BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Employer Health Plan
PRODUCT GUIDE

2023 PLANS

EMPLOYERS WITH 2-50 EMPLOYEES

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VALUE
OF BLUE

We are excited to share our 2023 product portfolio. These products were designed with you and your employees in mind. When you choose our plans, you will have the support you need, when you need it, every step of the way—from strategic planning, to implementation, to day-to-day operations.

Like you, we want your employees to be their absolute healthiest. Our integrated programs and resources are available to streamline and improve your employees' healthcare experience. A full range of programs, support, and tools are available to help them make the best choices for their health and wellness needs.

Throughout our history, Blue Cross® Blue Shield® of Arizona (BCBSAZ) has been committed to inspiring health in Arizona as the trusted leader in delivering affordable, innovative healthcare solutions.

2023 PLAN CHOICES THAT INSPIRE HEALTH

Low copays for Tier 1 generic drugs

All EverydayHealth PPO and HMO plans feature $3 copays on 30-day supplies of Tier 1a generic prescriptions including select insulin. Prescription drugs in Tier 1b have low copays that range from $5 to $35 on a 30-day supply, depending upon the plan.

For more information on BCBSAZ's Tier 1a Drug List, visit **azblue.com/pharmacy-management/Tier1a-Drug-List.**

Balanced Funding solution

Balanced Funding is a self-funded solution for employers with five or more enrolled employees.[1] Balanced Funding provides employers with financial predictability and control over monthly healthcare costs.[2] With Balanced Funding, employers pay a fixed, monthly amount that includes the cost of administrative services, stop-loss insurance, and all claims coverage.[3] Detailed claims and experience reports help employers manage their expenses. This product minimizes surprises and provides the opportunity to earn money back, if claims are lower than expected.

Network options for higher net savings

Network choice provides access to quality care and is a key money saver for employers and employees alike.

- Choosing a smaller network helps lower employees' premiums
- Staying in network lowers costs for medical services
- Knowing limits on out-of-network services, like emergencies, helps control costs

PLAN OPTIONS

PPO Plans

- A wide selection of primary care providers (PCPs) and specialists
- No requirement to have an assigned PCP or get referrals before seeing a specialist
- Access to healthcare out of state with the BlueCard® network when traveling or vacationing
- Out-of-network care covered, but at a higher cost

HMO Plans

- Primary care provider (PCP) assignment is required
- PCP coordinates care with other in-network providers
- PCP referrals required for specialist visits (some exceptions apply)[4]
- Out-of-network services not covered except in emergencies, select ancillary services performed by out-of-network providers at an in-network facility, and rare situations when preauthorized by BCBSAZ.

NETWORKS & PROVIDER AFFILIATIONS FOR PPO AND HMO PLANS

Statewide – Affiliations statewide
Alliance (Maricopa and Pinal counties) – Banner Health and HonorHealth
PimaConnect (Pima County) – Tucson Medical Center and Northwest Medical Center

[1] Prior to January 1, 2023, Balanced Funding was only available for businesses with 9 or more enrolled employees.
[2] Medical criteria are used to establish rates for Balanced Funding arrangements. Not all businesses will qualify.
[3] With Balanced Funding, composite rates are fixed. Monthly payments may still change based on a business's employee census, as employees or dependents are added or removed.
[4] Referrals not required for OB/GYN, chiropractic, and certain other in-network provider visits.

A PLAN FOR ALL NEEDS AND BUDGETS

Health plan options in 2023:

EverydayHealth

This popular product is a top choice for those who want comprehensive coverage. There are 20 PPO and seven HMO plan options that offer copays for many common services.

Portfolio (HSA-qualified plan)

There are six PPO and three HMO Portfolio plan options to choose from. When paired with a health savings account (HSA), a high-deductible PPO plan gives employees the flexibility to choose how their healthcare dollars are spent and offers potential tax savings. This plan is a popular choice for those who want to pair their health plan with an HSA and either:

- Don't expect to need frequent doctor visits or prescriptions, or
- Do expect higher medical costs, and want to use an HSA for its tax advantages

Both plans offer coverage for most common healthcare needs, such as:

- Doctor visits
- Prescriptions
- Urgent care and ER visits
- Surgeries
- Virtual visits with BlueCare Anywhere℠*
- Behavioral health needs
- Pediatric dental care from in-network providers
- Preventive care at $0 out-of-pocket cost from in-network providers
- Routine pediatric vision care

Employers benefit from consumer-directed health savings account (HSA) integration in several ways:

Easy
Hassle-free account setup, management, and eligibility data sharing

Streamlined
One bill captures monthly premiums and HSA administration fees

Convenient
Dedicated employer customer service for employers integrating any of the following types of spending accounts:

- HSAs
- HRAs
- FSAs
- DCFSAs
- LPFSAs

* Virtual visits do not provide emergency care. In an identified or probable emergency, the virtual visit provider will direct the patient to seek emergency care.

