Employer Health Insurance PRODUCT GUIDE

2017 PLANS FOR EMPLOYERS WITH 1-50 EMPLOYEES AND 51-99 EMPLOYEES

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

HEALTH INSURANCE PLANS FOR YOUR BUSINESS

Quality coverage for businesses of all sizes.

Offering health insurance is good for your employees – and your bottom line. Blue Cross Blue Shield of Arizona offers health insurance plans with a wide variety of price points and value-added services such as health and wellness programs. We also offer time-saving tools that help you work smarter, not harder, making plan management a breeze.

Choose from a wide range of plans to fit your needs.

Blue Cross Blue Shield of Arizona has many plan options so you can easily choose a plan to match your needs. Choose from a wide range of deductibles, including high deductible health plans that work with a health savings account (HSA).

Use our defined contribution program to meet the unique needs of each employee.

Our defined contribution program makes it easy to offer a wide variety of health plans to your employees. Under this program, you contribute a fixed amount to each employee's health benefits, regardless of which plan the employee chooses. Employees then choose the plan that best meets their needs and budget, while keeping in mind the contribution you have made. You choose which of the following PPO plans to offer your employees:

1-50 Employees

- EverydayHealth PPO 1000
- EverydayHealth PPO 2000
- EverydayHealth PPO 6000
- EverydayHealth Alliance PPO 1000
- EverydayHealth Alliance PPO 2000
- EverydayHealth Alliance PPO 6000
- Essential PPO 2000
- Essential PPO 6000
- Portfolio PPO 1500
- Portfolio PPO 2600
- Portfolio PPO 5500

51-99 Employees

- BlueAlliance PPO 5000
- BlueAlliance PPO 3000
- BluePreferred PPO HSA Plus 100 - 5000
- BluePreferred PPO HSA Plus 100 - 2600
- BluePreferred PPO 80 - 1500
- BluePreferred PPO 80 - 1000
- BluePreferred PPO 80 - 500
- BluePreferred PPO 100 - 5000
- BluePreferred PPO 100 - 2500
- BluePreferred PPO 100 - 1000

An Integrated HSA Solution.

Don't forget to ask about the advantages of pairing a Portfolio high deductible health plan with an integrated Health Savings Account (HSA) from HealthEquity[1]. The features of the integrated solution include:

- Eligibility data sharing for simplified account set up and management
- Combined billing from BCBSAZ for our monthly premiums and HealthEquity's HSA group administration fees
- Single sign-on link from the BCBSAZ member website to the HealthEquity portal
- Employees can use a secure HealthEquity website to directly pay providers for their member cost share
- Integrated HRA and FSA administration services also available from HealthEquity
- HealthEquity offers 24/7/365-days-a-year customer service for HSAs, HRAs, and FSAs

Eyewear and dental insurance, too.

Promote overall wellness by offering BluePreferred Eyewear and BluePreferred Dental plans. Our eyewear plan complements a medical plan's routine vision exam benefit—by offering benefits for glasses and contacts. Likewise, studies show that dental health can have a positive impact on an employee's overall health and wellness. Consider offering dental coverage as part of your overall compensation package to your employees. Combined, these benefit plans can be a key factor in a competitive compensation package to attract and retain employees. (Please note: BluePreferred Dental is available to organizations of all sizes and provides dental coverage for your employees and all of their dependents. It's separate from the pediatric dental benefits, for members under age 19, that are included in the plans described in this brochure for groups size 1-50.)

Enjoy quality health affordably.

Chances are good that your employees' current doctors are already part of our statewide network, which makes it easy to switch to a Blue Cross Blue Shield of Arizona health plan. Plans paired with our Alliance network offer an exclusive network alternative in Maricopa County, delivering significant savings on premiums. If you or your employees travel outside Arizona, all of our plans include access to in-network providers throughout the United States through the national BlueCard network.

Online tools for you and your employees.

You can manage your plan—enrolling members, checking and updating employee eligibility, making payments and more—conveniently online. Employees can go online to find doctors and hospitals, access health improvement programs, compare prices for common elective procedures, take advantage of special discounts for BCBSAZ members and more—even receive their Explanation of Benefits information electronically.

Choose the name you know and trust.

We've been serving Arizona businesses since 1939, and today we're the largest health insurance company based in Arizona. We've grown and thrived by providing reliable coverage and outstanding service at an affordable price. When you choose Blue, you're choosing a name you can rely on.

[1]HealthEquity is an independent and separate company contracted with BCBSAZ to administer health savings accounts for BCBSAZ members. HealthEquity does not provide BCBSAZ products or services and is solely responsible for any products and services that it offers.

PLAN DESCRIPTION
GROUP SIZE 1-50 EMPLOYEES

All Plans Feature:

Our plans are designed for Arizonans in every stage of life. Choose a plan that works best for you and your employees. Each plan gives you the option of selecting our large statewide network of doctors or the Alliance network in Maricopa County. All of the plans cover in-network preventive care services at no out-of-pocket cost to employees. All of the plans except Portfolio also cover pediatric in-network dental check-ups at no out-of-pocket cost to employees.

