

InnovaSM Plan Highlights

Innova's features:

- **Provider choice:** Members have direct access to their choice of providers. Coinsurance levels are lower for Category 1 services; coinsurance levels are higher for Category 2 and 3 services; members may be responsible for provider costs above the Category 3 allowed amount.
- **Upfront benefits (medical and preventive):** The first 4, 6 or unlimited office visits per calendar year are not subject to the deductible (Category 1 and 2 only). In addition, the first \$400 of outpatient radiology and laboratory services per calendar year are not subject to the deductible.
- **Additional benefits:** Subsequent office visits, outpatient radiology and laboratory beyond the first \$400 per calendar year, and all the other professional services are subject to member deductible and coinsurance levels as specified below.
- **Preventive care:** Preventive exams including outpatient radiology and laboratory are included in the plan with no separate dollar maximum.

Lifetime Maximum Benefit	\$2,000,000								
Calendar Year Deductible Applies to all covered expenses except where noted	Individual deductible options per calendar year: \$250, \$500, \$750, \$1,000, \$1,500, \$2,000, \$3,000, \$5,000 Family deductible is three times the individual amount								
Calendar Year Coinsurance Maximum Applies to all covered expenses except where noted When the coinsurance maximum is reached, this plan provides benefits at 100% of the allowed amount for the remainder of the calendar year	Individual coinsurance maximum options per calendar year: \$2,000, \$3,000, \$4,000, \$6,000 Family coinsurance maximum is three times the individual amount								
Covered Services	90/70/70 Plan			80/60/60 Plan			70/50/50 Plan		
	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)	Category 1 (Preferred)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
Upfront Office Visits Upfront office visit options: first 4, 6 or unlimited per calendar year Not subject to deductible Copay Options \$20 Category 1 / \$35 Category 2 \$30 Category 1 / \$45 Category 2	Category 1 copay	Category 2 copay	Not covered for upfront benefit	Category 1 copay	Category 2 copay	Not covered for upfront benefit	Category 1 copay	Category 2 copay	Not covered for upfront benefit
Upfront Outpatient Radiology and Laboratory First \$400 per calendar year Not subject to deductible	100%	100%	100%	100%	100%	100%	100%	100%	100%

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Benefits will be provided at the percentage of the allowed amount as specified below, applied after deductible is met and until coinsurance maximum is reached.									
Other Professional Services Deductible applies after upfront benefit limits are met. Office and inpatient services and supplies	90%	70%	70%	80%	60%	60%	70%	50%	50%
Other Outpatient Radiology and Laboratory Deductible applies after upfront benefit limits are met									
Hospital Services/Ambulatory Surgical Center Inpatient and outpatient services and supplies									
Maternity (Subscriber and spouse)									
Emergency Room Services \$100 copay per ER visit (waived if directly admitted)	90%	90%	90%	80%	80%	80%	70%	70%	70%
Ambulance Services Air and ground ambulance to nearest facility									
Immunizations - Adult	90%	70%	70%	80%	60%	60%	70%	50%	50%
Immunizations - Childhood Covered to age 18 Not subject to deductible	100%	100%	100%	100%	100%	100%	100%	100%	100%
Genetic Testing \$5,000 per lifetime maximum benefit (this limit does not apply to prenatal testing) Deductible applies after upfront benefit limits are met	90%	70%	70%	80%	60%	60%	70%	50%	50%
Nutritional Counseling Three visits per lifetime (this limit does not apply to diabetic counseling)									

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Durable Medical Equipment \$7,500 per calendar year maximum benefit (this limit does not apply to insulin pumps/supplies and lifesaving equipment such as oxygen and ventilators)									
Orthotics \$500 per calendar year maximum benefit (this limit does not apply to diabetic orthotics)									
Prostheses \$20,000 per calendar year maximum benefit (this limit does not apply to surgically implanted and external breast prostheses)									
Rehabilitation Services Inpatient: \$25,000 per calendar year maximum benefit Outpatient: \$1,500 per calendar year maximum benefit	90%	70%	70%	80%	60%	60%	70%	50%	50%
Neurodevelopmental Therapy For children age 6 and under Inpatient and outpatient combined: \$1,500 per calendar year maximum benefit									
Acupuncture 12 visits per calendar year									
Spinal Manipulations 10 spinal manipulations per calendar year									
Chemical Dependency (Groups of 2-50): \$14,500 combined inpatient/outpatient maximum benefit every 2 calendar years (Groups of 51+): No benefit maximums									
Home Health 130 visits per calendar year									

Covered Services	90/70/70 Plan			80/60/60 Plan			70/50/50 Plan		
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Hospice Respite care limited to 14 days inpatient/outpatient per lifetime									
Mental Health (Groups of 2-50): Inpatient: 8 days per calendar year Outpatient: 12 visits per calendar year (Groups of 51+): No benefit limits for inpatient/outpatient services									
Skilled Nursing Facility 60 inpatient days per calendar year	90%	70%	70%	80%	60%	60%	70%	50%	50%
Temporomandibular Joint Disorders (TMJ) Treatment \$1,000 per calendar year maximum benefit									
Transplants Services and supplies to \$250,000 lifetime maximum benefit \$50,000 donor expense maximum benefit per transplant 6-month waiting period									