This is only a brief summary of the benefit plans, designed to help you compare features of different plans. All plans are subject to the exclusions and limitations listed on page 20 of this summary. More detailed information about benefits, cost share, exclusions, and limitations is in the benefit plan booklets and plan Summary of Benefits and Coverage (SBC), which are available on request. If the terms of this summary differ from the terms of the benefit plan booklets, the terms of the booklets control and apply.

EverydayHealth PPO

	EverydayHealth PPO Platinum 500	EverydayHealth PPO Platinum 750	EverydayHealth PPO Platinum 1000	EverydayHealth PPO Gold 1000	EverydayHealth PPO Gold 1500	EverydayHealth PPO Gold 2000
Overall Deductible	In-network: $500/member and $1,000/family	In-network: $750/member and $1,500/family	In-network: $1,000/member and $2,000/family	In-network: $1,000/member and $2,000/family	In-network: $1,500/member and $3,000/family	In-network: $2,000/member and $4,000/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	10%	20%	20%	20%	10%	20%
Out-of-Pocket Maximum	In-network: $2,000/member and $4,000/family	In-network: $2,750/member and $5,500/family	In-network: $3,000/member and $6,000/family	In-network: $7,000/member and $14,000/family	In-network: $6,500/member and $13,000/family	In-network: $6,250/member and $12,500/family
Referral Required to Visit Specialist?	No	No	No	No	No	No
Primary Care (PCP) Visit	$15	$10	$10	$25	$30	$20
Specialist Visit	$30	$20	$20	$65	$70	$55
Urgent Care	$60	$60	$60	$65	$70	$60
Emergency Room Visit (In and Out of Network)	1st visit at $100 copay, then 10% after deductible	$100	1st visit at $150 copay, then 20% after deductible	20% after deductible	10% after deductible	$350
Emergency Transportation/ Ambulance (In and Out of Network)	10% coinsurance, deductible waived	20% coinsurance, deductible waived	20% coinsurance, deductible waived	20% coinsurance, deductible waived	10% coinsurance, deductible waived	20% coinsurance, deductible waived
Inpatient Physician and Surgical Services	10% after deductible	20% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible
Rx Deductible (Tiers 2 & 3)	n/a	n/a	n/a	n/a	n/a	n/a
Rx Tier 1a	$3	$3	$3	$3	$3	$3
Rx Tier 1b	$5	$15	$10	$15	$20	$20
Rx Tier 2	$20	$30	$25	$60	$70	$70
Rx Tier 3	$40	$60	$50	$130	$130	$130
Specialty Drug	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived
Preventive Care/ Immunization/Screenings	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge	No charge	No charge
Telehealth						
Medical Visit	No charge	No charge	No charge	No charge	No charge	No charge
Counseling Visit	$20	$20	$20	$20	$20	$20
Psychiatric Visit	$30	$20	$20	$45	$45	$45

Cost-share amounts are for covered services from providers in the plan's network. Services from out-of-network providers are typically subject to higher cost-share amounts.

Only formulary drugs are covered unless a formulary exception is approved. Members in plans with a copay drug benefit who pick a brand-name medication when a generic is available will pay the difference in cost plus the copay and any applicable deductible. All plans are subject to the exclusions and limitations listed on page 20.

EverydayHealth PPO continued

	EverydayHealth PPO Gold 2500	EverydayHealth PPO Gold 3000	EverydayHealth PPO Gold 3500	EverydayHealth PPO Silver 2500	EverydayHealth PPO Silver 3000	EverydayHealth PPO Silver 3250 / 60	EverydayHealth PPO Silver 3500
Overall Deductible	In-network: $2,500/member and $5,000/family	In-network: $3,000/member and $6,000/family	In-network: $3,500/member and $7,000/family	In-network: $2,500/member and $5,000/family	In-network: $3,000/member and $6,000/family	In-network: $3,250/member and $6,500/family	In-network: $3,500/member and $7,000/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	20%	20%	20%	50%	20%	40%	50%
Out-of-Pocket Maximum	In-network: $7,000/member and $14,000/family	In-network: $7,250/member and $14,500/family	In-network: $7,500/member and $15,000/family	In-network: $7,700/member and $15,400/family	In-network: $8,650/member and $17,300/family	In-network: $8,700/member and $17,400/family	In-network: $8,550/member and $17,100/family
Referral Required to Visit Specialist?	No	No	No	No	No	No	No
Primary Care (PCP) Visit	$15	$20	$25	$40	$45	$45	$25
Specialist Visit	$45	$60	$60	$85	$95	$95	$80
Urgent Care	$60	$60	$60	$85	$95	$95	$80
Emergency Room Visit (In and Out of Network)	1st visit at $250 copay, then 20% after deductible	$300	1st visit at $350 copay, then 20% after deductible	50% after deductible	20% after deductible	1st visit at $550 copay, then 40% after deductible	50% after deductible
Emergency Transportation/ Ambulance (In and Out of Network)	20% coinsurance, deductible waived	20% coinsurance, deductible waived	20% coinsurance, deductible waived	50% coinsurance, deductible waived	20% coinsurance, deductible waived	40% coinsurance, deductible waived	50% coinsurance, deductible waived
Inpatient Physician and Surgical Services	20% after deductible	20% after deductible	20% after deductible	50% after deductible	20% after deductible	40% after deductible	50% after deductible
Rx Deductible (Tiers 2 & 3)	n/a	n/a	n/a	$350/member	$400/member	n/a	n/a
Rx Tier 1a	$3	$3	$3	$3	$3	$3	$3
Rx Tier 1b	$10	$20	$20	$35	$35	$35	$25
Rx Tier 2	$50	$60	$70	$100	$90	$100	$75
Rx Tier 3	$100	$120	$130	$200	$180	$200	$155
Specialty Drug	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived
Preventive Care/ Immunization/Screenings	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Telehealth							
Medical Visit	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Counseling Visit	$20	$20	$20	$20	$20	$20	$20
Psychiatric Visit	$45	$45	$45	$45	$45	$45	$45

