

### Innova Benefit Highlights

Innova's features:

- **Provider choice:** Members have direct access to their choice of providers. Coinsurance levels are lowest for Category 1 providers. If a member chooses a Category 3 provider, the member may be required to pay costs above the Category 3 allowed amount.
- **Preventive care:** Preventive services and immunizations are covered according to guidelines set forth by the United States Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA).
- **Upfront benefits:** Office visits 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:** Outpatient radiology and laboratory beyond the first \$400 per calendar year, and all other professional services are subject to member deductible and coinsurance levels as specified below.

<b>Annual Maximum</b>	<b>\$2,000,000 Annual Maximum</b>								
<b>Calendar Year Deductible</b> Applies to all covered expenses except where noted	Individual deductible options per calendar year: <b>\$250, \$500, \$750, \$1,000, \$1,500, \$2,000, \$3,000, \$4,000, \$5,000, \$7,500</b>  Family deductible is three times the individual amount								
<b>Calendar Year Coinsurance Maximum</b> 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: <b>\$2,000, \$3,000, \$4,000, \$6,000</b>  Family coinsurance maximum is three times the individual amount								
<b>Covered Services</b>	<b>90/70/70 Plan</b>			<b>80/60/60 Plan</b>			<b>70/50/50 Plan</b>		
	<b>Category 1 (Preferred)</b>	<b>Category 2 (Participating)</b>	<b>Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)</b>	<b>Category 1 (Preferred)</b>	<b>Category 2 (Participating)</b>	<b>Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)</b>	<b>Category 1 (Preferred)</b>	<b>Category 2 (Participating)</b>	<b>Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)</b>
<b>Benefits for services below will be provided prior to deductible being met.</b>									
<b>Upfront Office Visits</b> Category 1 and 2 not subject to deductible									
<b>Copay Options</b> \$20 Category 1 / \$35 Category 2 OR \$30 Category 1 / \$45 Category 2	<b>Category 1 copay</b>	<b>Category 2 copay</b>	<b>Upfront benefits do not apply</b>	<b>Category 1 copay</b>	<b>Category 2 copay</b>	<b>Upfront benefits do not apply</b>	<b>Category 1 copay</b>	<b>Category 2 copay</b>	<b>Upfront benefits do not apply</b>
<b>Upfront Outpatient Radiology and Laboratory</b> First \$400 per calendar year	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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)
<b>Benefits for services below will be provided at the percentage of the allowed amount specified, <u>after</u> deductible is met and until coinsurance maximum is met.</b>									
<b>Preventive Care and Immunizations</b> Category 1 and 2: Not subject to deductible	100%	100%	Category 3 benefits apply	100%	100%	Category 3 benefits apply	100%	100%	Category 3 benefits apply
<b>Professional Services/ Outpatient Radiology and Laboratory</b> Office and inpatient services and supplies	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Hospital Services/ Ambulatory Surgical Center</b> Inpatient and outpatient services and supplies	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Home Health</b> 130 visits per calendar year	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Hospice</b> Respite care limited to 14 days inpatient/outpatient per lifetime	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Maternity</b> (Subscriber and spouse)	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Rehabilitation Services</b> Inpatient: 30 days per calendar year Outpatient: 25 visits per calendar year	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Skilled Nursing Facility</b> 60 inpatient days per calendar year	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Acupuncture</b> 12 visits per calendar year	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Spinal Manipulations</b> 10 spinal manipulations per calendar year	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Emergency Room Services</b> \$100 copay per ER visit (waived if directly admitted)	90%	90%	90%	80%	80%	80%	70%	70%	70%

**Prescription Medication Coverage**

Generics, insulin and diabetic supplies: not subject to deductible  
 Retail: 30-day supply per copay  
 Mail order: 90-day supply (one copay per 30-day supply)  
 Up to 30-day supply for covered self-administrable injectable medications at retail and mail order.

**Prescription Medication Options**

Tiered plan design with four copay/coinsurance maximum options and three deductible options

Prescription medication deductible options per calendar year: \$0, \$250, \$500 (not applied to prescription medication out-of-pocket maximum)  
*Copays and coinsurance apply to the out-of-pocket maximum*

Copay options:

**\$10 generic/ \$35 brand-name formulary/ \$75 brand-name non-formulary; no out-of-pocket maximum**  
**\$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**

Copays for self-administered chemotherapy medication, including oral (all options): \$10 generic / \$50 brand-name formulary / \$100 brand-name nonformulary  
 (not subject to prescription medication deductible or out-of-pocket maximum)

Member may be balance billed when a nonparticipating pharmacy is used.

We cover certain medications according to United States Preventive Services Task Force (USPSTF) guidelines at 100%, no deductible, no copay at participating pharmacies only. Member must have a prescription.

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.

**Optional Benefits Available With All Plans**

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)
<b>Spinal Manipulations</b> Option with no benefit maximum	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Pre-Deductible Spinal Manipulations</b> (groups 51+) 10 spinal manipulations per calendar year. Not subject to deductible (also waives deductible on outpatient mental health and chemical dependency services).	90%	70%	70%	80%	60%	60%	70%	50%	50%
<b>Vision</b> One routine eye exam per calendar year. Hardware limited to \$150 per calendar year. Not subject to deductible.	100%	100%	100%	100%	100%	100%	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**

<b>Waiting Periods</b>	No benefits are provided for treatment relating to a transplant until the member has been covered under this or a prior plan for six consecutive months. There is a waiting period that must be met prior to benefits being available for pre-existing conditions; groups with 1-50 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. Pre-existing condition waiting periods do not apply to Members up to age 19.
<b>Outside the Service Area</b>	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; except sales taxes for durable medical equipment and mobility enhancing equipment.
- **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
- **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
- **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.