An Independent Licensee of the Blue Cross Blue Shield Association

Choose the right plan for you and your family

A Healthier You Starts Here

For more than 80 years, Blue Cross® Blue Shield® of Arizona (BCBSAZ) has been committed to helping Arizonans get healthier faster, and stay healthier longer. Today, we offer health insurance and related products to over 1.7 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 BCBSAZ Affordable Care Act (ACA) plans offer you and your family

FREE primary care provider (PCP) visits—See your doctor with no copay or other out-of-pocket expenses.**

FREE or low-cost BlueCare Anywhere℠ online medical 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, see plan for costs.

FREE 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.

*Source: Blue Cross Blue Shield of Arizona. **Does not apply to Portfolio plans. Depending on your plan, there are two or more free PCP visits in a calendar year regardless of diagnosis. Visit must be with your designated PCP, and a visit for covered preventive care may count toward your limit, even though preventive care is always covered at no member cost share. ***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.

Health Is Personal—Your Healthcare Should Be, Too.

In these uncertain times, it's even more important to have a health plan from a strong company with a dedicated team to help you get the care you need—whenever you need it.

A Doctor Who Understands You. A Health Plan That Cares About You.

Your BCBSAZ health plan connects you with a designated doctor. Or, you can select your designated doctor, also known as a primary care provider, or PCP. All your healthcare needs start with your PCP, who is your main point of care and partner in your health. They get to know your current health, future goals, and guide you on the best steps to reach them. Plus, our Individual and Family plans include FREE PCP visits—no copay, deductible, or coinsurance.*

Your primary care provider helps in many ways:

- Looks out for your overall health by providing preventive care that includes 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

Having a designated doctor has proven to reduce unnecessary visits and lower prescription costs.**

ACA HEALTH PLANS COVER THESE 10 ESSENTIAL HEALTH BENEFITS:

1. Doctor visits
2. Prescription drugs
3. 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

*Free BlueCare Anywhere medical visits are included in the TrueHealth cost-share reduction plans.
**Source: BCBSAZ data 2016-2107

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 gives you what you need and fits your budget.

QUESTION #1:

What are my healthcare needs?

To figure out what benefits you need from a health plan, start with your overall health. Consider the following questions:

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.

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

QUESTION #2:

Do I qualify for financial help from the government?

If you find a plan you like but think you can't afford it, don't count it out right away. Find out if you can get financial help from the federal government in the form of a subsidy.

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 that make less than 250% federal poverty level (FPL).

American Indians and Alaska Natives with household incomes between 100% – 300% of the federal poverty level (FPL) can enroll in a "zero cost sharing" plan. That means there are no out-of-pocket costs; no deductibles, no copays, and no coinsurance.

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 now qualify for a subsidy
1	$17,609 to $19,140	$19,140 to $51,040	$51,041 and above
2	$23,971 to $25,860	$25,860 to $68,960	$68,961 and above
3	$29,974 to $32,580	$32,580 to $86,880	$86,881 and above
4	$36,156 to $39,330	$39,330 to $104,800	$104,801 and above
5	$42,338 to $46,020	$46,020 to $122,720	$122,721 and above
6	$48,521 to $52,740	$52,740 to $140,640	$140,641 and above

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.**

Source: U.S. Department of Health and Human Services Federal Poverty Level (FPL) Guidelines for 2020

QUESTION #3:

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: Blue **Everyday**Health **Silver**

Estimated monthly premium

$441.94

Your monthly payment to keep your plan active.

Deductible

$4,000

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

$8,550

Individual total

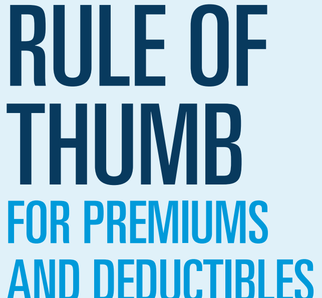
Once you reach this amount in a plan year, your plan will pay 100% of covered services.

Copayments/Coinsurance

Emergency room care: 40% coinsurance after deductible
Generic drugs: $10
Primary doctor: $0 for first 2 visits, then $15
Specialist doctor: $75

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 rate is for a 40-year-old who lives in Maricopa County.



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.

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 #4:

Are my doctors in the plan's network?