Cost-share amounts are for covered services from providers in the plan's network. Services from out-of-network providers are typically subject to higher cost-share amounts.

Only formulary drugs are covered unless a formulary exception is approved. Members in plans with a copay drug benefit who pick a brand-name medication when a generic is available will pay the difference in cost plus the copay and any applicable deductible. All plans are subject to the exclusions and limitations listed on page 20.

EverydayHealth PPO continued

	EverydayHealth PPO Silver 4000	EverydayHealth PPO Silver 5000	EverydayHealth PPO Silver 5800/100	EverydayHealth PPO Silver 6000	EverydayHealth PPO Silver 6500	EverydayHealth PPO Bronze 7000	EverydayHealth PPO Bronze 8700
Overall Deductible	In-network: $4,000/member and $8,000/family	In-network: $5,000/member and $10,000/family	In-network: $5,800/member and $11,600/family	In-network: $6,000/member and $12,000/family	In-network: $6,500/member and $13,000/family	In-network: $7,000/member and $14,000/family	In-network: $8,700/member and $17,400/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	50%	20%	0%	20%	30%	30%	0%
Out-of-Pocket Maximum	In-network: $8,250/member and $16,500/family	In-network: $8,000/member and $16,000/family	In-network: $8,500/member and $17,000/family	In-network: $9,000/member and $18,000/family	In-network: $8,500/member and $17,000/family	In-network: $8,700/member and $17,400/family	In-network: $8,700/member and $17,400/family
Referral Required to Visit Specialist?	No	No	No	No	No	No	No
Primary Care (PCP) Visit	$40	$40	$45	$25	$25	$55	$25
Specialist Visit	$95	$90	$100	$95	$95	$125	$95
Urgent Care	$95	$90	$100	$95	$95	$125	$95
Emergency Room Visit (In and Out of Network)	$750	20% after deductible	No charge after deductible	1st visit at $750 copay, then 20% after deductible	30% after deductible	30% after deductible	No charge after deductible
Emergency Transportation/ Ambulance (In and Out of Network)	50% coinsurance, deductible waived	20% coinsurance, deductible waived	No charge after deductible	20% coinsurance, deductible waived	30% coinsurance, deductible waived	30% coinsurance, deductible waived	No charge after deductible
Inpatient Physician and Surgical Services	50% after deductible	20% after deductible	No charge after deductible	20% after deductible	30% after deductible	30% after deductible	No charge after deductible
Rx Deductible (Tiers 2 & 3)	n/a	$550/member	n/a	n/a	$450/member	$750/member	n/a
Rx Tier 1a	$3	$3	$3	$3	$3	$3	$3
Rx Tier 1b	$35	$35	$35	$35	$25	$35	$25
Rx Tier 2	$90	$80	$110	$100	$80	$110	No charge after deductible
Rx Tier 3	$180	$160	$220	$200	$160	$200	No charge after deductible
Specialty Drug	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	No charge after deductible
Preventive Care/Immunization/ Screenings	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Telehealth							
Medical Visit	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Counseling Visit	$20	$20	$20	$20	$20	$20	$20
Psychiatric Visit	$45	$45	$45	$45	$45	$45	$45

Cost-share amounts are for covered services from providers in the plan's network. Services by out-of-network providers are typically subject to higher cost-share amounts.

Only formulary drugs are covered unless a formulary exception is approved. Members in plans with a copay drug benefit who pick a brand-name medication when a generic is available will pay the difference in cost plus the copay and any applicable deductible. All plans are subject to the exclusions and limitations listed on page 20.

