Blue makes it easy to find the right plan.

2023
AFFORDABLE CARE ACT HEALTH PLANS

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Helpful Resources When Shopping

Shop for or compare plans: **azblue.com/plans**
Prescriptions drugs: **azblue.com/pharmacy**

Find a doctor:
MaricopaFocus Network: **azblue.com/MaricopaFocus**
PimaFocus Network: **azblue.com/PimaFocus**
Neighborhood Network: **azblue.com/Neighborhood**
Statewide PPO Network: **azblue.com/PPO**

Let's connect:
Follow us for health tips and updates on Blue Cross® Blue Shield® of Arizona (BCBSAZ) news.

- Facebook.com/BCBSAZ
- Twitter.com/BCBSAZ
- YouTube.com/BCBSArizona
- Instagram.com/BCBSAZ
- TikTok.com/@BCBSAZ

If you have questions, call us at **1-855-329-2583.**

We're available Monday through Friday, 8 a.m. to 5 p.m. Arizona time. You can also call your broker with any questions. During Open Enrollment (November 1 to January 15), we're available Monday through Friday, 8 a.m. to 6 p.m. Arizona time.

We Are Inspired by You

For more than 80 years, Blue Cross Blue Shield of Arizona has been committed to helping Arizonans get healthier faster, and stay healthier longer. Today, we offer health insurance and related products to over 1.9 million customers.*

We understand there's more to health insurance than having access to affordable care when you need it. That's why we give you more ways to be healthier—and save along the way.

Here's what Our Affordable Care Act (ACA) plans offer you and your family

$0 primary care provider (PCP) visits—See your doctor with no copay.

$0-$3 generic drugs—Including drugs for diabetes, heart conditions, and mental health.

$0 preventive care services—Includes screenings, wellness checks, flu shots and other immunizations, and more.

$0 or low-cost online doctor visits***—Get medical care from a board-certified doctor 24/7 using your smartphone or other electronic device; English- and Spanish-speaking doctors are available. Psychiatry and counseling services also available.

$0 Nurse On Call—Talk with a registered nurse anytime, day or night, at no cost; English- and Spanish-speaking nurses are available.

MyBlue℠ member account and mobile app—Find a doctor, get estimates for prescription drug costs, pay your premium, check your deductible, and so much more—anytime, anywhere.

Discounts on health services and equipment—Save on a wide range of brand-name products and services with Blue365®, including vision services, wearable fitness devices, and more.

Earn up to $100 in rewards for preventive care—You can earn rewards for taking healthy actions like getting your annual wellness checkup. Regular health exams and screenings can help you catch health issues early.

*Source: Blue Cross Blue Shield of Arizona. **Applies to two or more visits (depending on your plan) in a calendar year. HMO plans must be with your designated PCP or with a designated PCP referral. PPO plans allow you to see any in-network doctor. $0/free visits are not available for Portfolio plans. ***Free BlueCare Anywhere℠ medical visits are included in the TrueHealth cost-share reduction plans. $5-$10 medical visits are included in the rest of the plans except for Portfolio and SimpleHealth where a deductible applies.

Plans to Fit Your Health and Budget

HMO Plans

HMO plans are lower cost with exclusive provider networks in your area.

- Plans cover services received from in-network providers.
- Emergency room services and emergency medical transportation are covered out of network.
- If you go to a doctor or hospital that is not in network, you could end up paying the full cost of those services.
- Members are assigned a designated primary care provider (PCP). You can change your PCP up to six times a year.
- A referral from your PCP is required for most specialists.

PPO Plans

PPO plans give you choice of doctors with no specialist referrals and the largest provider network in Arizona.

- You can go to any doctor or specialist without a referral.
- If you choose out-of-network providers, facilities, or other healthcare professionals, you will pay more than staying in network.
- You don't need to select a primary care provider (PCP), but we do recommend that you establish a relationship with one primary, in-network doctor whom you see regularly.
- Our PPO plans offer access to care both in Arizona and out of state through the BlueCard® program.

ACA HEALTH PLANS COVER THESE 10 ESSENTIAL HEALTH BENEFITS:

1. Doctor visits
2. Prescription drugs
3. Free preventive care, including screenings and immunizations
4. Outpatient care
5. Hospital stays
6. Maternity and newborn care
7. Mental and behavioral healthcare
8. Emergency care
9. Urgent care
10. Dental and vision care for children

Your primary care provider helps in many ways:

- Looks out for your overall health by providing preventive care, including annual checkups, screenings, and immunizations
- Coordinates with specialists and other healthcare providers to support all your healthcare needs, from minor illnesses to ongoing health conditions and mental health
- Works with BCBSAZ to help you get the right care at the right time

Healthcare is personal, so we make it easy to find the right plan for you.

