20 percent of the Allowed Amount and we pay 80 percent.

Continuing Care Patient: An individual who is (1) undergoing a course or treatment for a Serious and Complex Condition, (2) undergoing a course of institutional or inpatient care, (3) is scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery, (4) pregnant and undergoing a course of treatment for the pregnancy, or (5) determined to be terminally ill (under section 1861(dd)(3)(A) of the Social Security Act) and receiving treatment for such illness.

Copayment: A set amount you pay (for example, $50 for an office visit) for some services. Please refer to your Member Schedule to see if Copayments apply to your coverage.

Cost Sharing: The general term that refers to the share of costs for services covered by a plan or health insurance that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of types of Cost Sharing include copayments, deductibles, and coinsurance. Other costs, including your premiums, Balance Billing amounts, penalties you may have to pay**,** or the cost of care not allowed by a plan or policy are usually not considered Cost Sharing.

Cost-sharing Reductions: Discounts that lower Cost Sharing for certain services covered by individual health insurance purchased through the Health Insurance Marketplace. You can get these discounts if you are determined to be eligible by the Health Insurance Marketplace and choose a Silver level health plan. If you're a member of a federally recognized Indian tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation, you can qualify for Cost-sharing Reductions under any metal level and may qualify for additional Cost-sharing Reductions depending upon income.

Custodial Care: Care that we determine is provided primarily to assist the patient in the activities of daily living and does not require a person with medical training to provide the services. Custodial Care includes, but is not limited to, activities bathing, eating, dressing, toileting, continence, preparation of special diets and supervision over self-administered medications.

Deductible: The amount you are responsible for paying for most Covered Services before we begin to pay each year. The Deductible may not apply to all Covered Services. Benefits will begin paying for a member once that member meets the single Deductible for that year or, if the family Deductible is met by adding together the amounts of all family members, benefits will begin to pay for all family members.

Dependent: Your legal spouse and any children (natural, adopted, step, foster or under legal guardianship) through age 25.

Disease Management: Programs designed to improve the health and quality of life for Members with chronic conditions by preventing or minimizing the effects of the condition(s). Goals include identifying chronic conditions and working with Members and healthcare provider(s) in the treatment plan, educating and assisting Members to avoid complications, and to slow the progression of those diseases. Members are empowered to work with health care providers; to learn and use self-care strategies, employing a system of coordinated healthcare interventions and communications; and to manage their disease and prevent complications.
As part of a disease management program, all parties support the Provider-Member relationship and plan of care, use prevention and proactive interventions based on evidence-based guidelines, increase patient self-management, and continuously evaluate the patient's health status.

Durable Medical Equipment (DME): Equipment ordered by a health care Provider that has exclusive medical use. These Items must be reusable and may include: wheelchairs, Hospital-type beds, walkers, Prosthetic Devices, orthotics devices, oxygen, respirators, etc. To be considered DME eligible for coverage, the device or equipment's use must be limited to the patient for whom it was ordered.

Emergency: An unexpected and usually dangerous situation that calls for immediate action.

Enrollee: A qualified individual enrolled in a Qualified Health Plan.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm, including an illness or injury to an unborn child.

Emergency Services: Services, supplies and treatment for stabilization and/or initial treatment of an Emergency Medical Condition when provided at a Hospital Emergency Room.

Excluded Services: Health care services for which this Policy doesn't provide benefits or cover.

Formulary: A list of drugs your health insurance plan covers. A formulary may include how much you pay for each drug. If the plan uses "tiers," the formulary may list which drugs are in which tiers. For example, a formulary may include generic drug and brand name drug tiers.

Genetic Information: Information about your genetic tests or the genetic tests of your family members, or any request of or receipt by you or your family members of genetic services. Genetic Information does not include the age or sex of any individual.

Habilitation Services: Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings. All services must be provided by a licensed physical, occupational or speech therapist.

Health Insurance Coverage: Benefits for medical care provided directly, through insurance, reimbursement or otherwise. It does not include benefits or coverage provided under:

1. Coverage for accident or disability income insurance, or any combination of the two;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage that's specified in regulations where benefits for medical care are secondary or incidental to other insurance benefits;
9. If offered separately:
    a. Limited scope dental or vision benefits;
    b. Benefits for Long-term Care, nursing home care, home health care, community-based care or any combination of them;
    c. Such other similar, limited benefits as specified in regulations;
10. If offered as independent, non-coordinated benefits:
    a. Coverage only for a specified disease or illness;
    b. Hospital indemnity or other fixed indemnity insurance;

11. If offered as a separate insurance policy:
    a. Medicare supplemental Health Insurance;
    b. Coverage to supplement coverage provided under Military, TRICARE or CHAMPUS; and
    c. Coverage to supplement coverage under a group health plan.