EverydayHealth HMO

	EverydayHealth HMO Gold 1500	EverydayHealth HMO Silver 3000	EverydayHealth HMO Silver 4000	EverydayHealth HMO Silver 5000	EverydayHealth HMO Silver 6000	EverydayHealth HMO Bronze 7000	EverydayHealth HMO Bronze 8700
Overall Deductible	In-network: $1,500/member and $3,000/family	In-network: $3,000/member and $6,000/family	In-network: $4,000/member and $8,000/family	In-network: $5,000/member and $10,000/family	In-network: $6,000/member and $12,000/family	In-network: $7,000/member and $14,000/family	In-network: $8,700/member and $17,400/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	20%	20%	50%	20%	20%	30%	0%
Out-of-Pocket Maximum	In-network: $6,500/member and $13,000/family	In-network: $8,800/member and $17,600/family	In-network: $8,000/member and $16,000/family	In-network: $8,000/member and $16,000/family	In-network: $8,500/member and $17,000/family	In-network: $8,700/member and $17,400/family	In-network: $8,700/member and $17,400/family
Referral Required to Visit Specialist?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Primary Care (PCP) Visit	$35	$35	$35	$40	$40	$55	$25
Specialist Visit	$75	$95	$85	$90	$100	$125	$95
Urgent Care	$75	$95	$85	$90	$100	$125	$95
Emergency Room Visit (In and Out of Network)	$200	20% after deductible	50% after deductible	20% after deductible	20% after deductible	30% after deductible	No charge after deductible
Emergency Transportation/ Ambulance (In and Out of Network)	20% coinsurance, deductible waived	20% coinsurance, deductible waived	50% coinsurance, deductible waived	20% coinsurance, deductible waived	20% coinsurance, deductible waived	30% coinsurance, deductible waived	No charge after deductible
Inpatient Physician and Surgical Services	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	30% after deductible	No charge after deductible
Rx Deductible (Tiers 2 & 3)	n/a	$450/member	$450/member	n/a	$500/member	$750/member	n/a
Rx Tier 1a	$3	$3	$3	$3	$3	$3	$3
Rx Tier 1b	$25	$35	$35	$35	$35	$35	$25
Rx Tier 2	$70	$90	$90	$90	$90	$110	No charge after deductible
Rx Tier 3	$140	$180	$180	$180	$180	$200	No charge after deductible
Specialty Drug	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	50% coinsurance, deductible waived	No charge after deductible
Preventive Care/ Immunization/Screenings	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Telehealth							
Medical Visit	No charge	No charge	No charge	No charge	No charge	No charge	No charge
Counseling Visit	$20	$20	$20	$20	$20	$20	$20
Psychiatric Visit	$45	$45	$45	$45	$45	$45	$45

Cost-share amounts are for covered services from providers in the plan's network. Services by healthcare professionals outside the network are generally not covered except for emergencies, select ancillary services performed by out-of-network providers at an in-network facility, and other special circumstances when use is preapproved. Except for emergencies and urgent care, members must obtain primary care professional services from their designated PCP. If their designated PCP is in a practice with other providers, they may obtain primary care professional services from any primary care professional in the practice, including a nurse practitioner or a physician assistant. If the designated PCP is going to be unavailable, the PCP may appoint a "covering provider" to see patients in their absence. The member may also receive primary care professional services from a covering provider. PCP referrals are required for specialist visits; some exceptions apply (e.g., OB/GYN, chiropractic, and certain other in-network provider visits).

Only formulary drugs are covered unless a formulary exception is approved. Members in plans with a copay drug benefit who pick a brand-name medication when a generic is available will pay the difference in cost plus the copay and any applicable deductible. All plans are subject to the exclusions and limitations listed on page 20.

Portfolio PPO — HSA-Qualified

	Portfolio PPO Gold 1600[1]	Portfolio PPO Silver 3000	Portfolio PPO Silver 3750	Portfolio PPO Silver 4250	Portfolio PPO Bronze 5900	Portfolio PPO Bronze 7500
Overall Deductible	In-network: $1,600/member and $3,200/family	In-network: $3,000/member and $6,000/family	In-network: $3,750/member and $7,500/family	In-network: $4,250/member and $8,500/family	In-network: $5,900/member and $11,800/family	In-network: $7,500/member and $15,000/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	10%	20%	10%	10%	30%	0%
Out-of-Pocket Maximum	In-network: $5,500/member and $11,000/family	In-network: $6,650/member and $13,300/family	In-network: $6,850/member and $13,700/family	In-network: $7,100/member and $14,200/family	In-network: $7,200/member and $14,400/family	In-network: $7,500/member and $15,000/family
Referral Required to Visit Specialist?	No	No	No	No	No	No
Primary Care (PCP) Visit	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Specialist Visit	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Urgent Care	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Emergency Room Visit (In and Out of Network)	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Emergency Transportation/ Ambulance (In and Out of Network)	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Inpatient Physician and Surgical Services	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Rx Deductible (Tiers 2 & 3)	n/a	n/a	n/a	n/a	n/a	n/a
Rx Tier 1	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Rx Tier 2	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Rx Tier 3	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Specialty Drug	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Preventive Care/ Immunization/Screenings	No charge	No charge	No charge	No charge	No charge	No charge
Pediatric Dental	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Telehealth						
Medical Visit	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Counseling Visit	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible
Psychiatric Visit	10% after deductible	20% after deductible	10% after deductible	10% after deductible	30% after deductible	No charge after deductible

Cost-share amounts are for covered services from providers in the plan's network. Services from out-of-network providers are typically subject to higher cost-share amounts.
Only formulary drugs are covered unless a formulary exception is approved. All plans are subject to the exclusions and limitations on page 20.