EverydayHealth Statewide PPO
EverydayHealth Alliance PPO

EverydayHealth offers copays for many of the healthcare services your employees use most when they use an in-network provider. This includes doctor visits, urgent care, prescriptions, routine vision exams, and more. Choose from twelve deductible options to match your budget.

Portfolio Statewide PPO
Portfolio Alliance PPO

Employees can take charge of their own healthcare dollars like they do with their budget. Portfolio plans are designed to work with a Health Savings Account (HSA) from a qualified financial institution. Each of the six deductible options includes coverage for in-network preventive services at no out-of-pocket cost. Select the deductible level that fits your budget.

Essential Statewide PPO
Essential Alliance PPO

Many of your employees' basic care needs are covered at a lower cost by having an Essential plan. This means they pay fixed copays for the first three in-network primary and specialist care office visits each year. They also have a set cost for in-network urgent care, routine vision exams, and many prescriptions. Choose one of six deductible options that fit your budget.

This guide shows employees' in-network cost share amount. It's what they pay for care from a provider who is part of the BCBSAZ network.

Their cost share will be higher if they get care from an out-of-network provider. Also, when they go out-of-network, they usually have to pay the difference between what the provider charges and the allowed amount (called "the balance bill"). For example: if an out-of-network hospital charges $1,500 for a service and the allowed amount is $1,000, they may have to pay the $500 difference, plus their out-of-network deductible and coinsurance.

All of our plans are available with our extensive BCBSAZ statewide provider network and are also available at a lower cost with our exclusive network, called "Alliance," which includes hospitals and doctors that are part of Banner Health and HonorHealth (Scottsdale Healthcare and John C. Lincoln Health Network). If you choose the Alliance network, most Arizona in-network doctors and hospitals are located in Maricopa County.

If you or your employees travel outside Arizona, all of our plans include access to in-network providers throughout the United States for covered services through BlueCard.

This is only a brief summary of the benefit plans, and is designed to help you compare features of different plans. All plans are subject to the limitations and exclusions listed on page 17 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
Group Size 1-50

Set costs for the most common health care needs such as doctor visits and prescriptions when employees use in-network providers.

	EverydayHealth 500	EverydayHealth+ 1000	EverydayHealth 1500	EverydayHealth+ 2000	EverydayHealth 2500
Calendar Year Deductible The amount employees pay for covered services before the plan begins to pay. After they meet the deductible, they pay coinsurance. Copays are separate from the deductible and do not count towards the deductible.	$500/member and $1,000/family	$1,000/member and $2,000/family	$1,500/member and $3,000/family	$2,000/member and $4,000/family	$2,500/member and $5,000/family
Metal Level	Platinum ($$$$)	Gold ($$$)	Gold ($$$)	Silver ($$)	Silver ($$)
Provider Networks Available	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a copay or different coinsurance applies.	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Out-of-Pocket Limit The most employees will pay in a calendar year for covered services. This does not include premiums, precertification charges, or balance-bills.	$2,000/member and $4,000/family	$5,500/member and $11,000/family	$4,000/member and $8,000/family	$7,000/member and $14,000/family	$7,000/member and $14,000/family
Primary Care Physician/Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other physicians are specialists.	$15 copay	$20 copay	$30 copay	$35 copay	$30 copay
Specialist A physician or other health care professional who practices in a specific area other than those practiced by primary care providers.	$30 copay	$45 copay	$60 copay	$70 copay	$60 copay
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	$60 copay	$60 copay	$60 copay	$70 copay	$70 copay
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The physician determines whether a service is considered preventive.	No charge	No charge	No charge	No charge	No charge
Prescription Formulary Drugs* Does not include specialty drugs, which are subject to higher cost share.	Tier 1: $5 copay Tier 2: $20 copay Tier 3: $40 copay	Tier 1: $15 copay Tier 2: $50 copay Tier 3: $100 copay	Tier 1: $15 copay Tier 2: $60 copay Tier 3: $120 copay	Tier 1: $25 copay Tier 2: $70 copay Tier 3: $140 copay	Tier 1: $25 copay Tier 2: $50 copay Tier 3: $120 copay
Surgery (Inpatient/Outpatient)	10% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency Room Visit	$150 copay	$300 copay	$300 copay	$500 copay	$500 copay

*Only formulary drugs are covered unless a formulary exception is approved. If you are on a plan with a copay drug benefit and pick a brand medication when a generic is available, you will pay the difference in cost plus your copay and any applicable deductible.