PPO **For Those Wanting Choice of Doctors**

For those looking for maximum freedom and choice. This is the right plan if you want to choose your providers. Specialist referrals are not needed and you get access to the largest provider network in Arizona and across the United States.* Out-of-network care is covered inside and outside of Arizona.

AdvanceHealth HMO **For Peace-of-Mind Coverage**

For those in good health who don't see a doctor that often and want predictable low-cost care and prescriptions. This plan gives you peace of mind that you have coverage when you need it, even when the unexpected happens. Includes online doctor visits and a low monthly premium.

EverydayHealth HMO **Predictable Out-of-Pocket Costs for Every Budget**

For people, especially for those with a family, seeking predictable out-of-pocket costs. You visit the doctor often and take only generic prescription drugs. Get easy access, balancing monthly premium with fixed copays and doctor/Rx costs. Several deductibles to choose from.

TrueHealth HMO **For Those Who Need Specialist Care or Brand-Name Drugs**

For those with complex health conditions who are looking to take the hassle out of being healthy. You and your family see the doctor often. This plan has $0 primary care provider (PCP) visits and fixed copays for specialist doctors and certain brand-name drugs.

Portfolio HSA HMO & PPO **For the Health Planner**

For those who are health planners, building a nest egg, or are looking for more control over their health savings. Can be paired with a health savings account (HSA) to plan for healthcare costs. A great plan if you rarely get sick but want to be prepared with financial protection. This plan is also a good fit if you have ongoing health conditions and want to manage health expenses using an HSA.

Standardized HMO & PPO **Fixed Costs for Most Health Needs, Plus Mental and Behavioral Health**

For those, especially with mental health concerns or children with special needs, seeking fixed costs for many healthcare services. You visit the doctor often, may take prescription drugs, and see specialists frequently for a condition or disability that needs therapy and mental or behavioral health support.

*Source: BCBSAZ 2021 data

Questions to Ask When Choosing a Plan

When choosing a plan, it's important to think about your health needs (and those of your family) as well as your budget. This section will help you find a plan that fits your budget and overall health needs.

QUESTION #1:

Do I qualify for financial help from the government?

Most likely yes. Subsidies are given to individuals and families based on their household income and family size. All Blue Individual ACA plans qualify for subsidies.

There are two types of subsidies that can lower your overall cost of health insurance:

1. **Premium tax credit**—helps pay for all or part of your monthly premium depending on your household income. Income ranges that qualify for a $0 premium health plan or financial help are outlined in the chart below.
2. **Cost-share reduction**—a discount on your deductibles, copayments, and coinsurance; available on Silver plans only for those who make less than 250% federal poverty level (FPL).

Qualifying Income Levels

Subsidies are based on the household income earned during the year you will be covered.

Persons in Household	Income range that qualifies for $0 plans	Income range that qualifies for subsidy	Income range that may qualify for a subsidy
1	$18,754 to $20,385	$20,386 to $54,360	$54,361 and above
2	$25,268 to $27,465	$27,466 to $73,240	$73,241 and above
3	$31,781 to $34,545	$34,546 to $92,120	$92,121 and above
4	$38,295 to $41,625	$41,626 to $111,000	$111,001 and above
5	$44,809 to $48,705	$48,706 to $129,880	$129,881 and above
6	$51,322 to $55,785	$55,786 to $148,760	$148,761 and above

Source: U.S. Department of Health and Human Services Federal Poverty Level (FPL) Guidelines for 2022

You can apply for subsidies at **azblue.com/plans** as part of our online price quoting and application tool. If you have questions or need help with your application, call us at **1-855-329-2583.**

QUESTION #2:

What are my healthcare needs?

QUESTIONS TO THINK ABOUT	HELPS YOU FIGURE OUT
How often do you visit a doctor?	• Do you only go for routine services (like yearly checkups or wellness visits) or an occasional illness? • Or, do you have a condition that needs the care of a specialist?
Who do you need to cover?	• Do you need a plan for just you? • Or, do you need to cover other people in your family? Separate plans may save you money if your health needs are different.
Do you take any prescription drugs regularly?	Costs for prescriptions can be different from one plan to the next. If you take certain medications regularly, you'll want to check the drug list (sometimes called a *formulary)* for each plan to: **1)** Make sure your drugs are covered, and **2)** Find out how much they will cost. With most plans, drugs are assigned to pricing tiers. What you pay for a certain drug will depend on which tier it belongs to.
Do you expect to have any major healthcare needs?	• Are you pregnant or planning to get pregnant? • Do you expect to have surgery? • Are there other healthcare needs you need to discuss with your doctor? If you expect to have surgery or maternity care, you'll want to pick a plan with a deductible and out-of-pocket maximum that fit your budget.
Do you need coverage out of state?	• Do you travel and need medical coverage in another state? • Do you have college students on your policy that need coverage in another state?