[1]The member deductible applies only to an individual or self-only plan purchase. A member with any covered dependent(s) must meet the family deductible. The family deductible must be met by one or more of the covered members before coinsurance applies.

Portfolio HMO — HSA-Qualified

	Portfolio HMO Silver 3750	Portfolio HMO Silver 4250	Portfolio HMO Bronze 7500
Overall Deductible	In-network: $3,750/member and $7,500/family	In-network: $4,250/member and $8,500/family	In-network: $7,500/member and $15,000/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	10%	10%	0%
Out-of-Pocket Maximum	In-network: $6,500/member and $13,000/family	In-network: $7,100/member and $14,200/family	In-network: $7,500/member and $15,000/family
Referral Required to Visit Specialist?	Yes	Yes	Yes
Primary Care (PCP) Visit	10% after deductible	10% after deductible	No charge after deductible
Specialist Visit	10% after deductible	10% after deductible	No charge after deductible
Urgent Care	10% after deductible	10% after deductible	No charge after deductible
Emergency Room Visit (In and Out of Network)	10% after deductible	10% after deductible	No charge after deductible
Emergency Transportation/Ambulance (In and Out of Network)	10% after deductible	10% after deductible	No charge after deductible
Inpatient Physician and Surgical Services	10% after deductible	10% after deductible	No charge after deductible
Rx Deductible (Tiers 2 & 3)	n/a	n/a	n/a
Rx Tier 1	10% after deductible	10% after deductible	No charge after deductible
Rx Tier 2	10% after deductible	10% after deductible	No charge after deductible
Rx Tier 3	10% after deductible	10% after deductible	No charge after deductible
Specialty Drug	10% after deductible	10% after deductible	No charge after deductible
Preventive Care/Immunization/Screenings	No charge	No charge	No charge
Pediatric Dental	No charge after deductible	No charge after deductible	No charge after deductible
Telehealth			
Medical Visit	10% after deductible	10% after deductible	No charge after deductible
Counseling Visit	10% after deductible	10% after deductible	No charge after deductible
Psychiatric Visit	10% after deductible	10% after deductible	No charge after deductible

Cost-share amounts are for covered services from providers in the plan's network. Services by healthcare professionals outside the network are generally not covered except for emergencies, select ancillary services performed by out-of-network providers at an in-network facility, and other special circumstances when use is preapproved. Except for emergencies and urgent care, members must obtain primary care professional services from their designated PCP. If their designated PCP is in a practice with other providers, they may obtain primary care professional services from any primary care professional in the practice, including a nurse practitioner or a physician assistant. If the designated PCP is going to be unavailable, the PCP may appoint a "covering provider" to see patients in their absence. The member may also receive primary care professional services from a covering provider. PCP referrals are required for specialist visits; some exceptions apply (e.g., OB/GYN, chiropractic, and certain other in-network provider visits).

Only formulary drugs are covered unless a formulary exception is approved. All plans are subject to the exclusions and limitations listed on page 20.

PEDIATRIC DENTAL

Dental benefits for children who are under age 19 and covered by one of the plans described in this brochure for businesses with 2-50 employees.[1]

Type I Covered Services – Diagnostic and Preventive	
Oral exams	Two per year[2] in any combination of periodic, limited, or comprehensive exams
Prophylaxis – Cleanings	Two per year
X-rays	Any combination of X-rays billed on the same date of treatment cannot exceed the allowed amount for a full-mouth X-ray benefit
Bitewing X-rays	Two sets per year
Periapical X-rays	Covered
Full-mouth X-rays	One set per five-year period
Panoramic X-rays	One set per five-year period. Panoramic X-rays accompanied by bitewing X-rays are considered a set of full-mouth X-rays and are subject to the full-mouth X-ray limit.
Topical Fluoride	Two treatments per year
Sealants	Permanent molars with no decay or restoration only. One application per three-year period.
Space Maintainers	Temporary appliances to replace prematurely lost teeth until permanent teeth erupt
Type II and III Covered Services – Restorative All claims subject to processing based on the least expensive available treatment (LEAT)[3]	
Restorative Fillings	Amalgam and composite resin fillings covered
Simple and Surgical Extractions	Covered
Periodontics – Non-surgical	Periodontal scaling and root planing limited to one per quadrant per two-year period. Periodontal maintenance procedures limited to four per year; prophylaxis and cleanings count toward this limit.
Prosthodontics – Bridges and Dentures	Five-year replacement limit
General Anesthesia	Limited coverage per BCBSAZ dental coverage guidelines[4]
Endodontics – Root Canal	Covered
Crowns/Inlays/Onlays	Five-year replacement limit
Periodontics – Surgical	One procedure per three-year period
Implants	Limited coverage per BCBSAZ dental coverage guidelines[4]
Type IV Covered Services – Orthodontia Cosmetic orthodontia not covered	
Orthodontics (dentally necessary)	Limited coverage per BCBSAZ dental coverage guidelines[4]

In-network services available through the BluePreferred® Dental network. A listing of providers in the BluePreferred Dental network can be found at azblue.com.

[1] These plans are offered to employers considered small for purposes of the Affordable Care Act (ACA).