Prescription Medication Coverage
<p>Generics: not subject to deductible Retail: 30-day supply per copay Mail order: 90-day supply (one copay per 30-day supply)</p> <p>Prescription Medication Options</p> <p>Tiered plan design with three copay/coinsurance maximum options and three deductible options</p> <p><u>Prescription medication deductible options per calendar year: \$0, \$250, \$500</u> (not applied to prescription medication out-of-pocket maximum) <i>Copays and coinsurance apply to the out-of-pocket maximum</i></p> <p><u>Copay options:</u></p> <p>\$5 generic/\$25 brand-name formulary/\$50 brand-name non-formulary; \$3,000 out-of-pocket maximum \$7 generic/25% brand-name formulary/50% brand-name non-formulary; \$4,000 out-of-pocket maximum \$10 generic/35% brand-name formulary/50% brand-name non-formulary; \$5,000 out-of-pocket maximum</p> <p>Member may be balance billed when a nonparticipating pharmacy is used.</p> <p>If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name copay/coinsurance plus the difference in price between the equivalent generic medication and the brand-name medication not to exceed total retail cost.</p>

Covered Services	Optional Benefits Available With All Plans								
	90/70/70 Plan			80/60/60 Plan			70/50/50 Plan		
Spinal Manipulations Option with no benefit maximum	90%	70%	70%	80%	60%	60%	70%	50%	50%
Vision One routine eye exam per calendar year Hardware limited to \$150 per calendar year maximum benefit Not subject to deductible	100%			100%			100%		

Optional Program Available With All Plans
Employee Assistance Program (EAP) No cost to the member for: Up to four face-to-face sessions per incident to manage stress or work-life balance situations Legal and financial assistance 24/7 crisis line

Additional Information	
Waiting Periods	No benefits are provided for treatment relating to a transplant until the member has been covered under this or a prior Regence plan with the same group for six consecutive months. There is a waiting period that must be met prior to benefits being available for pre-existing conditions; groups with 2-50 eligible employees have a nine-month pre-existing condition waiting period and groups with 51 or more eligible employees have a three-month pre-existing condition waiting period. Members may receive credit from prior medical coverage.
Outside the Service Area	Members have the security of knowing they can access Blue Cross and/or Blue Shield (Blue Plan) providers across the country and worldwide through the BlueCard® Program. Plan benefits apply as described above, and members may receive discounts on their services.

General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly, and for breast reconstruction following a medically necessary mastectomy to the extent required by law
- **Counseling** in the absence of illness
- **Custodial Care:** Non-skilled care and helping with activities of daily living
- **Dental Examinations and Treatments**
- **Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest, or finance charges that a provider might bill
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program
- **Infertility** except to the extent covered services are required to diagnose such condition
- **Investigational Services:** Treatment or procedures (health interventions) and services, supplies, and accommodations provided in connection with investigational treatments or procedures
- **Medications without a Prescription Order**
- **Military Service Related Conditions:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection or conditions incurred in or aggravated during performance in the Uniformed Services
- **Motor Vehicle Coverage and Other Insurance Liability**
- **Non-Direct Patient Care** including appointments scheduled and not kept, charges for preparing medical reports, itemized bills or claim forms, and visits or consultations that are not in person, including telephone consultations and email exchanges
- **Obesity or Weight Reduction/Control:** Medical treatment, medication, surgical treatment (including reversals), programs, or supplies that are intended to result in or relate to weight reduction, regardless of diagnosis
- **Orthognathic Surgery** except for congenital conditions, temporomandibular joint disorder, injury, and sleep apnea

General Medical Exclusions

Coverage is not provided for any of the following, including direct complications or consequences that arise from:

- **Personal Comfort Items:** Items that are primarily for comfort, convenience, cosmetics, environmental control, or education
- **Physical Exercise Programs and Equipment** including hot tubs or membership fees at spas, health clubs, or other facilities; applies even if the program, equipment, or membership is recommended by the member's provider
- **Private Duty Nursing** including ongoing shift care in the home
- **Riot, Rebellion and Illegal Acts:** Services and supplies for treatment of an illness, injury or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection, or rebellion or sustained by a member while committing an illegal act or felony
- **Routine Foot Care** including treatment of corns and calluses and trimming of nails
- **Routine Hearing Care:** Routine hearing examinations, programs, or treatment for hearing loss including hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them, except for cochlear implants
- **Self-Help, Self-Care, Training, or Instructional Programs** including childbirth classes, diet and weight monitoring services and instruction programs, including those to learn how to stop smoking and programs that teach a person how to use durable medical equipment or how to care for a family member
- **Services and Supplies Provided by a Member of Your Family**
- **Services and Supplies That Are Not Medically Necessary**
- **Services to Alter Refractive Character of the Eye**
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, and counseling services for sexual reassignment
- **Sexual Dysfunction:** Regardless of cause, except for counseling provided by covered, licensed mental health practitioners
- **Third-Party Liability:** Services and supplies for treatment of illness or injury for which a third party is or may be responsible
- **Tobacco Addiction Treatment** including supportive items for addiction to tobacco, tobacco products, or nicotine substitutes, including prescription medications
- **Travel and Transportation Expenses** other than covered ambulance services
- **Work-Related Conditions** except for subscribers who are owners, partners, or corporate officers and are exempt from state or federal workers' compensation law

This is a brief summary of benefits; it is not a certificate of coverage. All benefits must be medically necessary. For full coverage provisions, refer to the contract.