



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

## Regence RealValue Benefit Highlights

RealValue's features:

- Members can choose from one of two networks for In-Network benefits: Preferred ValueCare Network or Preferred FocalPoint Network.
- 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).
- This plan offers optional dental packages. For details see the Optional Benefits Available section.

<b>Annual Maximum</b>	<b>\$2,000,000 Annual Maximum</b>	
<b>Calendar Year Deductible</b> Applies to all covered expenses except where noted.  Separate deductibles for In-Network and Out-of-Network services.	Individual deductible options per calendar year:  <b>In-Network: \$2,500 / Out-of-Network: \$5,000</b> <b>In-Network: \$5,000 / Out-of-Network: \$10,000</b> <b>In-Network: \$7,500 / Out-of-Network: \$15,000</b> <b>In-Network: \$10,000 / Out-of-Network: \$20,000</b>  Family deductible is three times the In-Network / Out-of-Network Individual deductible 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. (Applies only to services received in the applicable network for which the coinsurance maximum was reached).  Separate coinsurance maximums for In-Network and Out-of-Network services.	Individual coinsurance maximum per calendar year:  <b>In-Network: \$5,000 / Out-of-Network: \$10,000</b>  Family coinsurance maximum is three times the In-Network / Out-of-Network Individual coinsurance maximum amount	
<b>Covered Services</b>	<b>RealValue</b>	
	<b>Member Responsibility</b>	
	Coinsurance applies after In-Network / Out-of-Network deductible is met and until In-Network / Out-of-Network coinsurance maximum is reached.	
	<b>In-Network</b>	<b>Out-of-Network</b> (Member may be responsible for any provider costs above the allowed amount)
<b>Preventive Care and Immunizations</b>	0% (In-Network deductible waived)	25% (Out-of-Network deductible applies)

Covered Services	RealValue	
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	In-Network	Out-of-Network (Member may be responsible for any provider costs above the allowed amount)
<b>Professional Services/ Outpatient Radiology and Laboratory</b> Office and inpatient services and supplies	35% (In-Network deductible applies)	50% (Out-of-Network deductible applies)
<b>Hospital Services/Ambulatory Surgical Center</b> Inpatient and outpatient services and supplies	35% (In-Network deductible applies)	50% (Out-of-Network deductible applies)
<b>Home Health</b> 130 visits per calendar year	35% (In-Network deductible applies)	50% (Out-of-Network deductible applies)
<b>Hospice</b> Respite care limited to 14 days inpatient/outpatient per lifetime	35% (In-Network deductible applies)	50% (Out-of-Network deductible applies)
<b>Rehabilitation Services</b> Inpatient: 5 days per calendar year Outpatient: 15 visits per calendar year	35% (In-Network deductible applies)	50% (Out-of-Network deductible applies)
<b>Skilled Nursing Facility</b> 30 days per calendar year	35% (In-Network deductible applies)	50% (Out-of-Network deductible applies)
<b>Complex Outpatient Imaging (CT Scan, MRI, PET, MRA, SPECT, Bone Density)</b>	50% (In-Network deductible applies)	50% (Out-of-Network deductible applies)
<b>Emergency Room Services</b> \$200 copay per ER visit (waived if directly admitted).	35% (In-Network deductible and coinsurance maximum applies)	35% (In-Network deductible and coinsurance maximum applies)
Prescription Medication Coverage		
<p>No deductible \$10 copay for generics 35% coinsurance for brand diabetic drugs and supplies only. No other coverage for brand medications.</p> <p>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>We cover certain preventive 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	
Covered Services	RealValue Member Responsibility
<b>Dental Option I</b> Incentive Dental Plan When you incur services less than \$750, you may be rewarded with an additional benefit of \$250 the following year, not to exceed a total benefit of \$1,500. Waiting Periods: 6 months for Basic Services and 12 months for Major Services.	No deductible and 0% for Preventive dental care \$50 deductible per calendar year for Basic and Major Care 20% for Basic care 50% for Major care
<b>Dental Option II</b> Dollar-Based Dental Plan Waiting Periods: 6 months for all covered services \$750 per calendar year maximum benefit (Preventive, Basic and Major services combined)	No deductible 0% for the first \$200 of covered services then 50% up to the annual maximum
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 12 consecutive months. There is a 12 month waiting period that must be met prior to benefits being available for pre-existing conditions. 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:

- **Acupuncture**
- **Breast Reduction, Eye Lid Surgery and Varicose Vein Surgery.**
- **Cosmetic/Reconstructive Services and Supplies** except for reconstruction for functional injury and disease, to treat a congenital anomaly for members up to age 18, 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
- **Detoxification**
- **Fees, Taxes, Interest:** Charges for shipping and handling, postage, interest, or finance charges that a provider might bill
- **Genetic Testing**
- **Government Programs:** Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or governmental program
- **Hospitalization for Dentistry**
- **Immunizations** if the Insured receives them only for purposes of travel, occupation or residency in a foreign country.
- **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
- **Maternity Care:** Maternity benefits, except complications of pregnancy are covered as any illness condition; adoption services
- **Medications without a Prescription Order**
- **Mental Health and Chemical Dependency Treatment**
- **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**
- **Neurodevelopmental Therapy Services**
- **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
- **Orthotics** except for diabetic orthotics
- **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
- **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
- **Routine Vision Exam and Hardware**
- **Rural Telemedicine**
- **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 Dysfunction:** Regardless of cause
- **Sexual Reassignment Treatment and Surgery:** Treatment, surgery, and counseling services for sexual reassignment
- **Spinal Manipulations**
- **Temporomandibular Jaw Disorders (TMJ)**
- **Termination of Pregnancy** except under certain circumstances.
- **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.