[2] All per-year benefits mean per calendar year.

[3] Only the allowed amount, as based on least expensive available treatment (LEAT), if applicable (and not billed charges), counts to satisfy the deductible. There may be several methods for treating a specific dental condition. All claims for restorative services such as fillings and crowns are subject to analysis for the least expensive available treatment (LEAT). Benefits for restorative procedures will be limited to the LEAT only. For these procedures, BCBSAZ will only pay benefits up to the LEAT fee. Members may elect to receive a service that is more costly than the LEAT, but the member will be responsible for cost share based on the LEAT, and will also pay the difference between the fee for the LEAT and the more costly treatment (LEAT balance bill). Any payment made for this LEAT balance bill will not count toward the deductible or out-of-pocket maximum.

[4] BCBSAZ dental coverage guidelines are available upon request. Not all dentally necessary services are covered benefits.

THE MEMBER EXPERIENCE

The BCBSAZ Customer Service team is dedicated to providing members with solutions quickly and accurately.

Our concierge model of customer care delivers a one-and-done solution, which means customer service representatives handle benefit-related calls and inquiries about claims.

Claims and Customer Service

- Provide help navigating the healthcare system
- Have experienced staff with an average tenure of 5.5 years[1]
- Serve all members, regardless of resident state
- Are local, with Arizona-based call centers
- Offer direct access to qualified Spanish-speaking staff
- Provide assistance in over 140 languages (via translated services)

[1] BCBSAZ internal data, 2022

MEMBER ENGAGEMENT TOOLS AND RESOURCES

We have the tools and resources available for members to make educated decisions on their healthcare choices. Members can access all of the following by logging in to the member website at **azblue.com/MyBlue.**

Find a Doctor:

Members can easily find a provider, hospital, or lab in their plan's network with this online tool.

Spending Accounts:

Integrates a member's health spending account with the member portal for easy administration of funds.

Claims & Spending:

Simplifies the tracking of claims and spending by combining all activity into one monthly online statement.

Telehealth:

Members can have virtual visits with providers—any time, anywhere—using the BlueCare Anywhere telehealth service.

Discount Program:

Discounts are available through Blue365® on national brands for fitness gear, wearables, gym memberships, healthy eating options, and more.

Care Cost Estimator:

Members can shop and compare costs for more than 1,600 procedures such as common surgeries and diagnostic services.

Mobile Access:

Access to health plan information and resources is available by signing up for a personalized MyBlue℠ member account at **azblue.com/MyBlue** or downloading the MyBlue AZ℠ mobile app.

Wellness:

Online, self-paced wellness tools and resources are available for members.

Pharmacy Tools:

Members can quickly search for medications, verify if special authorization is needed, and check for quantity limits using the formulary drug search on **azblue.com.** Sign in to your MyBlue member account at **azblue.com/MyBlue** to submit and track medication home delivery requests.

TELEHEALTH SERVICES

NURSE ON CALL

Members can connect with a nurse 24/7 to get answers to questions about symptoms they are experiencing, minor illnesses and injuries, medical tests, or preventive care, as well as suggestions for next steps based on their situation.[1]

BLUECARE ANYWHERE

With BlueCare Anywhere, members can connect to board-certified doctors by live video for urgent medical care, psychiatry, and counseling sessions. The BlueCare Anywhere telehealth service is available any day, any time—from a computer, tablet, or mobile device.

MEDICAL

Board-certified doctors provide immediate care for a range of common illnesses, aches, and pains, and can prescribe medication.

COUNSELING

Licensed psychologists or counselors are available to treat issues—such as mental health and substance use—that can affect emotional, psychological, and social well-being.

PSYCHIATRY

Board-certified psychiatrists are available for assessments, evaluation, treatment, and can prescribe medication. By appointment only.

Download the BlueCare Anywhere mobile app[2] or visit **BlueCareAnywhereAZ.com.**

Call 911 in an emergency.

[1] BCBSAZ members should always consult with their healthcare provider about medical care or treatment. Recommendations, advice, services, or online resources are not a substitute for the advice, opinion, or recommendation of a healthcare provider.

[2] Your wireless plan's phone and data rates may apply. Search for "MyBlue AZ" and "BlueCare Anywhere" in the Google Play™ or Apple® App Store® online marketplaces.

HEALTH AND WELLNESS

BCBSAZ has partnered with Sharecare® to bring employers a truly differentiated digital health and wellness experience. Our members can expect immediacy, simplicity, and relevancy in a mobile app, while employers will find tools that drive sustained employee engagement to improve health outcomes and control rising costs at **azblue.sharecare.com.**

REALAGE TEST

Sharecare's next-generation health assessment evaluates a variety of behaviors and existing conditions to calculate the body's true age. For users, this is their first step toward optimizing their health. They are armed with information about how lifestyle choices can help them stay younger—or age faster—than their chronological age. After completing the RealAge® Test, members will be able to manage their health profile, get personalized recommendations, and receive expert guidance to stay supported and motivated.