All plans cover preventive services so things like wellness visits, vaccinations, and preventive medications are $0.

QUESTION #3:

What are Metal Levels and what's right for me?

Health plans are listed in categories called Metal Levels. Blue offers Bronze, Silver, and Gold levels of coverage. The different levels are determined by the amount the health plan pays toward medical costs, on average.

Why is this important? When looking for a plan, you want to look at the premium, but also your overall annual out-of-pocket cost. To find out which metal level and plan is the most affordable for your annual out-of-pocket costs, visit **azblue.com/plans.**

How you and Blue split costs

Plan Category	Blue Pays	You Pay
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%

Which Metal Level is right for you?

BRONZE 60%

PREMIUM
$

DEDUCTIBLE
$$$$

OUT-OF-POCKET MAXIMUM
$$$$

Bronze

- **Lowest** monthly premium
- **Highest** costs when you need care
- **Good choice if:** You want a low-cost way to protect yourself from worst-case medical scenarios, like serious sickness or injury. Your monthly premium will be low, but you'll have to pay for most routine care yourself.

SILVER 70%

PREMIUM
$$

DEDUCTIBLE
$$$

OUT-OF-POCKET MAXIMUM
$$$

Silver

- **Moderate** monthly premium
- **Moderate** costs when you need care
- **Good choice if:** You're willing to pay a slightly higher monthly premium than Bronze to have more of your routine care covered, or if you qualify for "extra savings."

If you qualify for cost-sharing reductions: You **must** pick a Silver plan to get the extra savings. You can save hundreds or even thousands of dollars per year if you go to the doctor a lot.

GOLD 80%

PREMIUM
$$$

DEDUCTIBLE
$$

OUT-OF-POCKET MAXIMUM
$$

Gold

- **Highest** monthly premium
- **Lowest** costs when you need care
- **Good choice if:** You're willing to pay more each month to have more costs covered when you get medical treatment. If you use a lot of care, a Gold plan could be a good value.

QUESTION #4:

How much does the plan cost for the care I need?

Once you have an idea of your healthcare needs, it's time to think about your budget. You'll want to look at the different out-of-pocket costs you will have with each health plan.

EXAMPLE: **Everyday**Health HMO **Silver**

Estimated monthly premium

$433.51

Deductible

$4,750
Individual total

Out-of-pocket maximum

$8,700
Individual total

Copayments/Coinsurance

Primary doctor: $0 for first 2 visits, then $20
Specialist doctor: $75
Generic drugs: $3 Tier 1a, $15 Tier 1b

EXAMPLE: **Everyday**Health HMO CSR **Silver 5**

Estimated monthly premium

$133.35

Your monthly payment to keep your plan active.

Deductible

$0
Individual total

Amount you pay before your health plan starts to pay for covered services. Some plans cover doctor visits and certain drugs before the deductible.

Out-of-pocket maximum

$3,000
Individual total

Once you reach this amount in a plan year, your plan will pay 100% of covered services.

Copayments/Coinsurance

Primary doctor: $0 for first 2 visits, then $15
Specialist doctor: $40
Generic drugs: $0

How much you pay for doctor visits, lab tests, and prescriptions. A copay is a fixed dollar amount; coinsurance is a fixed percentage of the bill. When we talk about your cost share, that's another way of saying "copay and/or coinsurance."

Premium rates are for a 40-year-old who lives in Maricopa County.

RULE OF THUMB
FOR PREMIUMS AND DEDUCTIBLES

HIGHER
deductible, higher out-of-pocket costs

LOWER
monthly premium

A higher-deductible plan is a good fit for you and your family if you are healthy and rarely need healthcare. You are willing to pay a higher out-of-pocket cost when you need care in exchange for a lower monthly premium.

HIGHER
monthly premium

LOWER
deductible, lower out-of-pocket costs

A lower-deductible plan is a good fit for you if you have an ongoing health condition. You are willing to pay a higher monthly premium for lower out-of-pocket costs for things like regular doctor visits and prescription drugs.

QUESTION #5:

Are my doctors in the plan's network?

Before you pick a plan, you'll want to check to see if your doctors are included in the plan's network. A plan network is a set of doctors who agree to offer care to members of that plan. These doctors are what you call in-network providers.

When checking a plan's network, keep these questions in mind:

- Are your doctors in the plan's network?
- If your primary care provider or specialist is not in the plan's network, would you be willing to see a different doctor?
- Would you consider using online doctor visits for illnesses and injuries that aren't serious?

HMO Plans

What's important to know is if you go to a doctor or hospital that is not in network, you could end up paying the full cost of those services. Out-of-network coverage may be limited, and may not be covered at all, except in emergencies and rare situations that we have preapproved. All our HMO plans typically have lower premiums than PPO plans and cover services received from in-network providers.

