



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

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, \$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 \$40 Category 1 / \$55 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%

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)
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									
Other Outpatient Radiology and Laboratory Deductible applies after upfront benefit limits are met	90%	70%	70%	80%	60%	60%	70%	50%	50%
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)									

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)
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 for external prostheses (this limit does not apply to external breast prostheses)									
Rehabilitation Services Inpatient: \$25,000 per calendar year maximum benefit Outpatient: \$1,500 per calendar year maximum benefit									
Neurodevelopmental Therapy For children age 6 and under Inpatient and outpatient combined: \$1,500 per calendar year maximum benefit	90%	70%	70%	80%	60%	60%	70%	50%	50%
Home Health 130 visits per calendar year									
Hospice 14 days inpatient/outpatient respite care per lifetime									
Skilled Nursing Facility 60 inpatient days per calendar year									
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 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> \$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 (Optional benefits that are not elected are excluded from coverage)		
	90/70/70 Plan	80/60/60 Plan	70/50/50 Plan
Chemical Dependency/Mental Health (Combined) Option 1 (groups of 2-50): 8 inpatient days/12 outpatient visits per calendar year (not subject to coinsurance maximum) Option 2 (all group sizes): no benefit maximums (subject to deductible and coinsurance maximum)	50%	50%	50%
Complementary Care Combined naturopathic, chiropractic, and acupuncture services and supplies limited to \$500 per calendar year maximum benefit Not subject to deductible or coinsurance maximum	80%	80%	80%
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 plan for six consecutive months. There is a twelve-month waiting period that must be met prior to benefits being available for pre-existing conditions. By pre-existing condition, we mean a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the enrollment date. 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:

- **Conditions Caused By Active Participation In a War or Insurrection:** The treatment of any condition caused by or arising out of a member's active participation in a war or insurrection.
- **Conditions Incurred In or Aggravated During Performances In the Uniformed Services:** The treatment of any member's condition that the Secretary of Veterans Affairs determines to have been incurred in, or aggravated during, performance of services in the uniformed services of the United States.
- **Cosmetic/Reconstructive Services and Supplies** except to treat a congenital anomaly for members up to age 18, to restore a physical bodily function lost as a result of injury or illness or related to 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 Services** provided to prevent, diagnose or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of the teeth.
- **Elective Abortion:** Termination of pregnancy (elective abortion), except when performed to preserve the life of the enrolled female member.
- **Expenses Before Coverage Begins or After Coverage Ends:** Services and supplies incurred before your effective date under the contract or after your termination under the contract, except as may be provided under the other continuation options of the contract.
- **Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest, or finance charges that a provider might bill.
- **Foot Care (Routine):** Routine foot care including treatment of corns and calluses and trimming of nails, except when indicated for diabetic patients.
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program.
- **Growth Hormone Therapy** (coverage for these services may be provided under the prescription medication benefit).
- **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. This exclusion does not apply to cochlear implants.
- **Infertility:** Treatment of infertility, except to the extent covered services are required to diagnose such condition including all assisted reproductive technologies and fertility drugs and medications.
- **Investigational Services:** Investigational treatment or procedures (health interventions) and services, supplies and accommodations provided in connection with investigational treatments or procedures.
- **Motor Vehicle Coverage and Other Insurance Liability** unless the automobile contract contains a coordination of benefits provision.
- **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 or psychological conditions.
- **Orthognathic Surgery:** Services and supplies for orthognathic surgery. By "orthognathic surgery," we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from injury, congenital anomaly or abnormal development to restore the proper anatomic and functional relationship of the facial bones. This exclusion does not apply to orthognathic surgery due to a temporomandibular joint disorder, injury, sleep apnea or congenital anomaly.
- **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 such 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.

General Medical Exclusions

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

- **Self-Help, Self-Care, Training, or Instructional Programs** including diet and weight monitoring services, childbirth-related classes including infant care and breast feeding classes, 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.**
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, or counseling services for sexual reassignment.
- **Sexual Dysfunction:** Services and supplies including medications for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners when mental health services are covered benefits under the contract.
- **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.
- **Travel and Transportation Expenses** other than covered ambulance services.
- **Vision Care:** Visual therapy, training and eye exercises, vision orthoptics, surgical procedures to correct refractive errors/astigmatism, reversal or revisions of surgical procedures which alter the refractive character of the eye.
- **Work-Related Conditions:** Expenses for services and supplies incurred as a result of any work-related injury or illness, including any claims that are resolved related to a disputed claim settlement. The only exception is if an enrolled employee is exempt from state or federal workers' compensation law.

General Pharmacy Exclusions

- **Acne Medication** for the treatment of acne in members over age 39.
- **Certain Contraceptives:** Prescription contraceptives that cannot be self-administered, including Norplant, surgically inserted contraceptive devices, IUDs and Depo-Provera (coverage for these contraceptives may otherwise be provided under the medical benefit).
- **Cosmetic Purposes:** Prescription medications used for cosmetic purposes including removal, inhibition or stimulation of hair growth, retardation of aging or repair of sun-damaged skin.
- **Devices or Appliances** (coverage for devices and appliances may otherwise be provided under the medical benefit).
- **Foreign Prescription Medications** except those associated with an emergency medical condition while you are traveling outside the United States, or those you purchase while residing outside the United States.
- **Growth Hormones** unless we preauthorize them.
- **Immunization Agents, Biological Sera, Blood, or Blood Plasma.**
- **Inhibition and/or Suppression of Sleepiness:** Prescription medications used to inhibit and/or suppress drowsiness, sleepiness, tiredness or exhaustion, unless we preauthorize them.
- **Insulin Pumps and Pump Administration Supplies** (coverage for insulin pumps and supplies is provided under the medical benefit).
- **Medications We Don't Consider Self-Administerable** (coverage for these medications may otherwise be provided under the medical benefit).
- **Nonprescription Medications:** Medications that by law do not require a prescription order.
- **Off-Label Use Prescription Medications:** Prescription medications that have not yet received FDA approval for the purpose and in the manner they are being prescribed.
- **Onychomycosis:** Prescription medications for the treatment of onychomycosis (nail fungus), unless we preauthorize them.
- **Prescription Medications Dispensed in a Facility:** Prescription medications dispensed to you while you are a patient in a hospital, skilled nursing facility, nursing home or other health care institution.
- **Prescription Medications Dispensed in Connection with Participation in a Clinical Trial.**
- **Prescription Medications For Treatment of Infertility.**
- **Prescription Medications For Smoking Cessation.**
- **Prescription Medications Not Dispensed by a Pharmacy Pursuant to a Prescription Order.**
- **Prescription Medications Not within a Provider's License:** Prescription medications prescribed by providers who are not licensed to prescribe medications (or that particular medication) or who have a restricted professional practice license.
- **Prescription Medications With No FDA Proven Therapeutic Indication.**
- **Prescription Medications Without Examination:** Prescriptions made by a provider without recent and relevant in-person examination of the patient, whether the prescription order is provided by mail, telephone, internet or some other means.
- **Professional Charges for Administration of Any Medication.**

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.

02020_ID_Inn_BenSum_120508