Health Insurance Marketplace (also known as the Marketplace, Exchange or Federally-Facilitated Marketplace/FFM): The health insurance exchange operated by the federal government at www.healthcare.gov to allow qualified individuals to purchase Qualified Health Plans. The Marketplace is a resource where individuals and families can learn about and compare health insurance plans based on costs, benefits, and other important features, as well as enroll in coverage. It also provides information on programs that help people with low to moderate income save on the monthly premiums and out-of-pocket medical expenses (see Premium Tax Credits and Cost-Sharing Reductions). Information about Medicaid and the Children's Health Insurance Program (CHIP) can also be found here. Customers can access the Marketplace through websites, call centers and in-person.

Health Status-Related Factor: Any of these: health status, medical condition (including both physical and mental conditions), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability, and conditions arising out of acts of domestic violence.

Hospital: An acute-care facility that:
1. Is licensed and operated according to the law; and
2. Primarily and continuously provides or operates medical, diagnostic, therapeutic and major surgical facilities for the medical care or Behavioral Health care and treatment of injured or sick people on an Inpatient basis. The care must be provided under the supervision of a staff of duly licensed Physicians; and
3. Provides 24-hour nursing services by or under the supervision of registered nurses (RNs).

The term Hospital may include a long-term acute care Hospital or Rehabilitation Facility, but does not include long-term, chronic-care institutions, Skilled Nursing Facility, or institutions (even when affiliated with or a part of the Hospital) that are, other than incidentally:
1. Convalescent, rest or nursing homes or facilities; or
2. Facilities primarily affording custodial, educational or rehabilitative care.

Incapacitated Dependent: A Dependent child who is: 1) incapable of self-sustaining employment because of a mental or physical handicap; and 2) mainly dependent upon you or your spouse for support and maintenance. The child must have developed the handicap before he or she reached the age at which coverage would otherwise terminate. To keep coverage for an Incapacitated Dependent, you must give us written proof of the disability from a Physician within 31 days of the Dependent's 26th birthday. For the child to remain covered, we must receive a Physician's written report every two years within 31 days of the child's birthday. Coverage must also remain in effect for you.

InHealth Network: The name of the Network of Providers applicable only to this Policy; this Network is a Health Maintenance Organization (HMO). Only Providers who contract with InStil Health Insurance Company to specifically participate in the InHealth Network are considered "in-Network" for purposes of reimbursement under this Policy. This Policy does not cover services rendered by out-of-Network Providers (except Emergency Services for an Emergency Medical Condition as defined by this Policy), who do not contract with InStil Health Insurance Company to specifically participate in the InHealth Network. No other provider networks for other products offered by InStil Health Insurance Company apply to this Policy.

Inpatient: A Member who is a registered bed patient in a Hospital, Skilled Nursing Facility, Rehabilitation Facility or Psychiatric/Substance Abuse facility for whom a room and board charge is made.

Inter-disciplinary Pain Management Program: A program that includes physicians of different specialties and non-physician Providers, who specialize in the assessment and management of patients with a range of painful diagnoses and chronic pain, to provide the interventions needed to allow the patients to develop pain coping skills and discontinue analgesic medication.

Investigational or Experimental: The use of services or supplies that we don't recognize in the United States as standard medical care for the treatment of conditions, diseases, illnesses or injuries. We may use the following criteria to determine whether a service or supply is Investigational or Experimental:

1. The service does not have final unrestricted market approval from the FDA or final approval from any other governmental regulatory body for the use in treatment of a specified condition.
2. The service does not have scientific evidence that permits conclusions concerning the effect of the technology on health outcomes.
3. The service does not improve the net health outcome.
4. The service has not been found to be as beneficial as any established alternatives.
5. The service does not show improvement outside the investigational settings.

If a service meets one or more of these criteria, it is Investigational or Experimental. We may consider opinions of professionals in a particular field and/or opinions and assessments of nationally recognized review organizations, but they are not determinative or conclusive.