PPO Plans

These plans offer the freedom and choice of doctors with the largest provider network in Arizona. Go to any doctor or specialist without a referral. You can choose doctors and hospitals in network or out of network as well as out of state. If you choose providers out of network you will pay more than in network.

If you need help finding out which doctors are in a particular plan network, you can use the "Find a Doctor" tool at **azblue.com/findadoctor.** Or you can call us at **1-855-329-2583.**

QUESTION #6:

When can I enroll?

You've found your health plan. Here's when you can enroll:

1. **During Open Enrollment (OE)**
   November 1 to January 15. This is the period each year when you can enroll in a health plan or change to a different plan.

2. **Special Enrollment Period**
   If you need health insurance outside of the dates of Open Enrollment, you will need to have a Qualifying Life Event. In most cases, your special enrollment period will be the 60 days following certain life events. In some cases, you may even be able to apply 60 days before the qualifying life event.

Qualifying Life Events include:

- Losing your job
- Getting married
- Having a baby
- Moving to a new state
- Aging off your parent's plan
- Newly eligible for financial help

Go to **azblue.com/plans** to shop and enroll.

Plans & Networks by County

We offer HMO and PPO ACA health plans in all 15 Arizona counties.

Network	Plans
Statewide PPO	• **PPO (Gold, Silver)** • **Portfolio HSA PPO NEW (Gold)** • **Standardized PPO NEW (Gold, Silver)**
MaricopaFocus HMO (Maricopa County only)	• **EverydayHealth HMO (Gold, Silver, Bronze)** • **TrueHealth HMO (Silver)** • **AdvanceHealth HMO (Gold, Silver, Bronze)** • **Portfolio HSA HMO (Bronze)** • **Standardized HMO NEW (Gold, Silver, Bronze)**
PimaFocus HMO (Pima County only)	
Neighborhood HMO (all other counties)	

Plans & Networks by County

Statewide PPO Network

- Covers 96% of all doctors in Arizona
- Broad statewide local network with out-of-network coverage
- Only available for residents who live in Arizona
- Covers 98% of all hospitals including Dignity Health, Banner Health, HonorHealth, Tucson Medical, Northwest Medical, and more
- Includes BlueCard, our national provider network with coverage in every US ZIP code

MaricopaFocus HMO Network

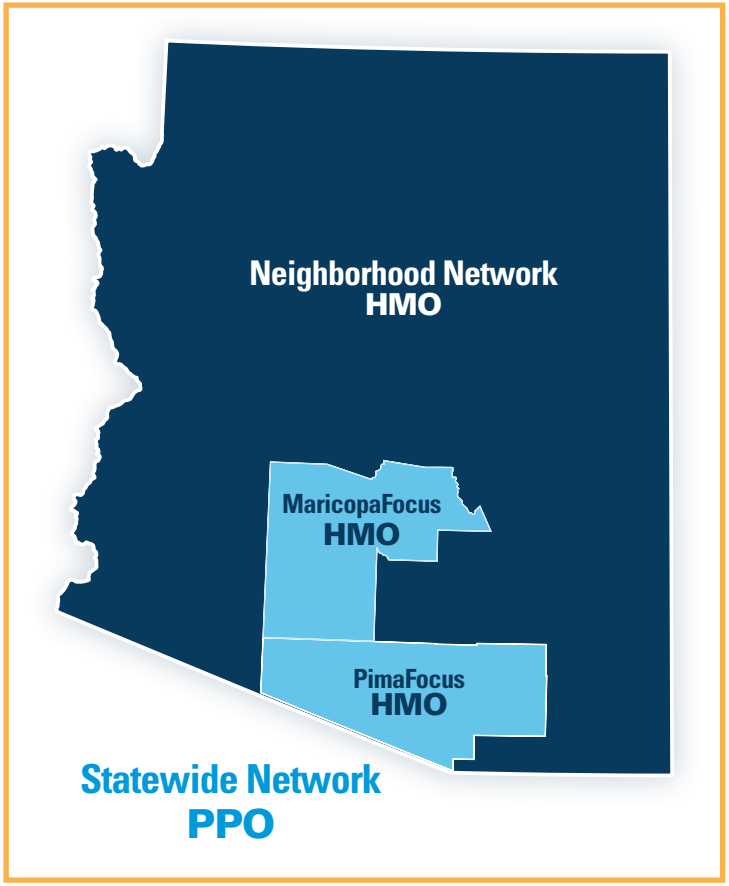
- Over 9,300 doctors, specialists, and hospitals in Maricopa County*
- Includes Abrazo Health, Dignity Health, and Phoenix Children's Hospital facilities and physicians
- Available to residents of Maricopa County

PimaFocus HMO Network

- Over 4,600 doctors, specialists, and hospitals in Pima County*
- Includes Tucson Medical Center and Carondelet Health Network facilities and physicians
- Available to residents of Pima County

Neighborhood HMO Network

- Over 27,000 doctors, specialists, and hospitals throughout the state and some in Maricopa County*
- Includes Dignity Health and Banner Health facilities and physicians
- Available to Arizona residents living outside of Maricopa County and Pima County



For HMO plans, only care from network providers are covered, except for emergencies and special situations preapproved by BCBSAZ.

