



Arizona Technology Council (AZTC) Medical and Dental Plan Product Guide

2020 PLANS

EMPLOYERS WITH
2+ EMPLOYEES

WE'RE HERE TO HELP

If you are a current member of Arizona Technology Council (AZTC), let us help you determine if our association health plan (AHP) is right for you and your employees. If you are not a member, reach out to us to learn about the benefits of AZTC.



An Independent Licensee of the Blue Cross Blue Shield Association



INSURANCE QUESTIONS:

AZTC@dimarinc.com

1-800-488-8277

MEMBERSHIP:

membership@aztechcouncil.org

Phoenix: 602-343-8324

Tucson: 520-388-5761

About association health plans (AHPs)

When multiple small businesses join together as one association, they can take advantage of affordable health plans to help attract and retain top talent. Blue Cross® Blue Shield® of Arizona (BCBSAZ) has created unique plans that are available only to AZTC members.

These plans provide:

Access—Statewide network, including the Mayo Clinic, with exclusive network options in Maricopa and Pima counties

Service—Local customer service for care and claims support

Flexibility—Coverage available for businesses with as few as two employees

Network options for higher net savings

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

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

BlueCare AnywhereSM is integrated into the medical benefits as a telehealth visit copay. Employees can visit with a doctor, counselor, or psychiatrist any day, anytime, anywhere—from their smartphone, computer, or tablet.



This is only a brief summary of the benefit plans and is designed to help 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 (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.

Cost-share amounts are for covered services by providers in the plan's network. Services by out-of-network providers are subject to higher cost-share amounts. All plans are subject to the exclusions and limitations on page 11.

For certain covered preventive medications and items, the cost-share is waived for the generic version of the medication or item and the member pays applicable cost-share for the brand-name version of the medication or item.

PLAN OPTIONS

PPO and HSA Qualified PPO Plans

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

NETWORKS	PROVIDER AFFILIATIONS
Statewide (Statewide)	Affiliations statewide
Alliance (Maricopa County)	Banner Health and HonorHealth
PimaConnect (Pima County)	Tucson Medical Center and Northwest Healthcare

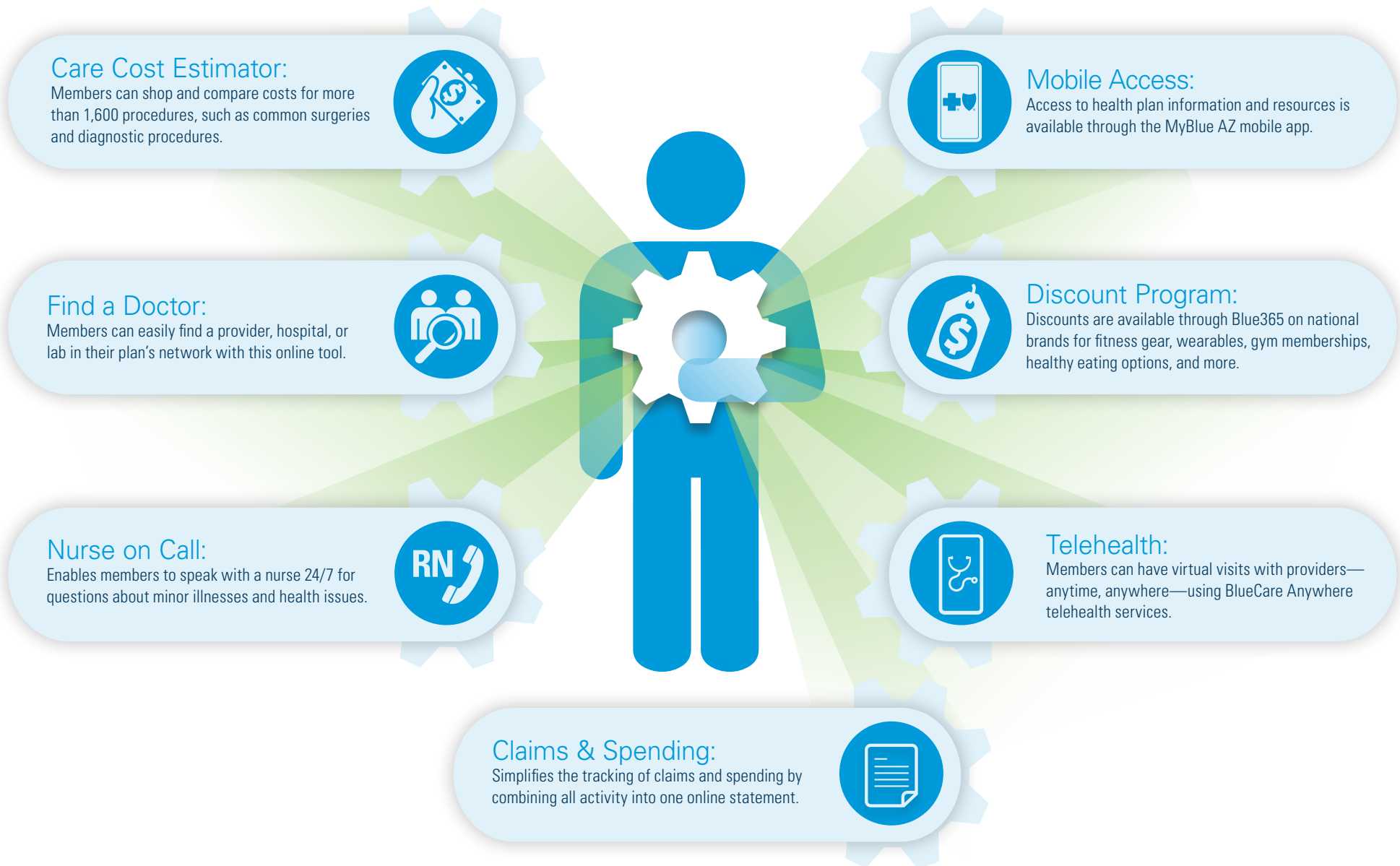
All plans offer coverage for most common healthcare needs, such as:

- Doctor visits
- Prescriptions
- Urgent care and ER visits
- Virtual visits with BlueCare Anywhere**
- Surgeries
- Preventive care at \$0 out-of-pocket cost from in-network providers

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

MEMBER ENGAGEMENT TOOLS AND RESOURCES

We have tools and resources available to help members make educated decisions about their healthcare choices.



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

Members can take advantage of the following programs:



HEALTH CONDITION MANAGEMENT

Members with a chronic health condition such as diabetes, congestive heart failure, asthma, COPD, coronary artery disease, or hypertension have access to programs and resources to help them get the support they need, when they need it. These programs take into consideration the risk level of the condition and provide assistance based on the level.



CASE MANAGEMENT

When a complex or catastrophic condition (e.g., a serious accident, cancer diagnosis, or high-risk pregnancy) impacts a member, a nurse case manager can help. The case manager will help coordinate their care among different providers, link them to community resources, and help them understand their benefits. Our case managers are registered nurses with an average of 16 years¹ clinical experience in specialty areas such as oncology, cardiology, neonatology, rehabilitation, etc.



HOSPITAL TO HOME

When members are transitioning home from a critical care hospital stay, we help ensure that they're getting the care, medications, and equipment they need to reduce potential hospital readmissions. We will assess the need for home healthcare services, if not already in place, and help them find providers in their network, if needed.

¹BCBSAZ internal data, 2018

THE CUSTOMER EXPERIENCE

The BCBSAZ customer service team is dedicated to providing members with solutions quickly and accurately.

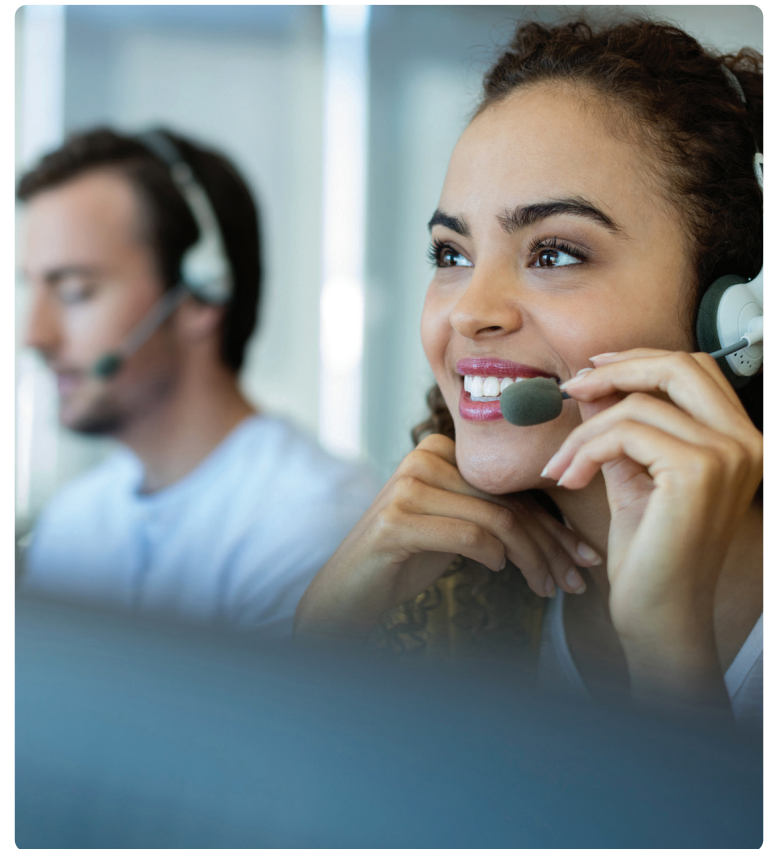
Our concierge customer care model delivers a one-and-done solution, which means customer service representatives handle benefit-related calls and inquiries about claims.