Our Medical Director, in making such determinations, may consult with or use medical and/or science industry references, including but not limited to the following sources of information:
1. FDA-approved market rulings
2. *The United States Pharmacopoeia and National Formulary*
3. The annotated publication titled, *Drugs, Facts, and Comparisons*, published by J. B. Lippincott Company
4. Available peer-reviewed literature
5. Appropriate consultation with professionals and/or Specialists on a local and national level.

Letter of Agreement: A formal agreement between InStil Health and the Provider, establishing the terms for reimbursement of medical services when the provider is not in the Network.

Long-term Care: Services that are not reasonably expected to result in measurable functional improvement in a reasonable and predictable period of time.

Marketplace: See Health Insurance Marketplace

Maximum out-of-pocket: The most you pay for Covered Services in a year before this Policy begins to pay 100 percent of the Allowed Amount. This limit never includes your Premium, Balance-Billed charges or health care your Plan doesn't cover.

Maximum Payment: The maximum amount we will pay (as determined by us, and in accordance with the Member Schedule) for a particular benefit. The Maximum Payment will be the lesser of the following:
1. The actual charge submitted to us for the service, procedure, supply or equipment by a Provider; or
2. An amount that has been agreed upon in writing by a Provider and us; or
3. An amount established by us, based upon factors including, but not limited to, (i) Medicare reimbursement rates applicable to the same or similar service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and/or circumstances giving rise to the need for the service, procedure, supply or equipment; or

4. The lowest amount of reimbursement we allow for the same or similar service, procedure, supply or equipment when provided by a Network Provider.

Medically Necessary or Medical Necessity: Health care services that a Physician, exercising prudent clinical judgment, would provide to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, Physician or other health care Provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas, and any other relevant factors.

Member: A person insured under this Policy.

Mental Health: Conditions defined, described or classified as behavioral or psychiatric disorders or conditions in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.

Minimum Essential Coverage: Any of the following: 1) coverage under certain government-sponsored plans; 2) employer-sponsored plans, with respect to any employee; 3) plans in the individual market; 4) grandfathered health plans; and 5) any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Health and Human Services Secretary.

Network: The Providers we have contracted with to specifically participate in the Network, a Health Maintenance Organization (HMO), to provide health care services to Members purchasing this Policy only. Only Providers who contract with InHealth to specifically participate in the Network are considered part of the Network for purposes of reimbursement under this Policy.

Open Enrollment Period: A period of time determined by the federal government during which all qualified individuals may enroll in new or different individual market Health Insurance coverage. During this period, you cannot be declined for such individual market coverage due to any Health Status-Related Factor.

Outpatient: Receiving services or supplies in a facility setting that does not require an overnight stay.

Physician and other Clinicians: A person (other than an intern, resident or house Physician) duly licensed as a medical doctor, dentist, oral surgeon, podiatrist, osteopath, optometrist, ophthalmologist, Physician's assistant, Nurse Practitioner, midwife, licensed independent social worker or licensed doctoral psychologist, legally entitled to practice within the scope of his or her license and who normally bills for his or her services.

Policyholder: You, or a parent or a legal guardian, who purchased this insurance Policy to cover you and/or your Dependents and who is the owner of the Policy and payer of the Premiums.

Premium: The amount that must be paid for your health insurance under this Policy.

Premium Tax Credits: Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drugs: Medications that require a prescription and can only be dispensed by a licensed pharmacy. Injectable insulin and diabetic supplies may also be also considered Prescription Drugs.

Prescription Drug Deductible: The amount you are responsible for paying for Prescription Drugs before we begin to pay each year. The Prescription Drug Deductible must be met in addition to any applicable Copayments.

Primary Care Physician (PCP): A family doctor, general Physician, OB/GYN, pediatrician, osteopath or internal medicine Physician.

Prosthetic Devices: Artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly. A Physician must order the appliance or device. Prosthetics don't include bioelectric, microprocessor or computer programmed prosthetic components.

Provider: Any of the following: A facility, Hospital, Skilled Nursing Facility, Rehabilitation/Habilitation facility, Mental Health or Substance Use Disorder facility, Residential Treatment Center, Physician or other clinician, Psychologist, other mental health clinicians, clinic, Ambulatory Surgical Center, or supplier licensed as required by the state where located, performing within the scope of the license, and acceptable to us. Providers also include:

1. Durable Medical Equipment supplier
2. Independent clinical laboratory
3. Occupational, Physical and Speech therapist
4. Pharmacy
5. Home Health Care Provider
6. Hospice Services Provider
7. Behavioral Health

Qualified Health Plan: A health plan that has been certified by HHS to be offered through an Exchange.