EverydayHealth 2500/100	EverydayHealth 3000	EverydayHealth 3500	EverydayHealth 4000	EverydayHealth 5000	EverydayHealth 5000/100	EverydayHealth+ 6000
$2,500/member and $5,000/family	$3,000/member and $6,000/family	$3,500/member and $7,000/family	$4,000/member and $8,000/family	$5,000/member and $10,000/family	$5,000/member and $10,000/family	$6,000/member and $12,000/family
Silver ($$)	Silver ($$)	Silver ($$)	Silver ($$)	Silver ($$)	Silver ($$)	Bronze ($)
Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance
No charge after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	10% after deductible
$7,000/member and $14,000/family	$6,000/member and $12,000/family	$6,000/member and $12,000/family	$6,500/member and $13,000/family	$6,500/member and $13,000/family	$6,500/member and $13,000/family	$7,000/member and $14,000/family
$40 copay	$40 copay	$35 copay	$30 copay	$30 copay	$30 copay	$40 copay
$80 copay	$80 copay	$70 copay	$60 copay	$50 copay	$50 copay	$85 copay
$80 copay	$80 copay	$70 copay	$60 copay	$60 copay	$60 copay	$85 copay
No charge	No charge	No charge	No charge	No charge	No charge	No charge
Tier 1: $30 copay Tier 2: $90 copay Tier 3: $160 copay	Tier 1: $25 copay Tier 2: $60 copay Tier 3: $130 copay	Tier 1: $25 copay Tier 2: $60 copay Tier 3: $130 copay	Tier 1: $15 copay Tier 2: $60 copay Tier 3: $130 copay	Tier 1: $15 copay Tier 2: $50 copay Tier 3: $110 copay	Tier 1: $15 copay Tier 2: $50 copay Tier 3: $110 copay	Tier 1: $40 copay Tier 2: $100 copay Tier 3: $200 copay
No charge after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	10% after deductible
$500 copay	$500 copay	$500 copay	$350 copay	$350 copay	$350 copay	$750 copay

EverydayHealth
Group Size 1-50

Set costs for the most common health care needs such as doctor visits and prescriptions when employees use in-network providers.

	EverydayHealth 500	EverydayHealth+ 1000	EverydayHealth 1500	EverydayHealth+ 2000	EverydayHealth 2500
Ambulance	10%	20%	20%	20%	20%
Maternity	$30 copay for all services included in the physician's global delivery charge, and 10% after deductible for all other services	$45 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$60 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$70 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$60 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services
Routine Vision 1 exam per year	$15 copay	$20 copay	$30 copay	$35 copay	$30 copay
Pediatric Dental 2 check-ups and cleanings per year. Services covered for members under age 19. Please see page 18 for more details.	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible

Cost share amounts are for covered services by in-network providers. Services by out-of-network providers are subject to higher cost share amounts. All plans are subject to the limitations and exclusions on page 17.

+ We also offer these three plans, paired with our statewide PPO, through the Small Business Health Options Program (SHOP), a federally sponsored health insurance marketplace. A Small Business Health Care Tax Credit is available to certain employers who purchase coverage through the SHOP. Blue Cross Blue Shield of Arizona is a Qualified Health Plan issuer in the Health Insurance Marketplace.

EverydayHealth 2500/100	EverydayHealth 3000	EverydayHealth 3500	EverydayHealth 4000	EverydayHealth 5000	EverydayHealth 5000/100	EverydayHealth+ 6000
No charge	20%	20%	20%	20%	No charge	10%
$80 copay for all services included in the physician's global delivery charge, and no charge after deductible for all other services	$80 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$70 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$60 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$50 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$50 copay for all services included in the physician's global delivery charge, and no charge after deductible for all other services	$85 copay for all services included in the physician's global delivery charge, and 10% after deductible for all other services
$40 copay	$40 copay	$35 copay	$30 copay	$30 copay	$30 copay	$40 copay
Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible

Choosing a Plan

EverydayHealth is our most popular health plan. EverydayHealth offers copays for most routine, in-network covered services. Surgeries and other major medical services are covered with a deductible and coinsurance. EverydayHealth may be the right plan for you and your employees if they:

- Want low-cost coverage for doctor visits and prescription drugs
- Need financial protection in case of an emergency or a major medical issue.
- Want comprehensive coverage, but don't want to pay too much each month.

Essential is designed for employees and their families who don't expect to frequently visit the doctor or take prescription medications, and who are looking for a lower monthly premium. Essential offers copays for the first three Primary Care Physician or Specialist office visits, and copays for prescription drugs after a deductible is met. Surgeries and other major medical services are covered with a deductible and coinsurance. Essential may be the right plan for you and your employees if they:

- Are likely to visit the doctor less than four times in a year
- Are likely to choose generic prescription drugs over brand name drugs
- Are willing to pay more if they do need medical services, in return for a lower monthly premium bill

Portfolio is a health plan designed to be paired with a Health Savings Account (HSA), which has certain tax advantages. For most medical services employees will need to meet their deductible before the health plan begins to pay for services. Portfolio may be the right plan for you and your employees if they:

- Want to pair a health plan with a Health Savings Account
- Don't expect frequent doctor visits or prescriptions, or
- Are expecting higher medical costs and want to use a Health Savings Account for its tax advantages

Note: Plans do not cover all health care expenses and have exclusions and limitations. See page 17.

Essential
Group Size 1-50

The first three in-network doctor office visits and most in-network generic prescription medications are covered with minimal cost.