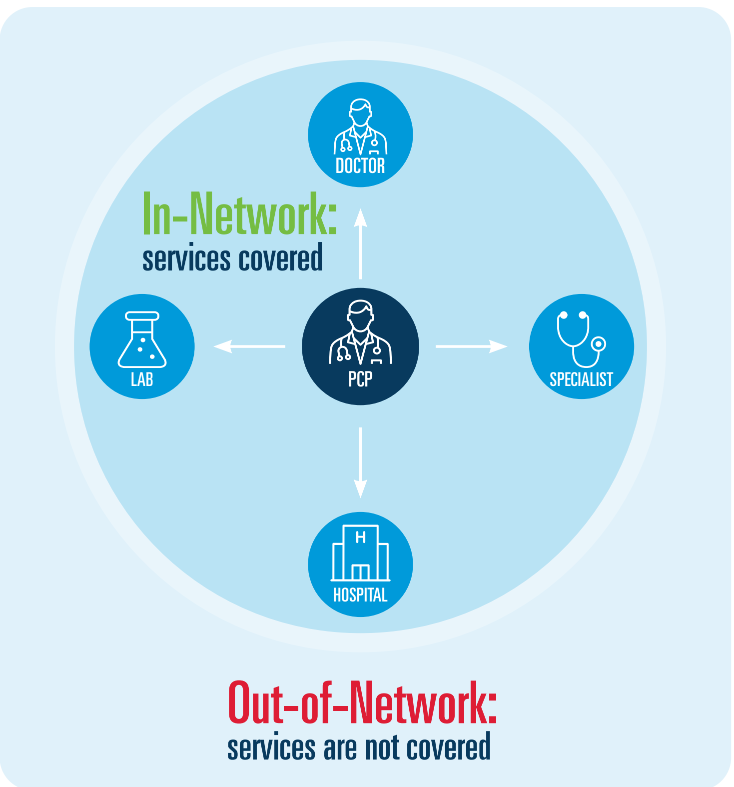
Before you pick a plan, you'll want to check to see if your doctors are included in the plan's network. A *plan network* is a set of doctors who agree to offer care to members of that plan. These doctors are what you call *in-network providers*.

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?

Your choice of networks is based on the county you live in: Maricopa County, Pima County, or all other Arizona counties. All our HMO plans cover services received from in-network providers. They won't cover services you receive from out-of-network providers, except in emergencies and rare situations that we have preapproved. So if you go to a doctor or hospital that is not in-network, you could end up paying the full cost of those services.

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.**



Plans & Networks by County

See which of our health plans and networks are available in your county.

Plan Name	Maricopa County	Pima County	All Other Arizona Counties
	MaricopaFocus Network	PimaFocus Network	Neighborhood Network
Blue EverydayHealth Gold	✓	✓	✓
Blue EverydayHealth Silver	✓	✓	✓
Blue EverydayHealth Bronze	✓	✓	✓
Blue TrueHealth Silver	✓	✓	✓
Blue AdvanceHealth Silver	✓	✓	NEW ✓
NEW Blue AdvanceHealth Bronze	✓	✓	✓
Blue Portfolio HSA 5000	NEW ✓	✓	✓
Blue SimpleHealth Catastrophic	✓	✓	✓

MaricopaFocus Network

- Over 7,000 doctors, specialists, and hospitals in Maricopa County*
- Includes Abrazo Health, Dignity Health, and Phoenix Children's Hospital facilities and providers
- Available to residents of Maricopa County

PimaFocus Network

- Over 2,400 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 Network

- Over 20,000 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

Only care from network providers associated with your health plan is covered, except for emergencies and special situations preapproved by BCBSAZ.

*Source: BCBSAZ internal data 2020

2021 Health Plans at a Glance

Here's a quick look at the plans we're offering for 2021. Plans are available in all counties.

All plans cover preventive services
(like wellness visits, vaccinations, and preventive medications)