Claims and Customer Service

- Provides help navigating the healthcare system
- Experienced staff with an average tenure of 12 years¹
- Serves all members, regardless of resident state
- Call centers located in Tucson, Phoenix, Chandler, and Flagstaff

Mi Consejero AzulSM: My Blue Advisor

- Dedicated bilingual staff
- Experienced staff with an average tenure of 12 years¹
- Calls answered in less than one minute, on average



¹BCBSAZ internal data, 2018



	PPO 90 \$500	PPO 90 \$1,000	PPO 80 \$500	PPO 80 \$1,000	PPO 80 \$2,000
Overall Deductible	\$500/member \$1,000/family	\$1,000/member \$2,000/family	\$500/member \$1,000/family	\$1,000/member \$2,000/family	\$2,000/member \$4,000/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	10%	10%	20%	20%	20%
Out-of-Pocket Maximum	\$3,500/member \$7,000/family	\$4,000/member \$8,000/family	\$4,000/member \$8,000/family	\$4,500/member \$9,000/family	\$5,500/member \$11,000/family
Primary Care (PCP) Visit	\$20	\$20	\$25	\$25	\$25
Specialist Visit	\$40	\$40	\$50	\$50	\$50
Urgent Care	\$50	\$50	\$50	\$50	\$50
Emergency Room Visit	\$300	\$300	\$350	\$350	\$350
Emergency Transportation/ Ambulance	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Rx Tier 1 / 2 / 3 / 4	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130
Specialty Drug Level A / B / C / D	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210



	PPO 80 \$3,000	PPO 80 \$5,000	PPO 80 \$6,000	PPO 100 \$5,000	PPO 100 \$7,900
Overall Deductible	\$3,000/member \$6,000/family	\$5,000/member \$10,000/family	\$6,000/member \$12,000/family	\$5,000/member \$10,000/family	\$7,900/member \$15,800/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	20%	20%	20%	0%	0%
Out-of-Pocket Maximum	\$5,750/member \$11,500/family	\$6,250/member \$12,500/family	\$7,250/member \$14,500/family	\$5,000/member \$10,000/family	\$7,900/member \$15,800/family
Primary Care (PCP) Visit	\$30	\$30	\$30	\$30	\$30
Specialist Visit	\$60	\$60	\$60	\$60	\$60
Urgent Care	\$50	\$50	\$50	\$50	\$50
Emergency Room Visit	\$400	\$400	\$400	\$400	\$400
Emergency Transportation/ Ambulance	20% coinsurance	20% coinsurance	20% coinsurance	No charge after deductible	No charge after deductible
Rx Tier 1 / 2 / 3 / 4	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130	\$15/\$35/\$75/\$130
Specialty Drug Level A / B / C / D	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210	\$60/\$110/\$160/\$210



	HSA 80 \$1,500*	HSA 80 \$3,000	HSA 80 \$4,500	HSA 100 \$3,500	HSA 100 \$6,900
Overall Deductible	\$1,500/member \$3,000/family	\$3,000/member \$6,000/family	\$4,500/member \$9,000/family	\$3,500/member \$7,000/family	\$6,900/member \$13,800/family
Provider Networks Available	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect	Statewide, Alliance, PimaConnect
Coinsurance (Member)	20%	20%	20%	0%	0%
Out-of-Pocket Maximum	\$4,500/member \$9,000/family	\$5,000/member \$10,000/family	\$5,500/member \$11,000/family	\$3,500/member \$7,000/family	\$6,900/member \$13,800/family
Primary Care (PCP) Visit	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	No charge after deductible
Specialist Visit	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	No charge after deductible
Urgent Care	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	No charge after deductible
Emergency Room Visit	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	No charge after deductible
Emergency Transportation/ Ambulance	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	No charge after deductible
Rx Tier 1 / 2 / 3 / 4	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	No charge after deductible
Specialty Drug Level A / B / C / D	20% after deductible	20% after deductible	20% after deductible	No charge after deductible	No charge after deductible

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

MEDICAL EXCLUSIONS AND LIMITATIONS

Excluded Services & Other Covered Services:

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

- | | |
|---|---|
| <ul style="list-style-type: none">• Acupuncture• Care that is not medically necessary• Cosmetic surgery, cosmetic services, and supplies• Custodial care• Dental care, except as stated in plan• Durable medical equipment (DME) rental/repair charges that exceed DME purchase price• Experimental and investigational treatments, except as stated in plan• Eyewear, except as stated in plan• Flat feet treatment and services• Genetic and chromosomal testing, except as stated in plan• Habilitation services, except certain autism services• Hearing aids• Home healthcare and infusion therapy exceeding 6 hours of care per member per day• Homeopathic services | <ul style="list-style-type: none">• Infertility medication and treatment• Inpatient extended active rehabilitation facility (EAR) treatment exceeding 120 days per calendar year and inpatient skilled nursing facility (SNF) treatment exceeding 180 days per calendar year• Long-term care, except long-term acute care up to a 365-day benefit plan maximum• Massage therapy other than allowed under medical coverage guidelines• Naturopathic services• Out-of-network mail order, out-of-network specialty, and out-of-network 90-day retail supplies of drugs• Private-duty nursing• Respite care, except as stated in plan• Routine foot care• Routine vision exams• Sexual dysfunction treatment and services• Weight-loss programs |
|---|---|

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

- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

HELPFUL TERMS AND DEFINITIONS

Allowed Amount

This is the amount of reimbursement that doctors, hospitals, or other healthcare providers who are in the network have agreed to accept for a covered service. Example: A doctor may normally charge \$100 for a particular service. But he has an agreement with the plan to accept only \$80 as reimbursement for that service. \$80 is the “allowed amount.” The allowed amount includes any amount paid by the plan, plus any amount the member pays as a cost share, including copays and deductibles.

Balance Bill

This is the difference between the BCBSAZ allowed amount and a noncontracted provider’s billed charge. Anytime a member sees a non-contracted 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.

Group Size Definition

These plans are offered to employers who are members of AZTC and are 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.

Out-of-Pocket Costs

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

Emergency Services

For emergency services, members will pay their in-network cost share, even if services are received from out-of-network providers. In the event a provider’s billed charges exceed the allowed amount, balance billing will apply.

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.

Medications and Prescriptions

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

- A step therapy program that requires members to take preferred products, including but not limited to the generic version of certain medications, before BCBSAZ and/or the pharmacy benefit manager will consider coverage of the brand-name version of that medication
- A preferred generics program. This means that when a member or provider selects a brand product when a generic product is available, the member will be responsible for their copay and any applicable deductible plus the cost difference between the brand and generic product. Exceptions are made only when the member is approved for the brand-name medication through the step therapy program or if BCBSAZ prefers the brand product over the generic product. No additional exceptions to this cost-sharing amount will be made.

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

	BlueDental SM Value Series			BlueDental Optimum Series	
	BlueDental PPO Plans		BlueDental DHMO Plans	BlueDental PPO Plans	
	PPO 50-1000 A V	PPO 50-1500 A V	DHMO High	PPO 50-1500 A2 O	PPO 25-2000 A2 O with 1500 Adult and Child Ortho
Funding Arrangement	Employer paid	Employer paid	Employer paid	Employer paid	Employer paid
Plan Type	PPO	PPO	DHMO	PPO	PPO
Annual Maximum Benefit (In-Network/Out-of-Network)	\$1,000	\$1,500	Unlimited	\$1,500	\$2,000
Deductible (Single/Family)	\$50/\$150	\$50/\$150	None	\$50/\$150	\$25/\$75
In-Network (Preventive/Basic/Major)	100/80/50	100/80/50	Copay schedule	100/80/50	100/90/60
Out-of-Network (Preventive/Basic/Major)	80/60/40	80/60/40	None (emergency only)	80/60/40	80/70/40
Out-of-Network Reimbursement	Maximum allowable charge	Maximum allowable charge	None	Maximum allowable charge	Maximum allowable charge

In-network services available through 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 least expensive available treatment (LEAT). Benefits for restorative procedures will be limited to the LEAT only. For these procedures, BCBSAZ will pay benefits only up to the LEAT fee. Members may elect to receive a service that is more costly than the LEAT, but the member will be responsible for cost-share based on the LEAT, and will also pay the difference between the fee for the LEAT and the more costly treatment (LEAT balance bill). Any payment made for this LEAT balance bill will not count toward the deductible or out-of-pocket maximum.

³ Detailed information about benefits, exclusions, and limitations is in the Dental Benefit Book or rider and is available prior to enrollment upon request.

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TO LEARN MORE
VISIT
[AZTEHCOUNCIL.ORG/AHP](https://aztechcouncil.org/AHP)



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