	Essential 1500	Essential 2000	Essential 3000	Essential 4000	Essential 5000	Essential 6000
Calendar Year Deductible The amount employees pay for covered services before the plan begins to pay. After they meet the deductible, they pay coinsurance. Copays are separate from the deductible and do not count towards the deductible.	$1,500/member and $3,000/family	$2,000/member and $4,000/family	$3,000/member and $6,000/family	$4,000/member and $8,000/family	$5,000/member and $10,000/family	$6,000/member and $12,000/family
Metal Level	Gold ($$$)	Gold ($$$)	Silver ($$)	Silver ($$)	Silver ($$)	Bronze ($)
Provider Networks Available	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a copay or different coinsurance applies.	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	10% after deductible
Out-of-Pocket Limit The most employees will pay in a calendar year for covered services. This does not include premiums, precertification charges, or balance-bills.	$3,000/member and $6,000/family	$3,000/member and $6,000/family	$6,000/member and $12,000/family	$5,000/member and $10,000/family	$5,500/member and $11,000/family	$7,000/member and $14,000/family
Primary Care Physician/ Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other physicians are specialists.	$25 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$25 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$25 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$25 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$30 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$45 copay or 10% after deductible (limit of three copays with a PCP or specialist per calendar year)
Specialist A physician or other health care professional who practices in a specific area other than those practiced by primary care providers.	$50 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$50 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$50 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$50 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$70 copay or 20% after deductible (limit of three copays with a PCP or specialist per calendar year)	$90 copay or 10% after deductible (limit of three copays with a PCP or specialist per calendar year)
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	$60 copay	$75 copay	$75 copay	$75 copay	$75 copay	$90 copay
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The physician determines whether a service is considered preventive.	No charge	No charge	No charge	No charge	No charge	No charge

Cost share amounts are for covered services by in-network providers. Services by out-of-network providers are subject to higher cost share amounts.
All plans are subject to the limitations and exclusions on page 17.

	Essential 1500	Essential 2000	Essential 3000	Essential 4000	Essential 5000	Essential 6000
Prescription Formulary Drugs* The prescription drug deductible is the amount employees pay for covered tier 2 and tier 3 prescription drugs before a copay or coinsurance applies. Does not include specialty drugs, which are subject to higher cost share.	Deductible: $200 Tier 1: $10 copay Tier 2: $30 copay Tier 3: 40% coinsurance up to $300 but no less than $100	Deductible: $200 Tier 1: $10 copay Tier 2: $30 copay Tier 3: 40% coinsurance up to $180 but no less than $60	Deductible: $400 Tier 1: $10 copay Tier 2: $35 copay Tier 3: 40% coinsurance up to $300 but no less than $100	Deductible: $400 Tier 1: $10 copay Tier 2: $35 copay Tier 3: 40% coinsurance up to $300 but no less than $100	Deductible: $400 Tier 1: $10 copay Tier 2: $35 copay Tier 3: 40% coinsurance up to $300 but no less than $100	Deductible: $750 Tier 1: $40 copay Tier 2: $100 copay Tier 3: 40% coinsurance up to $600 but no less than $200
Surgery (Inpatient/ Outpatient)	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	10% after deductible
Emergency Room Visit	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	10% after deductible
Ambulance	20%	20%	20%	20%	20%	10%
Maternity**	$50 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$50 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$50 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$50 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$70 copay for all services included in the physician's global delivery charge, and 20% after deductible for all other services	$90 copay for all services included in the physician's global delivery charge, and 10% after deductible for all other services
Routine Vision 1 exam per year	$25 copay	$25 copay	$25 copay	$25 copay	$30 copay	$45 copay
Pediatric Dental 2 check-ups and cleanings per year. Services covered for members under age 19. Please see page 18 for more details.	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge Restorative & Orthodontia: 50% after deductible

Cost share amounts are for covered services by in-network providers. Services by out-of-network providers are subject to higher cost share amounts.

All plans are subject to the limitations and exclusions on page 17.

*Only formulary drugs are covered unless a formulary exception is approved. If you are on a plan with a copay drug benefit and pick a brand medication when a generic is available, you will pay the difference in cost plus your copay and any applicable deductible.

** Office visit copay is limited to three visits per member, per calendar year, PCP and specialist combined. For maternity services, after the limit is reached, deductible and coinsurance are waived for the global charge, and the member pays deductible and coinsurance for other maternity services.

Portfolio
Group Size 1-50

A low premium plan eligible for use with a Health Savings Account (HSA) from a qualified financial institution. This plan provides flexibility on how employees' healthcare dollars are spent while offering potential tax savings when paired with an HSA. Many in-network preventive services are covered at no out-of-pocket cost to employees.

	Portfolio 1500	Portfolio 2600	Portfolio 3250	Portfolio 4000	Portfolio 5500	Portfolio 6550
Calendar Year Deductible The amount employees pay for covered services before the plan begins to pay. After they meet the deductible, they pay coinsurance.	$1,500/member and $3,000/family	$2,600/member and $5,200/family	$3,250/member and $6,500/family	$4,000/member and $8,000/family	$5,500/member and $11,000/family	$6,550/member and $13,100/family
Metal Level	Gold ($$$)	Silver ($$)	Silver ($$)	Silver ($$)	Bronze ($)	Bronze ($)
Provider Networks Available	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance	Statewide PPO, Alliance
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a copay or different coinsurance applies.	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Out-of-Pocket Limit The most employees will pay in a calendar year for covered services. This does not include premiums, precertification charges, or balance-bills.	$3,000/member and $6,000/family	$4,250/member and $8,500/family	$5,500/member and $11,000/family	$4,500/member and $9,000/family	$6,550/member and $13,100/family	$6,550/member and $13,100/family
Primary Care Physician/ Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other physicians are specialists.	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Specialist A physician or other health care professional who practices in a specific area other than those practiced by primary care providers.	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible

Cost share amounts are for covered services by in-network providers. Services by out-of-network providers are subject to higher cost share amounts.
All plans are subject to the limitations and exclusions on page 17.