PLAN DESCRIPTION	PLAN BENEFITS	
Blue EverydayHealth **Predictable Out-of-Pocket Costs for Every Budget** EverydayHealth might be right for you if you visit the doctor often and take only generic drugs. With several deductibles to choose from and predictable costs, EverydayHealth has a plan to fit every family.	**Deductibles as low as** $1,750 **2 free primary care provider visits*** **Doctor visits as low as** $10 **Prescription drugs as low as** $10	*For those who qualify for extra financial help from the federal government:* **Deductibles as low as** $0 **2 free primary care provider visits*** **Doctor visits as low as** $5 **Prescription drugs as low as** $5
Blue TrueHealth **For Those Who Need Specialist Care or Brand-Name Drugs** If you have an ongoing health condition, TrueHealth makes it easy to plan your healthcare costs. With $0 PCP visits and fixed copays for specialist doctors and certain brand-name drugs, TrueHealth takes the hassle out of being healthy.	**Deductible:** $6,000 **Unlimited free primary care provider visits*** **Doctor visits as low as** $0 **Prescription drugs as low as** $10	*For those who qualify for extra financial help from the federal government:* **Deductibles as low as** $550 **Unlimited free primary care provider visits*** **Doctor visits as low as** $0 **Prescription drugs as low as** $0
Blue AdvanceHealth **For Peace-of-Mind Coverage** AdvanceHealth is there for you when you need it. With low-cost generic drugs and online doctor visits, AdvanceHealth helps keep you healthy, even when the unexpected happens.	**Deductible:** $7,750 **4 free primary care provider visits*** **Doctor visits as low as** $10 **Prescription drugs as low as** $5	*For those who qualify for extra financial help from the federal government:* **Deductibles as low as** $700 **4 free primary care provider visits*** **Doctor visits as low as** $5 **Prescription drugs as low as** $0
Blue Portfolio **For the Health Planner** Portfolio can be paired with a health savings account (HSA) to help you plan for your healthcare costs. Whether you're getting ready for an upcoming surgery or saving for the future, an HSA allows you to pay for healthcare using pretax dollars. Portfolio gives you more control.	**Deductible:** $6,900 **Coinsurance:** Meet deductible, then pay nothing for all covered services **Health savings account eligible**	
Blue SimpleHealth **For the Young and Healthy** SimpleHealth is an affordable way to protect yourself, "just in case." If you're under 30, healthy, have a hardship exemption, or don't qualify for a subsidy SimpleHealth may be the right plan for you.	**Deductible:** $8,550 **Coinsurance:** Meet deductible, then pay nothing for all covered services. **3 free primary care provider visits***	

Note: All plans are subject to limitations, exceptions, and cost-share requirements. See page 13 for specific benefit limitations and exclusions.

*Depending on your plan, there are two or more free PCP visits in a calendar year regardless of diagnosis. Visit must be with your designated PCP, and a visit for covered preventive care may count toward your limit, even though preventive care is always covered at no member cost share.

Detailed Plan Information
2021 Plan Options

	EverydayHealth			TrueHealth	AdvanceHealth		Portfolio HSA	SimpleHealth
	GOLD	SILVER	BRONZE	SILVER	SILVER	BRONZE	BRONZE	CATASTROPHIC
Deductible	$1,750	$4,000	$7,000	$6,000	$7,750	$8,550	$6,900	$8,550
Coinsurance (Plan/Member)	70%/30%	60%/40%	50%/50%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%
Out-of-Pocket Maximum	$6,750	$8,550	$8,550	$8,550	$7,750	$8,550	$6,900	$8,550
Primary Care Provider (PCP) Visit	$0 for first 2 visits, then $15	$0 for first 2 visits, then $15	$0 for first 2 visits, then $40	Unlimited $0 visits	$0 for first 4 visits, then Deductible	$0 for first 4 visits, then Deductible	Deductible	$0 for first 3 visits, then Deductible
Specialist Visit	$50	$75	$150	$95	Deductible	Deductible	Deductible	Deductible
Online Medical Doctor Visit*	$10	$10	$10	$10	$10	$10	Deductible	Deductible
Online Counseling Visit*	$10	$10	$10	Deductible	Deductible	Deductible	Deductible	Deductible
Online Psychiatry Visit*	$10	$10	$10	Deductible	Deductible	Deductible	Deductible	Deductible
Urgent-Care Visit	$60	$60	$75	$100	Deductible	Deductible	Deductible	Deductible
Emergency Room Visit	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible
Lab Tests & Imaging	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible
Inpatient Care	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible
Outpatient Facility – Non ASC**	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible
Outpatient Facility – ASC**	Coinsurance (deductible waived)	Coinsurance (deductible waived)	Coinsurance (deductible waived)	50% Coinsurance (deductible waived)	Deductible	Deductible	Deductible	Deductible
Outpatient Care	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible/ Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible
Drug Deductible (Tiers 2 and 3)	$400	$600	$800	N/A	N/A	N/A	N/A	N/A
Tier 1 Drugs	$10	$10	$20	$10	$5	$20	Deductible	Deductible
Tier 2 Drugs	$60 after prescription drug deductible	$75 after prescription drug deductible	$200 after prescription drug deductible	$150	Deductible	Deductible	Deductible	Deductible
Tier 3 Drugs	50% after prescription drug deductible	50% after prescription drug deductible	50% after prescription drug deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Specialty Drug	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	Deductible	Deductible	Deductible	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 13 for specific benefit limitations and exclusions.