Qualified Individual: An individual who seeks to enroll in a Qualified Health Plan offered through an Exchange, resides in – or intends to reside in – South Carolina and is determined to be eligible by the Health Insurance Marketplace.

Recognized Amount: The lesser of the out-of-Network Provider's billed charges or our median contracted rate for in-Network Providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

Rehabilitation Facility: A Hospital or other freestanding medical facility that has a written agreement with us to provide on services directed toward restoring full function and independent living for patients with neurological or other physical illnesses or injuries. These services consist of a multidisciplinary therapeutic program that includes physical therapy, occupational therapy and other therapeutic interventions on an Inpatient basis.

Rehabilitation Services: Health care services that help a person improve skills and functioning that have been lost or impaired due to an illness or injury. These services may include physical, occupational and speech therapy services in a variety of Inpatient and/or Outpatient settings if provided by a licensed physical, occupational or speech therapist.

Resident/South Carolina Resident: Person who resides primarily within the State of South Carolina, typically at least six months of the calendar year. Residency may be shown by possession of a current government identification (such as a South Carolina driver's license, South Carolina voters registration card, etc.), the most recent year's tax return document, or a current utility bill showing the state of South Carolina as residence. For children, residency may be shown by the existence of the above documents for a custodial parent. For this InHealth product, all persons covered under this policy must also reside in one of the five counties in which coverage is available: Chesterfield, Darlington, Florence, Spartanburg and York counties of South Carolina.

Residential Treatment Center: A licensed institution, other than a Hospital, which meets all seven (7) of these requirements:

1. Maintains permanent and full-time facilities for bed care of resident patients; and
2. The facility is licensed OR accredited by the appropriate agency; and
3. Has the services of a psychiatrist and/or addictionologist, for Substance Use Disorder (SUD) admissions, or psychiatric mental health nurse practitioner, or physician assistant available at all times and is responsible for the clinical evaluation and provides face-to-face evaluation services with documentation a minimum of once/week and as needed or as indicated;
4. Has a registered nurse (RN) who oversees patient care on site a minimum of 8 hours/day 7 days a week and on call 24 hours per day/seven days per week. The response time to the facility must be 60 minutes or less when on call. Licensed nursing personnel for residential facilities performing detoxification must be on site 24 hours/day seven days/week; and
5. An awake licensed clinician must be on site 24 hours/day seven days/week; and
6. Keeps a daily medical record for each patient; and
7. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care.

Schedule: The attachment to the Policy that specifies the amount of coverage provided, your Copayments, Coinsurance, Deductibles and limitations.

Serious and Complex Condition: A condition that is —

1. In the case of an acute illness, serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
2. In the case of a chronic illness, (a) life-threatening, degenerative, potentially disabling, or congenital; and (b) requires specialized medical care over a prolonged period of time.

Examples of a Serious and Complex Condition include cancer, acute myocardial infarction and pregnancy, but may also include other medical or behavioral health conditions that meet the above definitions.

Skilled Nursing Facility: A licensed institution, other than a Hospital, that has a written agreement with us which meets all six of these requirements:

1. Maintains permanent and full-time Facilities for bed care of resident patients; and
2. Has the services of a Physician available at all times; and
3. Has a registered nurse (RN) or Physician on full-time duty who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) on duty at all times; and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing continuous skilled nursing care for sick or injured patients during the recovery stage of their illnesses or injuries and is not, other than incidentally, a rest home or a home for Custodial Care for the aged; and
6. Is operating lawfully as a skilled nursing home in the area where it is located.

In no event, will the term "Skilled Nursing Facility" include an institution, such as a Residential Treatment Center, that mainly provides care and treatment for Substance Use Disorder, alcohol abuse, or Mental Health.

Sound Natural Tooth: Teeth that are free of active or chronic decay, have at least 50 percent bony support, are functional in the arch and have not been excessively weakened by multiple dental procedures. Also includes teeth that have been restored to normal function.

Specialist: A Physician who is not a Primary Care Physician.

Substance Use Disorder: The continued use, abuse and/or dependence of legal or illegal substance(s), despite significant consequences or marked problems associated with the use as defined, described or classified in the latest publication of The American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.