*Source: BCBSAZ internal data 2022

Detailed Plan Information: 2023 Plan Options

	EverydayHealth HMO			TrueHealth HMO	AdvanceHealth HMO			Portfolio HSA HMO	PPO		Portfolio HSA PPO NEW
	GOLD	SILVER	BRONZE	SILVER	GOLD	SILVER	BRONZE	BRONZE	GOLD	SILVER	GOLD
Deductible	$2,000	$4,750	$7,500	$6,750	$4,375	$6,900	$8,700	$7,000	$1,250	$4,100	$1,500
Coinsurance (Plan/Member)	70%/30%	60%/40%	50%/50%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	80%/20%	80%/20%	100%/0%
Out-of-Pocket Maximum	$7,250	$8,700	$9,100	$8,700	$4,375	$6,900	$8,700	$7,000	$9,100	$9,100	$5,000
Specialist Referral Required	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Primary Care Provider (PCP) Visit	$0 for first 2 visits, then $15	$0 for first 2 visits, then $20	$0 for first 2 visits, then $40	Unlimited $0 visits	$0 for first 4 visits, then deductible	$0 for first 4 visits, then deductible	$0 for first 4 visits, then deductible	Deductible	$0 for first 2 visits, then $5	$0 for first 2 visits, then $15	30% after deductible
Specialist Visit	$50	$75	$150	$95	Deductible	Deductible	Deductible	Deductible	$25	$75	30% after deductible
Online Medical Doctor Visit*	$10	$10	$10	$10	$10	$10	$10	Deductible	$10	$10	30% after deductible
Online Counseling or Psychiatry Visit*	$10	$10	$10	Deductible	Deductible	Deductible	Deductible	Deductible	$10	$10	30% after deductible
Urgent Care Visit	$60	$60	$75	$100	Deductible	Deductible	Deductible	Deductible	$50	$75	30% after deductible
Emergency Room Visit	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Lab Tests & Imaging	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Inpatient Care	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Outpatient Facility – Non ASC**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Outpatient Facility – ASC**	Coinsurance (deductible waived)	Coinsurance (deductible waived)	Coinsurance (deductible waived)	50% coinsurance (deductible waived)	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Outpatient Care	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Drug Deductible (Tiers 2 and 3)	$400	$600	$800	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30% after deductible
Tier 1a (Generic Drugs)	$3	$3	$3	$3	$0	$0	$0	N/A	$3	$3	30% after deductible
Tier 1b (Generic Drugs)	$15	$15	$20	$10	$5	$5	$20	Deductible	$5	$15	30% after deductible
Tier 2 (Preferred Brand Drugs)	$70 after prescription drug deductible	$75 after prescription drug deductible	$200 after prescription drug deductible	$150	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Tier 3 (Non-Preferred Brand Drugs)	50% after prescription drug deductible	50% after prescription drug deductible	50% after prescription drug deductible	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible
Specialty Drugs	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	30% after deductible

*The BlueCare Anywhere service should not be used in health emergencies. If you have a health emergency or need immediate help for an illness, accident, or injury, seek emergency care or call 911.
**Ambulatory surgery center
Note: All plans are subject to limitations, exceptions, and cost-share requirements. See page 19 for specific benefit limitations and exclusions.

Detailed Plan Information: 2023 Standardized Plan Options

	Standardized HMO NEW			Standardized PPO NEW	
	GOLD	SILVER	BRONZE	GOLD	SILVER
Deductible	$2,000	$5,800	$7,500	$2,000	$5,800
Coinsurance (Plan/Member)	75%/25%	60%/40%	50%/50%	75%/25%	60%/40%
Out-of-Pocket Maximum	$8,700	$8,900	$9,000	$8,700	$8,900
Specialist Referral Required	Yes	Yes	Yes	No	No
Primary Care Provider (PCP) Visit	$30	$40	$50	$30	$40
Specialist Visit	$60	$80	$100	$60	$80
Online Medical Doctor Visit*	$30	$40	$50	$30	$40
Online Counseling or Psychiatry Visit*	$30	$40	$50	$30	$40
Urgent Care Visit	$45	$60	$75	$45	$60
Emergency Room Visit	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Lab Tests & Imaging	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Care	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Facility – Non ASC**	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Facility – ASC**	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Care	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Drug Deductible (Tiers 2 and 3)	N/A	N/A	N/A	N/A	N/A
Tier 1 (Generic Drugs)	$15	$20	$25	$15	$20
Tier 2 (Preferred Brand Drugs)	$30	$40	$50 after deductible	$30	$40
Tier 3 (Non-Preferred Brand Drugs)	$60	$80 after deductible	$100 after deductible	$60	$80 after deductible
Specialty Drugs	$250	$350 after deductible	$500 after deductible	$250	$350 after deductible