	Portfolio 1500	Portfolio 2600	Portfolio 3250	Portfolio 4000	Portfolio 5500	Portfolio 6550
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The physician determines whether a service is considered preventive.	No charge	No charge	No charge	No charge	No charge	No charge
Prescription Formulary Drugs Does not include specialty drugs, which are subject to different cost share.	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Surgery (Inpatient/ Outpatient)	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Emergency Room Visit	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Ambulance	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Maternity	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Routine Vision 1 exam per year	10% after deductible	20% after deductible	10% after deductible	10% after deductible	20% after deductible	No charge after deductible
Pediatric Dental 2 check-ups and cleanings per year. Services covered for members under age 19. Please see page 18 for more details.	Diagnostic & Preventive: No Charge after deductible Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge after deductible Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge after deductible Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge after deductible Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge after deductible Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No Charge after deductible Restorative & Orthodontia: No Charge after deductible

PLAN DESCRIPTION
GROUP SIZE 51-99 EMPLOYEES

Features of All Plans for 51-99 Employees:

If your business has grown beyond the size considered "small" by the Affordable Care Act and Arizona law, BCBSAZ offers a suite of benefit plans for organizations with 51-99 employees. Some plans give you the option of selecting our large statewide network of doctors or the Alliance network in Maricopa County. All of the plans cover in-network preventive care services at no out-of-pocket cost to employees.

BluePreferred PPO

- The convenience of copays on in-network office visits, urgent care and retail pharmacy
- A wide variety of deductible and coinsurance options
- Choose a higher deductible for savings on monthly premiums for both you and your employees
- Some plans can be paired with an exclusive PPO network for employees who receive their healthcare in Maricopa County

BlueSelect HMO Plus

- A health maintenance organization (HMO) plan that requires members to use network providers for most covered services
- Copays apply to many covered services
- PCP referrals are not required for visits to network specialists

BlueAlliance PPO

- An exclusive network PPO option for employees who receive their healthcare in Maricopa County
- One of our lowest priced plans for businesses with 51-99 employees
- Four deductible options: $1,500, $3,000, $5,000 and $6,000

BluePreferred HSA Plus

- A qualified high-deductible PPO plan that can be used with a health savings account (HSA)
- An option to encourage more employee responsibility in health care decisions
- When paired with an HSA, gives your employees a tax-advantaged method to manage payment for qualifying medical costs
- Some plans can be paired with an exclusive PPO network for employees who receive their healthcare in Maricopa County

This guide shows employees' in-network cost share amounts. It's what they pay for care from a provider who is part of the BCBSAZ network.

Members of the HMO plan: They generally receive out-of-network coverage only for emergencies and other limited circumstances.

Members of PPO plans: Their cost share and deductible will be higher if they get care from an out-of-network provider. Also, for PPO plans, when they go out-of-network, they usually have to pay the difference between what the provider charges and the allowed amount (the difference is called "the balance bill"). For example: if an out-of-network hospital charges $1,500 for a service and the allowed amount is $1,000, they may have to pay the $500 difference, plus their out-of-network deductible and coinsurance. For HMO plans, most services are not covered out-of-network.

Networks: Most of our plans are available with an extensive BCBSAZ statewide provider network. BlueAlliance is available, instead, with our exclusive network, called Alliance. Certain BluePreferred PPO plans and certain BluePreferred HSA Plus plans are available with either the statewide PPO or Alliance networks. The Alliance network includes contracted hospitals and doctors that are part of Banner Health and HonorHealth (Scottsdale Healthcare and John C. Lincoln Health Network). If you choose the Alliance network, most Arizona in-network doctors, facilities, and hospitals are located only in Maricopa County.

If you or your employees travel outside Arizona, all of our plans include access to in-network providers throughout the United States. For an HMO plan, members have limited benefit coverage outside the state and generally have out-of-network coverage only for emergencies and other limited circumstances.

This is only a brief summary of the benefit plans, and is designed to help you compare features of different plans. All plans are subject to the limitations and exclusions listed on page 17 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), and is available prior to enrollment, 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.