REALAGE PROGRAM

Upon completion of the RealAge Test, users can begin participating in Sharecare's RealAge program, a healthy behavior program targeting the highest lifestyle risks—stress, sleep, nutrition, and activity. The program is personalized to the individual based on risk level for each lifestyle category gathered through RealAge Test responses and personal interest. It's fully integrated with other features of Sharecare, such as Trackers, to drive sustained engagement and promote behavior change that can lead to a lower RealAge.

Sharecare is an independent company contracted to provide this online program and/or services for BCBSAZ. Information provided by Sharecare is not a substitute for the advice or recommendations of your healthcare provider. RealAge and Sharecare are registered trademarks of Sharecare, Inc.

CARE MANAGEMENT

BCBSAZ's programs support the patient/provider relationship and enhance the overall healthcare experience for our members. When we help members better manage their health, they can more effectively manage their daily activities, be more productive at work, and reduce their (and your) healthcare costs.

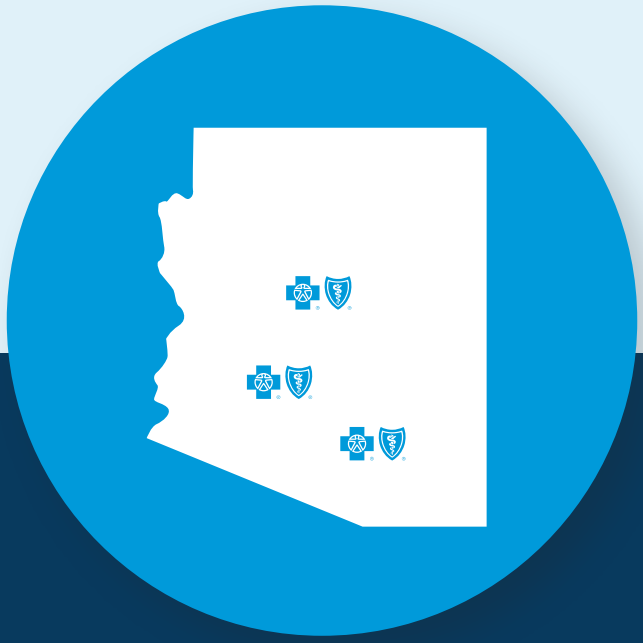
Members can take advantage of the following programs:

HEALTH MANAGEMENT

Members with conditions like diabetes, congestive heart failure, asthma, COPD, coronary artery disease, behavioral health, or hypertension can get extra help. Care managers work with members to understand their health needs, help coordinate care, find health resources, and provide guidance for managing their condition and health goals.

HOSPITAL TO HOME

When members are transitioning home from a critical care hospital stay, we help ensure that they're getting the care, medications, and equipment they need to reduce potential hospital readmissions. We will assess the member's needs and assist the member with follow-up doctor and therapy appointments, equipment, and community services, to name a few.



WE'RE HERE TO HELP

Our team is here to help you find the right health plans for your needs. Reach us at any of the following locations, or visit **azblue.com** for more details on our products and services.

PHOENIX
602-864-5792
1-800-232-2345, ext. 5792
FAX 602-864-5800

TUCSON
520-745-1615
1-800-621-5563
FAX 1-866-772-2020

FLAGSTAFF
928-526-7226
1-800-601-1946
FAX 602-864-5800

HELPFUL TERMS AND DEFINITIONS

Allowed Amount

The amount BCBSAZ has agreed to pay for a covered service. The allowed amount includes both the BCBSAZ payment and your cost share. Example: A doctor may normally charge $100 for a particular service. But he has an agreement with your plan to accept only $80 as reimbursement for that service. $80 is the "allowed amount." The allowed amount includes any amount paid by the plan, plus any amount the member pays as a cost share, including copays and deductibles.

Balance Bill

This is the difference between the BCBSAZ allowed amount and a non-contracted provider's billed charge. Noncontracted providers have no obligation to accept the allowed amount, with the exception of emergency and ancillary services provided in an in-network facility. Any amounts paid for balance bills do not count toward any deductible, coinsurance, or out-of-pocket limit.

Business Size Definitions

2-50: These plans are offered to employers considered small for purposes of the Affordable Care Act (ACA)—the average number of total employees on business days during the previous calendar year was 50 or fewer. These plans are also available to an employer considered large for purposes of the ACA, but considered small for purposes of Arizona law (on a typical business day, 50 or fewer employees are eligible for health benefit plan coverage).

Emergency Services

For emergency services, members will pay their in-network cost share, even if services are received from out-of-network providers. Also, out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.

Out-of-Pocket Costs

These are expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services, plus all costs for services that aren't covered. Not all out-of-pocket expenses are applied to the plan's maximum out-of-pocket benefit.

Precertification

Some services and medications require precertification (sometimes referred to as prior authorization). Except for emergencies, urgent care, and maternity admissions, precertification is always required for inpatient admissions (acute care, behavioral health, long-term acute care, extended active rehabilitation, and skilled nursing facilities), home health services, and most specialty medications. Precertification may be required for other covered services and medications.