Surgery: 1) a procedure performed on a living body usually with instruments especially for the repair of damage or defect or the restoration of health, including endoscopic examinations and other invasive procedures; 2) the correction or treatment of fractures and dislocations, including the placement of casts; and 3) other procedures deemed as reasonable and approved by us. This includes the usual, necessary and related pre- and post-operative care.

Telehealth: The exchange of Member information during which a Member can have a telephone, video or web-based appointment with a licensed Provider. Telehealth does not require two-way audio or video consultations between a Referring Provider and/or Specialist.

Telemedicine: The exchange of Member information from one eligible referring licensed Provider (for purposes of Telemedicine outlined herein, the "Referring Provider") site to another eligible consulting licensed Provider (for purposes of Telemedicine outlined herein, the "Consulting Provider") site for the purpose of providing medical care to a Member in circumstances in which in person, face-to-face contact with the Consulting Provider is not necessary. The exchange must occur via two-way, real-time, interactive, HIPAA-compliant, electronic audio and video telecommunications systems.

Telemonitoring: Services where a Member transmits, whether by facsimile, e-mail, telephone or any other format, his or her specific health data (e.g. blood pressure, weight, etc.) to a Provider.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room care.

Urgent Treatment Center: A medical facility where ambulatory patients can be treated on a walk-in basis, without appointment, and receive immediate non-emergency care. It does not include a Hospital emergency room.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

(i) With respect to one life, regardless of the number of policies or contracts:

- $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or

- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each payee of a structured settlement annuity or beneficiary if the payee is deceased, $300,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any,

(iii) the association is not obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for health benefit plans, in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual or with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(iv) the limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(v) benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

INSTIL® HEALTH

InHealth
Major Medical Expense Coverage
Policy Form No. InHealth OOC (Rev. 1/2027)
Outline of Coverage

How to Get Help from Instil Health Insurance Company – If you need information about the Policy, call InStil Health at (833) 738-0978.

If the policy you choose has a coinsurance amount of 25% or more, the policy is considered a limited benefit policy.

When we receive your application, we will issue you this Policy and an ID card, but the Policy will not be in effect until we receive any payment due from you, including your portion of the first month's premium.

Read Your Policy Carefully

This Outline of Coverage briefly describes the important features of your Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail your rights and obligations and those of InStil Health Insurance Company. It is important that you READ YOUR POLICY CAREFULLY.

Major Medical Expense Coverage

Policies of this category are designed to provide coverage to persons insured for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital medical services and out-of-Hospital care subject to any Deductibles, Copayments or other limitations that may be set forth in the Policy.

Preauthorization Requirement

Preauthorization is also called prior authorization, prior approval or precertification. It is important to understand what Preauthorization means. It means the service has been determined to be medically appropriate for the patient's condition. **A Preauthorization does not guarantee that we will pay benefits.**

Preauthorization must be obtained for certain categories of benefits; a failure to get preauthorization may result in benefits being denied. We will make our final benefit determination when we process your claims. Even when a service is preauthorized, we review each claim to make sure:

- The patient is a Member under the Policy at the time service is provided.
- The service is a Covered Service. Policy limitations or exclusions may apply.
- The service provided was medically appropriate.

Providers

Your coverage requires you to use the InHealth network, an Health Maintenance Organization (HMO). Benefits are generally covered in-Network only. The InHealth network includes Physicians and Clinicians, Hospitals, Skilled Nursing Facilities, home health agencies, hospices and other Providers who have agreed to provide health care services to our Members at a discounted rate.

To find a Provider, go to: https://instilhealth.com/links/2027/providers

InStil Health Insurance Company does not discriminate on the basis of race, color, national origin, disability, age or sex in the administration of the plan, including enrollment and benefit determination. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. For questions about your coverage, please contact InStil Health at (833) 738-0978.