Group Size 51-99 Employees

	BlueAlliance PPO	BluePreferred HSA Plus 100/90/80/70	BluePreferred PPO 100/90/80
Calendar Year Deductible The amount employees pay for covered services before the plan begins to pay. After they meet the deductible, they pay coinsurance. In some cases, such as services to which a copay applies, the plan begins to pay before the deductible is satisfied. Copays are separate from the deductible and do not count towards the deductible.	**Alliance** Member: $1,500, $3,000, $5,000, or $6,000 Family: $3,000, $6,000, $10,000, or $12,000	**Alliance** Member: $3,000, $4,000, $5,000, or $6,000 Family: $6,000, $8,000, $10,000, or $12,000 **Statewide PPO** Member: $2,600, $3,000, $4,000, $5,000, $6,000, or $6,550 Family: $5,200, $6,000, $8,000, $10,000, $12,000, or $13,100	**Alliance** Member: $1,000, $3,000, $5,000, or $6,000 Family: $2,000, $6,000, $10,000, or $12,000 **Statewide PPO** Member: $250, $500, $1,000, $1,500, $2,000, $2,500, $3,000, $4,000, $5,000, or $6,000 Family: $500, $1,000, $2,000, $3,000, $4,000, $5,000, $6,000, $8,000, $10,000, or $12,000
Provider Networks Available	Alliance	Alliance, Statewide PPO	Alliance, Statewide PPO
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a copay or different coinsurance applies.	**Alliance** 30% after deductible	**Alliance** 10%, 20%, or 30% after deductible **Statewide PPO** 0%, 10%, 20%, or 30% after deductible	**Alliance** 20% after deductible **Statewide PPO** 0%, 10%, 20% after deductible
Out-of-Pocket Limit The most employees will pay in a calendar year for all covered services. This does not include premiums, precertification charges, or balance-bills.	Member: $6,350 Family: $12,700 6000 plan: Member: $7,150 Family: $14,300	Member: $5,000 - $6,550[1] Family: $10,000 - $13,100	Member: $1,250 - $7,150[1] Family: $2,500 - $14,300
Primary Care Physician/Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other physicians are specialists.	$20 copay	0%, 10%, 20%, or 30% after deductible	$25 copay
Specialist A physician or other health care professional who practices in a specific area other than those practiced by primary care providers.	$50 copay	0%, 10%, 20%, or 30% after deductible	$40 copay
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	$75 copay	0%, 10%, 20%, or 30% after deductible	$60 copay
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The physician determines whether a service is considered preventive.	No charge	No charge	No charge
Prescription Drugs Does not include specialty drugs, which are subject to higher cost share.	Tier 1: $15 copay Tier 2: $35 copay Tier 3: $65 copay Tier 4: $120 copay	0%, 10%, 20%, or 30% after deductible	Tier 1: $15 copay Tier 2: $35 copay Tier 3: $65 copay Tier 4: $120 copay
Surgery (Inpatient/Outpatient)	30% after deductible	0%, 10%, 20%, or 30% after deductible	0%, 10%, or 20% after deductible
Emergency Room Visit	$500 copay	0%, 10%, 20%, or 30% after deductible	$250 copay
Ambulance	30% after deductible	0%, 10%, 20%, or 30% after deductible	0%, 10%, or 20% after deductible
Maternity	$50 copay for all services included in the physician's global delivery charge, and 30% after deductible for all other services	0%, 10%, 20%, or 30% after deductible	$40 copay for all services included in the physician's global delivery charge, and 0%, 10% or 20% after deductible for all other services
Routine Vision 1 exam per year	$20 copay	0%, 10%, 20%, or 30% after deductible	$25 copay

[1] For specific out-of-pocket limit amount for each deductible option, please see chart on page 15.

Cost share amounts listed above refer to services provided by in-network providers. Services provided by out-of-network providers may not be covered, or may be subject to a higher cost share amount. For BlueSelect HMO Plus, network providers must be used for services to be covered (except for emergency services and other limited circumstances). All plans are subject to the limitations and exclusions on page 17.

Group Size 51-99 Employees

	BluePreferred PPO 70	BlueSelect HMO Plus
Calendar Year Deductible The amount employees pay for covered services before the plan begins to pay. After they meet the deductible, they pay coinsurance. In some cases, such as services to which a copay applies, the plan begins to pay before the deductible is satisfied. Copays are separate from the deductible and do not count towards the deductible.	**Alliance** Member: $1,000, $3,000, $5,000, or $6,000 Family: $2,000, $6,000, $10,000, or $12,000 **Statewide PPO** Member: $250, $500, $1,000, $1,500, $2,000, $2,500, $3,000, $4,000, $5,000, or $6,000 Family: $500, $1,000, $2,000, $3,000, $4,000, $5,000, $6,000, $8,000, $10,000, or $12,000	**Statewide HMO** $0/member and $0/family
Provider Networks Available	Alliance, Statewide PPO	Statewide HMO
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a copay or different coinsurance applies.	**Alliance** 30% after deductible **Statewide PPO** 30% after deductible	**Statewide HMO** None. (Except: No charge for certain therapy services up to a maximum number per calendar year. 50% coinsurance, for services over that maximum.)
Out-of-Pocket Limit The most employees will pay in a calendar year for all covered services. This does not include premiums, precertification charges, or balance-bills.	Member: $6,350 Family: $12,700 6000 plan: Member: $7,150 Family: $14,300	Member: $6,350 Family: $12,700
Primary Care Physician/Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other physicians are specialists.	$25 copay for first three office visits (PCP & specialist combined) then 30% after deductible	$25 copay
Specialist A physician or other health care professional who practices in a specific area other than those practiced by primary care providers.	$40 copay for first three office visits (PCP & specialist combined) then 30% after deductible[1]	$40 copay
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	$60 copay	$60 copay
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The physician determines whether a service is considered preventive.	No charge	No charge
Prescription Drugs Does not include specialty drugs, which are subject to higher cost share.	Tier 1: $15 copay Tier 2: $35 copay Tier 3: $65 copay Tier 4: $120 copay	Tier 1: $15 copay Tier 2: $35 copay Tier 3: $65 copay Tier 4: $120 copay
Surgery (Inpatient/Outpatient)	30% after deductible	Inpatient: $250 each day for the first 3 days then no charge Outpatient: $100 copay
Emergency Room Visit	$250 copay	$150 copay
Ambulance	30% after deductible	No charge
Maternity	$40 copay[1] for all services included in the physician's global delivery charge, and 30% after deductible for all other services	$40 copay for all services included in the physician's global delivery charge, and applicable copays for all other services
Routine Vision 1 exam per year	$25 copay	$25 copay