Detailed Plan Information

2021 Cost-Share Reduction (CSR) Plan Options

	SILVER 73AV PLAN 4	SILVER 87AV PLAN 5	SILVER 94AV PLAN 6
Eligibility Category	73% COST-SHARING REDUCED PLANS Plans available to members with household incomes between 200% and 250% of the federal poverty level.	87% COST-SHARING REDUCED PLANS Plans available to members with household incomes between 150% and 200% of the federal poverty level.	94% COST-SHARING REDUCED PLANS Plans available to members with household incomes between 138% and 150% of the federal poverty level.

	EverydayHealth CSR			TrueHealth CSR			AdvanceHealth CSR		
	SILVER 4	SILVER 5	SILVER 6	SILVER 4	SILVER 5	SILVER 6	SILVER 4	SILVER 5	SILVER 6
Deductible	$3,500	$0	$0	$4,850	$1,950	$550	$5,500	$2,000	$700
Coinsurance (Plan/Member)	60%/40%	60%/40%	80%/20%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%	100%/0%
Out-of-Pocket Maximum	$6,800	$2,850	$1,750	$6,800	$2,500	$600	$5,500	$2,000	$700
Primary Care Provider (PCP) Visit	$0 for first 2 visits, then $10	$0 for first 2 visits, then $10	$0 for first 2 visits, then $5	$0	$0	$0	$0 for first 4 visits then Deductible	$0 for first 4 visits then Deductible	$0 for first 4 visits then Deductible
Specialist Visit	$60	$30	$10	$65	$5	$2	Deductible	Deductible	Deductible
Online Medical Doctor Visit*	$5	$5	$5	$0	$0	$0	$5	$5	$5
Online Counseling Visit*	$5	$5	$5	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Online Psychiatry Visit*	$5	$5	$5	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Urgent-Care Visit	$60	$40	$20	$75	$10	$10	Deductible	Deductible	Deductible
Emergency Room Visit	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Lab Tests & Imaging	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Inpatient Care	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Outpatient Facility – Non ASC**	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Outpatient Facility – ASC**	Coinsurance (deductible waived)	Coinsurance	Coinsurance	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	Deductible	Deductible	Deductible
Outpatient Care	Coinsurance/ Deductible	Coinsurance	Coinsurance	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Drug Deductible (Tiers 2 and 3)	$400	$250	$50	N/A	N/A	N/A	N/A	N/A	N/A
Tier 1 Drugs	$10	$5	$5	$5	$0	$0	$0	$0	$0
Tier 2 Drugs	$75 after prescription drug deductible	$75 after prescription drug deductible	$10 after prescription drug deductible	$150	$35	$15	Deductible	Deductible	Deductible
Tier 3 Drugs	50% after prescription drug deductible	50% after prescription drug deductible	50% after prescription drug deductible	Deductible	Deductible	Deductible	Deductible	Deductible	Deductible
Specialty Drug	50% coinsurance (deductible waived)	50% coinsurance	50% coinsurance	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	50% coinsurance (deductible waived)	Deductible	Deductible	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.

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.

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.

Primary Care Provider
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."

Specialist Services
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.

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

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** or **1-800-232-2345** and then enter ext. **4723.** For medical service precertifications, statewide, call **1-800-232-2345.**

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.

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.

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
- 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 2021 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[1] 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)[2]	
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[3]
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[3]
Type IV Covered Services – Orthodontia Cosmetic orthodontia not covered	
Orthodontics (dentally necessary)	Limited coverage per BCBSAZ dental coverage guidelines[3]

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.**

[1] All "per year" benefits mean per calendar year.

[2] 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.

[3] 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 hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. 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。

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 ܡܢ ܦܠܚܘܬܐ ܕܗܝܪܬܐ ܕܝܠܟܘܢ، ܐܝܬ ܠܗ ܫܘܐܠܐ ܒܘܕ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܟܘܢ ܙܕܩܐ ܕܩܒܠܝܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܐ ܕܝܠܟܘܢ ܡܓܢܐܝܬ.
ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܝ ܠܡܢܝܢܐ 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: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona
คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม 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 or 1-877-475-4799 for all other languages and other aids and services.

Notes

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 4:30 p.m. Arizona time.
You can also call your broker with any questions.

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