Benefit Description

InHealth Plans					
Plans	**Coinsurance**	**Copayments**	**Deductible**	**Out-of-Pocket**	**Prescription Drugs**
InHealth Basic 1	**50%***	$35 per Primary Care Physician (PCP) Office visit combined with Mental Health & Substance Use Disorder/Behavioral Services $60 per Specialist Office visit $60 per Urgent Care Center visit $20 per visit for Rehabilitation services, including Speech, Occupational, or Physical Therapy or per Habilitation Services visit $20 per Outpatient Rehabilitation Services visit $500 per Ambulatory Surgery Center facility charge $25 per Chiropractic Care Service visit	$6,000 per Member per Benefit Period and $12,000 per family per Benefit Period. With family coverage, once one person meets the $6,000 Deductible, benefits will begin paying for that person. When the family meets the $12,000 Deductible, benefits begin paying for the entire family. For Tier 3 and 4 Prescription Drugs a $12,000 Prescription Drug Deductible per Member per Benefit Period and $24,000 Prescription Drug Deductible per family per Benefit Period. With family coverage, once one person meets the $12,000 Deductible, benefits will begin paying for that person. When the family meets the $24,000 Deductible, benefits begin paying for the entire family.	$12,000 per Member per Benefit Period for single coverage and $24,000 per family per Benefit Period. With family coverage, once one Member meets a $12,000 Maximum Out-of-pocket, benefits will begin paying at 100% for that Member only.	**Retail:** Tier 0: $0 Tier 1: $12 Tier 2: $25 Tier 3 and 4: 0% after Prescription Drug Deductible **Mail-Order**: Tier 0: $0 Tier 1: $17 Tier 2: $68 Tier 3: 0% after Prescription Drug Deductible Tier 4: N/A
InHealth Basic 2	**35%***	$30 per Primary Care Physician (PCP) Office visit combined with Mental Health & Substance Use Disorder/Behavioral Services $55 per Specialist Office visit $55 per Urgent Care Center visit $500 per Ambulatory Surgery Center facility charge $300 per Emergency Room visit subject to the Deductible and Coinsurance $25 per Chiropractic Care Service visit	$5,300 per Member per Benefit Period and $10,600 per family per Benefit Period. With family coverage, once one person meets the $5,300 Deductible, benefits will begin paying for that person. When the family meets the $10,600 Deductible, benefits begin paying for the entire family.	$10,600 per Member per Benefit Period for single coverage and $21,200 per family per Benefit Period. With family coverage, once one Member meets a $10,600 Maximum Out-of-pocket, benefits will begin paying at 100% for that Member only.	**Retail:** Tier 0: $0 Tier 1: $20 Tier 2: $60 Tier 3: $100 Tier 4: 50% after Deductible **Mail-Order**: Tier 0: $0 Tier 1: $28 Tier 2: $162 Tier 3: $270 Tier 4: N/A

InHealth Standard Plans					
Plans	**Coinsurance**	**Copayments**	**Deductible**	**Out-of-Pocket**	**Prescription Drugs**
InHealth Basic Plus Standard	**25%***	$30 per Primary Care Physician (PCP) Office visit combined with Mental Health & Substance Use Disorder/Behavioral Services $60 per Specialist Office visit $45 per Urgent Care Center visit $30 per visit for Rehabilitation services, including Speech, Occupational, or Physical Therapy or per Habilitation Services visit $30 per Outpatient Rehabilitation Services visit $25 per Chiropractic Care Service visit	$2,500 per Member per Benefit Period and $5,000 per family per Benefit Period. With family coverage, once one person meets a $2,500 Deductible, benefits will begin paying for that person. When the family meets the $5,000 Deductible, benefits begin paying for the entire family.	$8,600 per Member per Benefit Period for single coverage and $17,200 per family per Benefit Period. With family coverage, once one Member meets a $8,600 Maximum Out-of-pocket, benefits will begin paying at 100% for that Member only.	**Retail:** Tier 0: $0 Tier 1: $15 Copayment Tier 2: $30 Copayment Tier 3: $60 Copayment Tier 4: $250 Copayment **Mail-Order:** Tier 0: $0 Tier 1: $21 Copayment Tier 2: $81 Copayment Tier 3: $162 Copayment Tier 4: N/A
InHealth Basic Standard	**40%***	$40 per Primary Care Physician (PCP) Office visit combined with Mental Health & Substance Use Disorder/Behavioral Services $80 per Specialist Office visit $60 per Urgent Care Center visit $40 per visit for Rehabilitation services, including Speech, Occupational, or Physical Therapy or per Habilitation Services visit $40 per Outpatient Rehabilitation Services visit $25 per Chiropractic Care Service visit	$6,400 per Member per Benefit Period and $12,800 per family per Benefit Period. With family coverage, once one person meets a $6,400 Deductible, benefits will begin paying for that person. When the family meets the $12,800 Deductible, benefits begin paying for the entire family.	$10,300 per Member per Benefit Period for single coverage and $20,600 per family per Benefit Period. With family coverage, once one Member meets a $10,300 Maximum Out-of-pocket, benefits will begin paying at 100% for that Member only.	**Retail:** Tier 0: $0 Tier 1: $20 Copayment Tier 2: $40 Copayment Tier 3: $80 after Deductible Tier 4: $350 after Deductible **Mail-Order:** Tier 0: $0 Tier 1: $28 Copayment Tier 2: $108 Copayment Tier 3: $216 after Deductible Tier 4: N/A