*The BlueCare Anywhere service should not be used in health emergencies. If you have a health emergency or need immediate help for an illness, accident, or injury, seek emergency care or call 911.
**Ambulatory surgery center
Note: All plans are subject to limitations, exceptions, and cost-share requirements. See page 19 for specific benefit limitations and exclusions.

Detailed Plan Information:

2023 Cost-Share Reduction (CSR) Plan Options

	SILVER 73AV PLAN 4	SILVER 87AV PLAN 5	SILVER 94AV PLAN 6
Eligibility Category	Plans available to members with household incomes between 200% and 250% of the federal poverty level.	Plans available to members with household incomes between 150% and 200% of the federal poverty level.	Plans available to members with household incomes between 100% and 150% of the federal poverty level.

	EverydayHealth HMO CSR			TrueHealth HMO CSR			AdvanceHealth HMO CSR			PPO CSR		
	SILVER 4	SILVER 5	SILVER 6	SILVER 4	SILVER 5	SILVER 6	SILVER 4	SILVER 5	SILVER 6	SILVER 4	SILVER 5	SILVER 6
Deductible	$4,500	$0	$0	$5,900	$1,900	$525	$5,350	$1,750	$525	$3,650	$1,150	$250
Coinsurance (Plan/Member)	60%/40%	60%/40%	80%/20%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	80%/20%	80%/20%	80%/20%
Out-of-Pocket Maximum	$7,250	$3,000	$1,025	$6,800	$2,200	$575	$5,350	$1,750	$525	$7,250	$2,500	$750
Specialist Referral Required?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Primary Care Provider (PCP) Visit	$0 for first 2 visits, then $20	$0 for first 2 visits, then $15	$0 for first 2 visits, then $5	Unlimited $0 visits	Unlimited $0 visits	Unlimited $0 visits	$0 for first 4 visits, then deductible	$0 for first 4 visits, then deductible	$0 for first 4 visits, then deductible	No charge for first 2 visits, then $15	No charge for first 2 visits, then $5	No charge for first 2 visits, then $5
Specialist Visit	$70	$40	$10	$65	$5	$2	Deductible	Deductible	Deductible	$75	$25	$10
Online Medical Doctor Visit*	$5	$5	$5	$0	$0	$0	$5	$5	$5	$10	$10	$10
Online Counseling or Psychiatry Visit*	$5	$5	$5	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	$10	$10	$10
Urgent Care Visit	$60	$40	$20	$75	$10	$10	Deductible	Deductible	Deductible	$75	$50	$25
Emergency Room Visit	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Lab Tests & Imaging	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Inpatient Care	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Facility – Non ASC**	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Facility – ASC**	Coinsurance (deductible waived)	Coinsurance	Coinsurance	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Care	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Drug Deductible (Tiers 2 and 3)	$600	$300	$50	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tier 1a (Generic Drugs)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3	$3	$3
Tier 1b (Generic Drugs)	$10	$6	$5	$5	$5	$5	$5	$5	$5	$15	$5	$5
Tier 2 (Preferred Brand Drugs)	$75 after prescription drug deductible	$75 after prescription drug deductible	$10 after prescription drug deductible	$150	$35	$15	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Tier 3 (Non-Preferred Brand Drugs)	50% after prescription drug deductible	50% after prescription drug deductible	50% after prescription drug deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible
Specialty Drugs	50% coinsurance (deductible waived)	50% coinsurance	50% coinsurance	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	Deductible	Deductible	Deductible	20% after deductible	20% after deductible	20% after deductible

*The BlueCare Anywhere service should not be used in health emergencies. If you have a health emergency or need immediate help for an illness, accident, or injury, seek emergency care or call 911.
**Ambulatory surgery center
Note: All plans are subject to limitations, exceptions, and cost-share requirements.

Detailed Plan Information:

2023 Standardized Cost-Share Reduction (CSR) Plan Options

Eligibility Category	SILVER 73AV PLAN 4	SILVER 87AV PLAN 5	SILVER 94AV PLAN 6
	Plans available to members with household incomes between 200% and 250% of the federal poverty level.	Plans available to members with household incomes between 150% and 200% of the federal poverty level.	Plans available to members with household incomes between 100% and 150% of the federal poverty level.

