

## Summary of Benefits

Innova Plans			
<b>Lifetime Maximum</b>	\$2 million		
<b>Provider Networks</b>	Preferred Provider Plan (PPP), Participating (PAR) or non-contracted		
<b>Deductible Choices</b>	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		
<b>Coinsurance</b>	PPP: 90% PAR: 70% Non-contracted: 70%	PPP: 80% PAR: 60% Non-contracted: 60%	PPP: 70% PAR: 50% Non-contracted: 50%
<b>Coinsurance Maximum</b>	Individual coinsurance maximum options per calendar year: \$2,000, \$3,000, \$4,000, \$6,000 Family coinsurance maximum is three times the individual amount		
UPFRONT BENEFITS (Not subject to deductible or coinsurance)			
<b>Office Visits (E&amp;M)</b> Three office visit options: first 4, 6 or unlimited per calendar year. Three copayment options	PPP: \$20, \$30 or \$40 PAR: \$35, \$45 or \$55 Non-contracted: not covered for upfront benefit	PPP: \$20, \$30 or \$40 PAR: \$35, \$45 or \$55 Non-contracted: not covered for upfront benefit	PPP: \$20, \$30 or \$40 PAR: \$35, \$45 or \$55 Non-contracted: not covered for upfront benefit
<b>Outpatient Diagnostic Radiology &amp; Lab (DRL)</b> First \$400 per calendar year	Covered at 100%	Covered at 100%	Covered at 100%
IMMUNIZATIONS			
<b>Immunizations - Adult</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Immunizations - Childhood</b> Covered to age 18	Covered at 100%, Deductible waived	Covered at 100%, Deductible waived	Covered at 100%, Deductible waived
PROFESSIONAL SERVICES AND URGENT CARE PROFESSIONALS			
<b>Office Visits (E&amp;M)</b> After upfront limits met	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Outpatient Diagnostic Radiology &amp; Lab (DRL)</b> After upfront limits met	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Maternity Care</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Rehabilitation</b> Inpatient: \$25,000 per calendar year maximum. Outpatient: \$1,500 per calendar year maximum	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Genetic Testing</b> \$5,000 per lifetime maximum benefit (this limit does not apply to prenatal testing)	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Nutritional Counseling</b> Three visits per lifetime (this limit does not apply to diabetic counseling)	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Neurodevelopmental Therapy</b> For children age 18 and under Inpatient and outpatient combined: \$1,500 per calendar year maximum benefit	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Temporomandibular Joint Disorders (TMJ) Treatment</b> \$1,000 per calendar year maximum benefit	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance

## Summary of Benefits

Innova Plans			
FACILITY SERVICES			
<b>Inpatient &amp; Outpatient Facility Care</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Emergency Room</b> Copay waived on inpatient admit	\$100 copayment, Deductible & 90% coinsurance	\$100 copayment, Deductible & 80% coinsurance	\$100 copayment, Deductible & 70% coinsurance
<b>Chemical Dependency &amp; Mental Health</b> Mental health residential treatment programs: 45-day limit per calendar year	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Home Health</b> 130 visits per calendar year	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Hospice</b> 14 days inpatient/outpatient respite care per lifetime	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Skilled Nursing Facility</b> 60 days inpatient per calendar year	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
MISCELLANEOUS BENEFITS AND INFORMATION			
<b>Ambulance</b> Air and ground to nearest facility	Deductible & 90% coinsurance	Deductible & 80% coinsurance	Deductible & 70% coinsurance
<b>Durable Medical Equipment (DME)</b> \$7,500 per calendar year maximum benefit (this limit does not apply to insulin pumps/supplies and lifesaving equipment such as oxygen and ventilators)	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Transplants</b> \$250,000 lifetime maximum, \$50,000 donor expense maximum per transplant. 24-month waiting period.	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Orthotics</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
<b>Prostheses</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance
PRESCRIPTION MEDICATIONS			
<b>Rx Deductible Choices</b>	\$0, \$250, \$500		
<b>Rx Copayment Choices</b>	Three plans available generic/brand formulary/brand non-formulary: \$5/\$25/\$50, \$7/25%/50%, \$10/35%/50%		
ADDITIONAL BENEFIT CHOICES AVAILABLE			
<b>Vision</b>	One routine exam per calendar year. Not subject to deductible and coinsurance. Hardware limited to \$150 per calendar year maximum		
<b>Dental</b>	Three plans available: Expressions, Encore and Radiance		
<b>Complementary Care</b> \$500 per calendar year maximum	Combined naturopathic, chiropractic and acupuncture services and supplies 80% coinsurance, not subject to deductible or coinsurance maximum		