*** This Coinsurance amount makes the Policy a Limited Benefits Policy.**

Copayments apply to the Out-of-pocket Limit, but not to your Deductible. Deductibles and Copayments apply to the Maximum Out-of-pocket Limit.

Covered Services will be paid at 100% of the Allowed Charge when you reach your Out-of-Pocket Limit.

The Out-of-Pocket Limit includes Copayments, Deductibles and Coinsurance. It doesn't include premiums Balance-billed charges or health care the Policy doesn't cover.

Covered Services

We provide Essential Health Benefits according to the provisions described in this Policy and as shown in your Member Schedule. We base benefits on a percentage of the Allowed Amount. Benefits may be subject to Deductibles, Copayments, Coinsurance, Benefit Period Maximums, exclusions and limitations. There are no annual or lifetime dollar limits on the Essential Health Benefits provided. Benefits are generally provided in-Network only. All Covered Services must be Medically Necessary and include only the services specifically described unless limited or excluded in other provisions of the Policy.

The following is a list of Essential Health Benefits but are described in detail in our Policy.

- Ambulatory Patient Services
- Emergency Services
- Habilitation and Rehabilitation Services
- Hospital Services
- Laboratory Services
- Maternity and Newborn Care
- Mental Health & Substance Use Disorder Services
- Pediatric Services
- Prescription Drugs
- Preventive Services

Emergency Services
Use of the Emergency Room is intended only for persons who are experiencing an Emergency Medical Condition. See the Definitions section of the Policy for Emergency, Emergency Medical Condition, and Emergency Services for more details.

Benefits are available to treat an Emergency Medical Condition when provided at a Hospital Emergency Room or an Urgent Treatment Center, and only for as long as your condition continues to be considered an Emergency. If you receive care for an Emergency Medical Condition and are treated in the Emergency Room at a Hospital, the charges for Emergency Services are paid as follows:

1. **Emergency Services provided by an in-Network Provider**
   When Emergency Services are received from an in-Network Provider, benefits are provided as any other in-Network service under this Policy.

2. **Emergency Services by an out-of-Network Provider**
   When Emergency Services are received from an out-of-Network Provider, benefits will be provided for Emergency Services, and you will be subject to in-Network Cost-Sharing based on the Recognized Amount.

   The Allowed Amount for benefits for Emergency Services for an Emergency Medical Condition when provided by an out-of-Network Provider will be no less than the amount required under applicable law. See the Special Out-of-Network Rules section in the Policy for more information.

   Non-Emergency care outside the MUSC Health Alliance network is not covered; any follow-up care must be provided by an In-Network Provider.

Excluded Services
Notwithstanding any provision of the policy to the contrary, if the policy generally provides benefits for any type of injury, then in no event shall an exclusion or limitation of benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health condition), whether or not the condition is diagnosed before the Policy Effective Date.

This is a summary of the Exclusions and Limitations contained in the InHealth Policy. Please refer to the Policy for a complete explanation of Covered Services and a detailed list of Exclusions.