	Standardized HMO CSR NEW			Standardized PPO CSR NEW		
	SILVER 4	SILVER 5	SILVER 6	SILVER 4	SILVER 5	SILVER 6
Deductible	$5,700	$800	$0	$5,700	$800	$0
Coinsurance (Plan/Member)	60%/40%	70%/30%	75%/25%	60%/40%	70%/30%	75%/25%
Out-of-Pocket Maximum	$7,200	$3,000	$1,700	$7,200	$3,000	$1,700
Specialist Referral Required	Yes	Yes	Yes	No	No	No
Primary Care Provider (PCP) Visit	$30	$20	$0	$30	$20	$0
Specialist Visit	$60	$40	$10	$60	$40	$10
Online Medical Doctor Visit*	$30	$20	$0	$30	$20	$0
Online Counseling or Psychiatry Visit*	$30	$20	$0	$30	$20	$0
Urgent Care Visit	$45	$30	$5	$45	$30	$5
Emergency Room Visit	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Lab Tests & Imaging	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Care	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Facility – Non ASC**	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Facility – ASC**	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Care	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Drug Deductible (Tiers 2 and 3)	N/A	N/A	N/A	N/A	N/A	N/A
Tier 1a (Generic Drugs)	$20	$10	$0	$20	$10	$0
Tier 1b (Generic Drugs)	$20	$10	$0	$20	$10	$0
Tier 2 (Preferred Brand Drugs)	$40	$20	$15	$40	$20	$15
Tier 3 (Non-Preferred Brand Drugs)	$80 after deductible	$60 after deductible	$50	$80 after deductible	$60 after deductible	$50
Specialty Drugs	$350 after deductible	$250 after deductible	$150	$350 after deductible	$250 after deductible	$150

*The BlueCare Anywhere service should not be used in health emergencies. If you have a health emergency or need immediate help for an illness, accident, or injury, seek emergency care or call 911.
**Ambulatory surgery center
Note: All plans are subject to limitations, exceptions, and cost-share requirements.

Important Information

Allowed Amount
All claims are processed using the BCBSAZ *allowed amount*. BCBSAZ reimbursement, member cost-share payments, and accumulations toward deductibles and out-of-pocket limits are calculated using the BCBSAZ allowed amount. The allowed amount is the total amount of reimbursement allocated to a covered service, and includes both the BCBSAZ payment and the member cost-share payment. It does not include any balance bill. The allowed amount is based on BCBSAZ or other fee schedules. It is not tied to and does not necessarily reflect a provider's regular billed charges.

Balance Bill
This is the difference between the amount a doctor in your network charges for covered healthcare and the allowed amount.

Emergency Services
For emergency services, you will pay your network cost share, even if services are received from healthcare providers outside your network.

Medications and Prescriptions
BCBSAZ applies limitations to certain prescription medications obtained through the pharmacy benefit. A list of these medications and limitations is available online at **azblue.com** or by calling BCBSAZ. These limitations include, but are not limited to, quantity, age, gender, dosage, and frequency of refills. Prescription drugs are only covered if they are on the drug *formulary* (a list of drugs that BCBSAZ and/or the pharmacy benefit manager has designated as covered under the pharmacy benefit) unless a formulary exception is approved. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.

Precertification
Some services and medications require preapproval, also known as *precertification*. 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. Information on precertification requirements, including a list of medications that require precertification, and the process for obtaining precertification are available on the BCBSAZ website at **azblue.com.** For medication precertifications, call **1-844-807-5106.** For local medical service precertifications, call **602-864-4320.** For out of state medical service precertifications, call **1-800-232-2345.**

Primary Care Provider (HMO plans)
Your health plan provides a designated primary care provider (PCP) as your main doctor and central point of care. If your doctor isn't available, you can see another doctor at your PCP's practice or get a referral from your doctor to see another PCP at a different practice. If you see a doctor or go to a clinic or hospital that is not in your plan's network, you will be responsible for paying the full amount of your bill. You can change your PCP up to six times a year. To switch, sign in to MyBlue at **azblue.com/member,** and then click "Manage My PCP." Referrals and designated PCP only applies to HMO plans.

Providers, Claims, and Out-of-Pocket Costs
All healthcare professionals in your network, also known as network providers, are independent contractors exercising independent medical judgment, and are not employees, agents, or representatives of BCBSAZ. BCBSAZ has no control over any diagnosis, treatment, or service rendered by any provider. Network providers will file members' claims and generally cannot charge more than the allowed amount for covered services. Services from healthcare professionals outside your network are not covered on HMO plans except for emergencies and in limited circumstances when preapproved by BCBSAZ.

Qualified Health Plan
BCBSAZ is a qualified health plan issuer in the Health Insurance Marketplace. All BCBSAZ Individual and Family plans are qualified health plans available through the Health Insurance Marketplace.