Prescriptions and Medications

BCBSAZ applies limitations to certain prescription medications obtained through the pharmacy benefit. A complete formulary list of covered medications and limitations is available online at **azblue.com** or by calling BCBSAZ. These limitations include, but are not limited to, prior authorization, quantity, age, gender, dosage, and frequency of refill limitations. Plans are also subject to:

- A closed formulary. This means that only medications included on the formulary listing are covered. Any medications not found on that list would require a formulary exception to be made or is simply not a benefit of the plan (please refer to the benefit book for a list of excluded categories).
- A step therapy program that requires members to take preferred products, including but not limited to, the generic version of certain medications before BCBSAZ will consider coverage of the brand-name version of that medication.
- A preferred generics program. This means that when a member or provider selects a brand-name product when a generic product is available, the member will be responsible for their copay and any applicable deductible plus the cost difference between the brand-name and generic product. Exceptions are only made when the member is approved for the brand-name medication through the step therapy program or if BCBSAZ prefers the brand-name product over the generic product. No additional exceptions to this cost-sharing amount will be made.
- $3 Tier 1a generic prescription drugs. $3 copays on 30-day supplies of common everyday prescriptions including select insulin. Prescription drugs in Tier 1b have low copays that range from $5 to $35 on a 30-day supply, depending upon your plan.

BCBSAZ prescription medication limitations are subject to change at any time without prior notice.

PLAN EXCLUSIONS AND LIMITATIONS

PPO Excluded Services & Other Covered Services

Services our plans generally do NOT cover. (Check the policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Adult routine vision exam
- Alternative medicine
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services, and supplies
- Custodial care
- Dental care and orthodontic services (adult), except as stated in plan
- Durable medical equipment (DME) rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments, except as stated in plan
- Eyewear, except as stated in plan
- Fertility and infertility medication and treatment
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in plan
- Long-term care, except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Orthodontic services (pediatric) that are not dentally necessary
- Private-duty nursing, except when medically necessary or when skilled nursing is not available
- Respite care
- Routine foot care
- Sexual dysfunction treatment and services
- Weight-loss programs

Other covered services. (Limitations may apply to these services. This isn't a complete list. Please see our plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids, up to one per ear per calendar year
- Non-emergency care when traveling outside the U.S.

HMO Excluded Services & Other Covered Services

Services our plans generally do NOT cover. (Check the policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Adult routine vision exam
- Alternative medicine
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services, and supplies
- Custodial care
- Dental care and orthodontic services (adult), except as stated in plan
- Durable medical equipment (DME) rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments, except as stated in plan
- Eyewear, except as stated in plan
- Fertility and infertility medication and treatment
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in plan
- Long-term care, except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Non-emergency care when traveling outside the U.S.
- Orthodontic services (pediatric) that are not dentally necessary
- Private-duty nursing, except when medically necessary or when skilled nursing is not available
- Respite care
- Routine foot care
- Services from providers outside the network, except in emergencies and other limited situations when use is preauthorized
- Sexual dysfunction treatment
- Weight-loss programs

Other covered services. (Limitations may apply to these services. This isn't a complete list. Please see our plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids, up to one per ear per calendar year

PEDIATRIC DENTAL EXCLUSIONS AND LIMITATIONS

Examples of services not covered

This is only a partial list of services that are limited or not covered by the health plans featured in this guide. Expenses for services that exceed the benefit limit are not covered. Detailed information about benefits, exclusions, and limitations is in the benefit plan booklet or rider and is available prior to enrollment, upon request.

- Alternative dentistry
- Athletic mouth guards
- Biopsies
- Bleaching of any kind
- CT scans (e.g., cone beam) and tomographic surveys
- Correction of congenital malformations, except as required by Arizona state law, for newborns, adopted children, and children placed for adoption
- Cosmetic services and any related complications
- Dental services and supplies not provided by a dentist, except as stated in plan
- Duplicate, provisional, and temporary devices, appliances, and services
- Experimental or investigational services
- Fixed pediatric partial dentures
- Genetic tests for susceptibility to oral diseases
- Inpatient or outpatient facility services
- Laboratory and pathology services
- Locally administered antibiotics
- Major restorative and prosthodontic services performed on other than a permanent tooth
- Maxillofacial prosthetics and any related services
- Medications dispensed in a dentist's office, except as stated in plan
- Non-dentally necessary services—services that are not dentally necessary, as determined by BCBSAZ. BCBSAZ may not be able to determine dental necessity until after services are rendered.
- Occlusal guards for the treatment of temporomandibular joint syndrome or sleep apnea
- Oral hygiene instruction, plaque control programs, and dietary instructions
- Removal of appliances, fixed space maintainers, or posts
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Sealants for teeth other than permanent molars
- Services resulting from failure to comply with professionally prescribed treatment
- Telephonic and electronic consultations, except as required by law
- Therapy or treatment of the temporomandibular joint, orthognathic surgery, or ridge augmentation
- Tooth transplantation

NOTES

NOTES

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OUR OTHER OPTIONS FOR YOUR BUSINESS, VISIT azblue.com OR CALL US.

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