[1] Office visit copay is limited to three visits per member, per calendar year, PCP and specialist combined. For maternity services, after the limit is reached, deductible and coinsurance are waived for the global charge, and the member pays deductible and coinsurance for other maternity services.

Cost share amounts listed above refer to services provided by in-network providers. Services provided by out-of-network providers may not be covered, or may be subject to a higher cost share amount. For BlueSelect HMO Plus, network providers must be used for services to be covered (except for emergency services). See exclusions on page 17.

Group Size 51-99 Employees

In-Network Out-of-Pocket Limits for BluePreferred 100/90/80 and BluePreferred HSA Plus 100/90/80/70

In-Network Deductible Option	In-Network Out-of-Pocket Limit		
	BluePreferred 100	BluePreferred 90	BluePreferred 80
$250/member, $500/family	$1,250/member, $2,500/family	$3,250/member, $6,500/family	$4,250/member, $8,500/family
$500/member, $1,000/family	$1,500/member, $3,000/family	$3,500/member, $7,000/family	$4,500/member, $9,000/family
$1,000/member, $2,000/family	$2,000/member, $4,000/family	$4,000/member, $8,000/family	$5,000/member, $10,000/family
$1,500/member, $3,000/family	$2,500/member, $5,000/family	$4,500/member, $9,000/family	$5,500/member, $11,000/family
$2,000/member, $4,000/family	$3,000/member, $6,000/family	$5,000/member, $10,000/family	$6,000/member, $12,000/family
$2,500/member, $5,000/family	$3,500/member, $7,000/family	$6,350/member, $12,700/family	$6,350/member, $12,700/family
$3,000/member, $6,000/family	$4,000/member, $8,000/family	$6,350/member, $12,700/family	$6,350/member, $12,700/family
$4,000/member, $8,000/family	$5,000/member, $10,000/family	$6,350/member, $12,700/family	$6,350/member, $12,700/family
$5,000/member, $10,000/family	$6,000/member, $12,000/family	$6,350/member, $12,700/family	$6,350/member, $12,700/family
$6,000/member, $12,000/family	$7,150/member, $14,300/family	$7,150/member, $14,300/family	$7,150/member, $14,300/family

Please see other benefits for BluePreferred 100/90/80 on page 13.

In-Network Deductible Option	In-Network Out-of-Pocket Limit			
	BluePreferred HSA Plus 100	BluePreferred HSA Plus 90	BluePreferred HSA Plus 80	BluePreferred HSA Plus 70
$2,600/member, $5,200/family	$2,600/member, $5,200/family	$5,000/member, $10,000/family	$5,000/member, $10,000/family	$5,000/member, $10,000/family
$3,000/member, $6,000/family	$3,000/member, $6,000/family	$5,000/member, $10,000/family	$5,000/member, $10,000/family	$5,000/member, $10,000/family
$4,000/member, $8,000/family	$4,000/member, $8,000/family	$5,000/member, $10,000/family	$5,000/member, $10,000/family	$5,000/member, $10,000/family
$5,000/member, $10,000/family	$5,000/member, $10,000/family	$6,550/member, $13,100/family	$6,550/member, $13,100/family	$6,550/member, $13,100/family
$6,000/member, $12,000/family	$6,000/member, $12,000/family	$6,550/member, $13,100/family	$6,550/member, $13,100/family	$6,550/member, $13,100/family
$6,550/member, $13,100/family	$6,550/member, $13,100/family	n/a	n/a	n/a

Please see other benefits for BluePreferred HSA Plus 100/90/80/70 on page 13.

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 on 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 BCBSAZ allowed amount and a noncontracted provider's billed charge. Any time, except emergencies, when a PPO member sees a noncontracted provider, the member is responsible for the balance bill. Any amounts paid for balance bills do not count toward any deductible, coinsurance, or out-of-pocket limit.

Providers, Claims, and Out-of-pocket Costs

All 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. In-network providers will file members' claims and generally cannot charge more than the allowed amount for covered services.

PPO Plans

These plans allow members to go to in and out-of-network providers. Members have lower out-of-pocket costs for covered services when they use in-network providers. Noncontracted providers can charge members full billed charges, which will include the difference between the allowed amount and the provider's regular billed charges ("the balance bill"). Members are responsible for paying up to a noncontracted provider's billed charges for covered services, even though BCBSAZ will reimburse members' claims based on the allowed amount, less any deduction for the member's cost share portion. Any amounts paid for balance bills do not count toward any deductible, coinsurance, or out-of-pocket limit.

HMO Plan for Groups Size 51-99

Members of this plan generally receive out-of-network services only for emergencies and other limited circumstances.