- Services provided before a Member's Policy is in effect or after he or she is no longer covered.
- Services that are not medically necessary.
- Benefits for procedures, services or pharmaceuticals when a required Preauthorization is not obtained or when coverage requires you to use a designated Provider and you choose another Provider. For Hospital or other facility stays, room and board charges will not be paid.
- When the member is entitled to payment from other sources, or is not legally obligated to pay for the services, including any service provided by the patient or a member of the patient's family.
- Services or treatment for complications resulting from any excluded procedure or condition.
- Dental, vision, or hearing services and supplies, except as specifically shown in the contract.
- Prescription drugs are covered only to the extent outlined in the contract.
- Human organ and tissue transplants. Preapproval is required.
- Investigational and experimental services.
- Abortion services, except as required or allowed by South Carolina law.
- Diagnosis or treatment of infertility, sexual dysfunction, or pre-conception testing (see Policy for allowed services).
- Cosmetic surgery, or surgery or treatment for the purpose of weight reduction.
- Any service or supply related to dysfunctional conditions of the chewing muscles, jaw bone(s) or muscles, orthognathic deformities or temporomandibular joint syndrome (headache, facial pain and jaw tenderness) caused by jaw problems usually known as TMJ.
- Admissions for rest cures, long-term residential care for medical or psychiatric conditions, custodial care and nursing homes.
- Medical social services, visual therapy or private duty nursing; orthomolecular therapy; luxury or convenience items; equipment available without a prescription, even if advised for a medical condition.
- Evaluation, diagnosis or counseling for learning and behavioral disabilities; intellectual disabilities; vocational rehabilitation; or relationship dysfunctions, including treatment through schools, camps or boarding homes.
- Travel expenses; ambulance services that do not meet criteria for emergency transport.
- Telehealth and telemedicine services which do not comply all of the requirements specified in the Covered Services section of this Policy.
- Charges for acupuncture, massage therapy, hypnotism and TENS unit, or services for chronic pain management programs.
- Bioelectric, microprocessor or computer-programmed prosthetic components.

Individual Transfer Right
Except for persons who purchase the Policy through the Health Insurance Marketplace, any person purchasing an individual accident, health or accident and health insurance policy, will have the right to transfer to any individual policy of equal or lesser benefits offered for sale by InStil Health at the time transfer is sought. Any person who receives an Advance Premium Tax Credit may enroll, disenroll or transfer only as allowed by the Health Insurance Marketplace.

About Premiums
We base Premiums on coverage selected, tobacco use, age, where you live at the time this Policy is issued and regulatory fees. Regulatory fees are fees taxes required by Affordable Care Act. Premiums may only be changed at the beginning of your Benefit Period. At least 31 days prior to your new Benefit Period, you will receive notice of your new Premium and any benefit charges for the new Benefit Period. **If you receive an Advance Premium Tax Credit, the amount you are billed each month is reduced by the tax credit you receive. If the tax credit changes at any time during the Benefit Period, your billed premium will change. This change will occur without notice to you.** If the Member's age, tobacco use or residence has been misstated an adjustment in Premiums will be made based on the Member's true age, tobacco usage or residence.

Extension of Benefits After Termination of Coverage
If your Policy is terminated or not renewed, coverage may be extended if a Member is Totally Disabled or in a Hospital or other facility on the day coverage ends. Please review the Policy for details on Extension of Benefits. We recommend that you notify us if you wish to exercise the Extension of Benefits rights. We will then determine if you are eligible for benefits. In order for us to recognize Extension of Benefits and ensure proper processing, we must receive a Physician's statement of disability.

Renewability Provision
This Policy renews each calendar year and you can continue coverage by paying the Premium required by the first of each calendar month or within the grace period. We can cancel this Policy if:

1. You fail to pay Premiums according to the terms of the Policy; or
2. We determine you have committed an act or practice that constitutes fraud or an intentional misrepresentation of a material fact under the terms of the Policy; or
3. We decide to discontinue offering InHealth for everyone who has this Policy form. If we discontinue the product, we must:
   a. Provide notice to each individual covered by this Policy of the discontinuance at least 90 days before the date the Policy is discontinued or within time frames as directed by a governmental agency;
   b. Offer to each individual covered by this Policy, the option to purchase other individual Health Insurance Coverage currently offered by us; and
   c. In exercising the option to discontinue the Policy or offering the option to purchase other individual coverage we act uniformly without regard to any Health Status-related Factor.
4. If we decide to discontinue offering all products in the Individual market in South Carolina, we will provide 180 days notice to each person covered by the Policy.

At the time of renewal, we may modify this Policy for everyone who has it as long as the modification is consistent with federal and state law and effective on a uniform basis. However, we cannot cancel your Policy simply because of a change in your physical or mental health.

Summary of Benefits and Coverage
A Summary of Benefits and Coverage (SBC) summarizes the benefit options of your insurance plan. All insurance companies are required to provide you with an SBC. You can find your SBC by logging into your My Health Toolkit® at https://instilhealth.com/ You may also contact a Customer Service Advocate and ask us to send you a copy of the SBC. We can send it to you electronically or mail a paper copy (free of charge).