Specialist Services (HMO plans)
A referral from your designated PCP is required for non-emergency and non-urgent specialist services. The requirement to obtain a referral from your designated PCP does not apply to services from providers who specialize in obstetrics or gynecology, chiropractic services, outpatient mental health services, pediatric dental and vision services, urgent care, and services provided by walk-in clinics.

If you do not obtain a referral from your designated PCP for services that require a referral, the services will not be covered under your benefit plan and you will be responsible for paying the provider's billed charges for those services.

IMPORTANT WARNING

THIS IS ONLY A BRIEF SUMMARY OF THE BENEFIT PLANS AND IS DESIGNED TO HELP YOU COMPARE FEATURES OF DIFFERENT PLANS. MORE DETAILED INFORMATION ABOUT BENEFITS, COST SHARE, EXCLUSIONS, AND LIMITATIONS IS IN THE BENEFIT PLAN BOOKLETS AND PLAN SUMMARY OF BENEFITS AND COVERAGE (SBCs). BENEFIT PLAN BOOKLETS AND SBCs ARE AVAILABLE UPON REQUEST AND ON AZBLUE.COM/2019INDBOOKS. IF THE TERMS OF THIS SUMMARY DIFFER FROM THE TERMS OF THE BENEFIT PLAN BOOKLETS, THE TERMS OF THE BOOKLETS CONTROL AND APPLY.

Exclusions and Limitations

Examples of services and supplies not covered

The following is a *partial* list of conditions and services that are excluded or limited. Expenses for services that exceed the benefit limits are not covered. Detailed information about benefits, exclusions, and limitations is in the benefit plan booklets and is available upon request.

- Abortions
- Acupuncture
- Adult routine vision
- Alternative medicine
- Care that is not medically necessary
- Chiropractic services exceeding 20 visits per calendar year. Only applies to HMO plans.
- Cosmetic surgery, services, and supplies
- Custodial care
- Dental care, except as stated in plan, and adult orthodontic services
- DME rental/repair charges that exceed DME allowed amount
- Experimental and investigational treatments
- Eyewear, except as stated in plan
- Fertility and infertility medication and treatment
- Flat feet treatment and services
- Genetic and chromosomal testing
- Habilitation outpatient services exceeding 60 visits per calendar year
- Home healthcare and infusion therapy exceeding 42 visits (of up to four hours each) per calendar year
- Inpatient EAR and SNF treatment exceeding 90 combined days per calendar year
- 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
- Pediatric dental checkups exceeding two checkups and cleanings per calendar year
- Pediatric glasses or contact lenses exceeding one pair of glasses or contact lenses per calendar year
- Pediatric routine vision exam exceeding one visit per calendar year
- Private-duty nursing except when medically necessary or when skilled nursing is not available
- Rehabilitation outpatient services exceeding 60 visits per calendar year
- Respite care
- Routine foot care
- Services from providers outside the network, except in emergencies and other limited situations when use is preapproved
- Sexual dysfunction treatment and services
- Weight-loss programs

Pediatric Dental

All BCBSAZ 2023 qualified health plans include dental coverage for children under age 19.
Pediatric dental benefits described below are covered with healthcare professionals in your network only.

Type I Covered Services – Diagnostic and Preventive	
Oral exams	Two per year* 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)**	
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/cleanings count toward this limit.
Prosthodontics – Bridges and Dentures	Five-year replacement limit
General Anesthesia	Limited coverage per BCBSAZ dental coverage guidelines***
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***
Type IV Covered Services – Orthodontia Cosmetic orthodontia not covered	
Orthodontics (dentally necessary)	Limited coverage per BCBSAZ dental coverage guidelines***

Dental benefits are available through dental providers participating in the BlueDental℠ network. A listing of providers in the BlueDental network can be found at **azblue.com.**

*All "per year" benefits mean per calendar year.

**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 LEAT. Benefits for restorative procedures will be limited only to the LEAT. 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 deductible or out-of-pocket maximum.

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

Pediatric Dental Exclusions and Limitations

Examples of services and supplies not covered

The following is a *partial* list of services that are excluded or limited. 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
- Behavior management of any kind
- Biopsies
- Bleaching of any kind
- Complications of noncovered services
- 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 charges
- 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
- Over-the-counter items
- 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 provided by a dentist outside your network, except for emergencies or special circumstances when use is preapproved
- Services resulting from your 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

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh íłínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish or 1-877-475-4799 for all other languages and other aids and services.

Notes

Ready to enroll?

When you've found your perfect plan, or want more information, go to azblue.com/plans, or call us at 1-855-329-2583.

We're available Monday through Friday, 8 a.m. to 5 p.m. Arizona time. You can also call your broker with any questions. During Open Enrollment (November 1 to January 15), we're available Monday through Friday, 8 a.m. to 6 p.m. Arizona time.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

FOLLOW US

D32350 10/22

1055508-22