Emergency Services

For emergency services, you will pay your in-network cost share, even if services received are from out-of-network providers.

Precertification

Some services and medications require 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 is available on the BCBSAZ website at azblue.com. You may also call BCBSAZ at (602) 864-4273 or (800) 232-2345, ext. 4273 for precertification of medications, or at (602) 864-4400 (Maricopa County), (520) 745-1881 (Pima County), or (800) 232-2345 (statewide) for precertification of all other medical services.

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 at refill limitations.

Plans for groups of 1-50 are also subject to:

- a restricted formulary.
- a Step Therapy Program that requires members to take the generic version of certain medications before BCBSAZ and/or the PBM will consider coverage of the brand-name version of that medication.
- a requirement, for plans that include a copay drug benefit, to pay the difference in cost between a brand and generic medication plus applicable copay and deductible.

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

Group Size Definitions

1-50: 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 is 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).

51-99: These plans are offered to employers considered large for purposes of the Affordable Care Act (ACA) -- the average number of total employees on business days during the previous calendar year is 51 or more.

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 prior to enrollment upon request.

- Acupuncture
- Cosmetic surgery and services
- Custodial care
- Dental services or the services of a dentist, except pediatric dental for groups size 1-50 and as stated in plan
- DME rental/repair charges that exceed DME purchase price
- Experimental or investigational services
- Eyewear, except as stated in plan
- Fertility and infertility services (except for diagnosis)
- Flat feet treatment and services
- Group size 51-99: Habilitation services, except certain autism services
- Genetic and chromosomal testing
- Home health services exceeding:
  - Group size 1-50: 42 visits (of up to four hours) per calendar year
  - Group size 51-99: six hours of care per member per day
- Homeopathic services
- Inpatient EAR & SNF treatment exceeding:
  - Group size 1-50: 90 days combined per member, per calendar year
  - Group size 51-99 (except HMO): 120 days EAR and 180 days SNF per member, per calendar year
  - Group size 51-99 (HMO only): 60 days EAR and 90 days SNF per member, per calendar year
- Long-term care, except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Medications supplied by out-of-network provider for 90-day retail supplies of drugs, mail order, and specialty drugs
- Naturopathic services
- Non-medically necessary services
- Personal comfort services and items
- Preventive services not required to be covered by state or federal law
- (Group size 51-99 only) Private-duty nursing. For group size 1-50, private duty nursing covered only as stated in the plan.
- (Group size 1-50 only) PT, OT, ST, and C&PR rehabilitation services exceeding 60 outpatient visits per calendar year
- (Group size 1-50 only) PT, OT, ST, and C&PR, and habilitation services exceeding 60 outpatient visits per calendar year.
- (Group size 1-50 only) Respite care. For group size 51-99, respite care covered only as stated in the plan.
- Routine foot care
- Routine vision exam exceeding one exam per calendar year
- Services and medications for sexual dysfunction
- Services, tests and procedures that are excluded under medical coverage guidelines
- Weight loss programs

Pediatric Dental
For Employers Size 1-50

Dental benefits for children under age 19 and covered by one of the plans described in this brochure for groups size 1-50.*

BCBSAZ 2017 health plans for groups of 1-50[1] include dental coverage for children under age 19.

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 planning limited to one per quadrant per two year period. Periodontal maintenance procedures limited to four per year; prophylaxis/cleanings count towards 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.

* Our 2017 plans for clients size 51-99 do not include pediatric dental benefits.

[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 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 the out-of-pocket maximum.
[4] BCBSAZ dental coverage guidelines are available upon request. Not all dentally necessary services are covered benefits.

PEDIATRIC DENTAL EXCLUSIONS AND LIMITATIONS

Examples of services 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 prosthodontics 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 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

NOTES

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 nílínigií Blue Cross Blue Shield of Arizona haada yit'éego bína'ídílkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídílkidgo beehaz'áanii hóló̜ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á̜ doo bá̜á̜h ílínígóó. Ata' halne'ígíí koji̜' bich'i̜' 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。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 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.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید 877-475-4799 تماس حاصل نمایید.

Assyrian:

ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܐܢܬܘܢ ܥܒܕܝܬܘܢ ܗܝܪܐ ܠܗ، ܐܝܬ ܠܗ ܫܘܐܠܐ ܒܘܬ Blue Cross Blue Shield of Arizona، ܐܢܬܘܢ ܐܝܬܠܟܘܢ ܙܕܩܐ ܠܫܩܠܬܐ ܕܗܝܪܬܐ ܘܡܥܠܘܡܘܬܐ ܒܠܫܢܐ ܕܝܘܟܘܢ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܡܬܪܓܡܢܐ، ܩܪܘ ܥܠ ܡܢܝܢܐ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 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 and 1 (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/ portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

To learn more about our other options for your business,
please visit azblue.com, call us at one of the phone numbers below,
or contact your broker.

PHOENIX
(602) 864-5792
(800) 232-2345, ext. 5792
(602) 864-5800 fax

TUCSON
(520) 745-1615
(800) 621-5563
(866) 772-2020 fax

FLAGSTAFF
(928) 526-4126
(800) 601-1946
(866) 550-3330 fax

BlueCross BlueShield of Arizona

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