

### 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.
- Group network choice for category 1 coverage. Preferred or North Idaho Health Network (NIHN).
- 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>\$500, \$750, \$1,000, \$1,500, \$2,000, \$3,000, \$4,000, \$5,000, \$7,500</b>  Family deductible options of two or 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

Covered Services	80/60/60 Plan			70/50/50 Plan		
	Category 1 (Preferred) or Category 1 (NIHN)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)	Category 1 (Preferred) or Category 1 (NIHN)	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 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 OR \$40 Category 1 / \$55 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>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>

Covered Services	80/60/60 Plan			70/50/50 Plan		
	Category 1 (Preferred) or Category 1 (NIHN)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)	Category 1 (Preferred) or Category 1 (NIHN)	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
<b>Professional Services/ Outpatient Radiology and Laboratory</b> Office and inpatient services and supplies	80%	60%	60%	70%	50%	50%
<b>Hospital Services/ Ambulatory Surgical Center</b> Inpatient and outpatient services and supplies	80%	60%	60%	70%	50%	50%
<b>Home Health</b> 130 visits per calendar year	80%	60%	60%	70%	50%	50%
<b>Hospice</b> Respite care limited to 14 days inpatient/outpatient per lifetime	80%	60%	60%	70%	50%	50%
<b>Maternity</b> (Optional coverage for groups of 2-50). Subscriber and Spouse	80%	60%	60%	70%	50%	50%
<b>Rehabilitation Services</b> Inpatient: 22 days per calendar year Outpatient: 30 visits per calendar year	80%	60%	60%	70%	50%	50%
<b>Skilled Nursing Facility</b> 60 inpatient days per calendar year	80%	60%	60%	70%	50%	50%
<b>Emergency Room Services</b> \$100 copay per ER visit (waived if directly admitted)	80%	80%	80%	70%	70%	70%

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)  Up to 30-day supply for covered self-administrable injectable medications at retail and mail order.</p> <p><b>Prescription Medication Options</b>  Tiered plan design with four 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>  <b>\$10 generic/ \$35 brand-name formulary / \$75 brand-name non-formulary; no out-of-pocket maximum</b>  <b>\$5 generic/ \$25 brand-name formulary / \$50 brand-name non-formulary; \$3,000 out-of-pocket maximum</b>  <b>\$7 generic/ 25% brand-name formulary / 50% brand-name non-formulary; \$4,000 out-of-pocket maximum</b>  <b>\$10 generic/ 35% brand-name formulary / 50% brand-name non-formulary; \$5,000 out-of-pocket maximum</b></p> <p>Member may be balance billed when a nonparticipating pharmacy is used.</p> <p>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.</p>	

Optional Benefits Available With All Plans						
Covered Services	80/60/60 Plan			70/50/50 Plan		
	Category 1 (Preferred) or Category 1 (NIHN)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)	Category 1 (Preferred) or Category 1 (NIHN)	Category 2 (Participating)	Category 3 (Non-contracted) (Member may be responsible for any provider costs above the Category 3 allowed amount)
<b>Chemical Dependency Treatment/Mental Health (Combined)</b> <b>Option 1</b> (Groups of 2-50): 8 inpatient days/12 outpatient visits per calendar year (not subject to coinsurance maximum)  <b>Option 2</b> (Groups of 2-50): No benefit maximums (subject to deductible and coinsurance maximum)	50%	50%	50%	50%	50%	50%
(Groups of 51+): No benefit maximums (subject to deductible and coinsurance maximum)	80%	60%	60%	70%	50%	50%

<b>Optional Benefits Available With All Plans</b> (Optional benefits that are not elected are excluded from coverage)						
<b>Covered Services</b>	<b>80/60/60 Plan</b>			<b>70/50/50 Plan</b>		
	<b>Category 1 (Preferred) or Category 1 (NIHN)</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) or Category 1 (NIHN)</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>Complementary Care</b> Combined naturopathic, chiropractic, and acupuncture services and supplies limited to 12 visits or 36 visits per calendar year.  Not subject to deductible or coinsurance maximum.  Does not include tobacco cessation services	<b>80%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>
<b>Vision</b> One routine eye exam per calendar year. Hardware limited to \$150 per calendar year. Not subject to deductible.	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Optional Program Available With All Plans</b>						
<b>Employee Assistance Program (EAP)</b> 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						
<b>Additional Information</b>						
<b>Waiting Periods</b>	<p>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. Pre-existing condition waiting periods do not apply to Members up to age 19.</p> <p>Creditable coverage means with respect to an individual, health benefits or coverage provided under any of the following: Group health benefit plan; Health insurance coverage without regard to whether the coverage is offered in the group market, individual market or otherwise; Medicare; Medicaid; medical and dental care for members and certain former members of the uniformed services and their dependents ("uniformed services" means the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration and the Public Health Service); a medical care program of the Indian Health Services or of a tribal organization; a state high-risk pool coverage; Federal Employees Health Benefits Program (FEHBP); a public health plan (a plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage to individuals enrolled in the plan); or a health plan issued under the Peace Corps Act. A state Children's Health Insurance Program (CHIP), is creditable coverage, whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.</p>					
<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

We will not provide benefits for any of the following conditions, treatments, services, supplies or accommodations, including any direct complications or consequences that arise from them. However, these exclusions will not apply with regard to an otherwise Covered Service for: 1) an Injury, if the Injury results from an act of domestic violence or a medical condition (including physical and mental) and regardless of whether such condition was diagnosed before the Injury, as required by federal law; or 2) a preventive service as specified under the Preventive Care and Immunizations benefit in the Medical Benefits Section.

- **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.
- **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
- **Investigational Services:** 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:** Expenses that are payable under any automobile medical, personal injury protection ("PIP"), or automobile no-fault coverage (unless the automobile contract contains a coordination of benefits provision, in which case, the coordination of benefits provision of the plan shall apply); underinsured or uninsured motorist coverage, homeowner's coverage, commercial premises coverage or similar contract or insurance, whether or not you make a claim under such coverage. Once benefits under such contract or insurance are exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, we will provide benefits according to the plan.
- **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,
- **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
- **Over the Counter Contraceptives** including supplies and oral contraceptives (coverage for these services may be provided under the prescription medications benefit).
- **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
- **Private Duty Nursing** including ongoing shift care in the home.
- **Reversal of Sterilizations** including services and supplies related to reversal of sterilization.
- **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.
- **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
- **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.
- **Biological Sera, Blood, or Blood Plasma.**
- **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
- **Growth Hormones** unless we preauthorize them.
- **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.**

II0112BINNS, II0112BINNL, II0112BINNX, II0112BINNXG

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.