



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit

<https://ambetter.AZcompletehealth.com/2019-brochures.html>, or call 1-888-926-5057 (TTY/TDD 1-888-926-5180). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-888-926-5057 (TTY/TDD 1-888-926-5180) to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$1,400 individual/\$2,800 family.  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care services</a> , primary care, <a href="#">specialist</a> , and <a href="#">urgent care</a> office visits, generic and preferred brand drugs are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | For <a href="#">network providers</a> : \$5,750 individual/\$11,500 family. No, for <a href="#">non-network providers</a> .   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.  | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="#">Find a Provider</a> or call 1-888-926-5057 for a list of <a href="#">network providers</a> .   | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .  |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event   | Services You May Need  | What You Will Pay  |   | Limitation, Exceptions, & Other Important Information   |
|--|--|--|---|---|
|  |  | Network Provider (You will pay the least)                                    | Out-of-Network Provider (You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness                           | \$10 <a href="#">Copay</a> /visit; <a href="#">deductible</a> does not apply | Not covered                                     | ----None----  |
|  | <a href="#">Specialist</a> visit   | \$30 <a href="#">Copay</a> /visit; <a href="#">deductible</a> does not apply | Not covered                                     | ----None----  |
|  | <a href="#">Preventive care</a> / <a href="#">screening</a> / immunization | No charge  | Not covered                                     | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.           |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)                        | \$60 <a href="#">Copay</a> / test  | Not covered                                     | Prior authorization may be required. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details. |
|  | Imaging (CT/PET scans, MRIs)   | \$250 <a href="#">Copay</a> /test  | Not covered                                     | Prior authorization may be required.  |

| Common Medical Event   | Services You May Need                          | What You Will Pay   |   | Limitation, Exceptions, & Other Important Information   |
|--|--|---|---|---|
|  |  | Network Provider (You will pay the least)   | Out-of-Network Provider (You will pay the most) |   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">Preferred Drug List</a> . | Generic drugs (Tier 1)                         | Retail: \$15<br><u>Copay/prescription</u> ;<br>Mail order: \$45<br><u>Copay/prescription</u> ;<br><u>deductible</u> does not apply  | Not covered                                     | <u>Prescription drugs</u> are provided up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount.  |
|  | Preferred brand drugs (Tier 2)                 | Retail: \$50<br><u>Copay/prescription</u> ;<br>Mail order: \$150<br><u>Copay/prescription</u> ;<br><u>deductible</u> does not apply | Not covered                                     | Prior authorization may be required. <u>Prescription drugs</u> are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount. |
|  | Non-preferred brand drugs (Tier 3)             | Retail: \$70<br><u>Copay/prescription</u> ;<br>Mail order: \$210<br><u>Copay/prescription</u> .                                     | Not covered                                     | Prior authorization may be required. <u>Prescription drugs</u> are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount. |
|  | <a href="#">Specialty drugs</a> (Tier 4)       | 50% <u>Coinsurance</u>  | Not covered                                     | Prior authorization may be required. <u>Prescription drugs</u> are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3x retail <u>cost-sharing</u> amount. |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 10% <u>Coinsurance</u>  | Not covered                                     | Prior authorization may be required.  |
|  | Physician/surgeon fees                         | 10% <u>Coinsurance</u>  | Not covered                                     | Prior authorization may be required.  |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitation, Exceptions, & Other Important Information   |
|---|--|---|---|---|
|   |  | Network Provider (You will pay the least)   | Out-of-Network Provider (You will pay the most) |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$150 <u>Copay</u> /visit   | \$150 <u>Copay</u> /visit                       | -----None-----  |
|   | <a href="#">Emergency Medical transportation</a> | 10% <u>Coinsurance</u>  | 10% <u>Coinsurance</u>                          | -----None-----  |
|   | <a href="#">Urgent Care</a>                      | \$50 <u>Copay</u> /visit; <u>deductible</u> does not apply  | Not covered                                     | -----None-----  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | \$375 <u>Copay</u> per day for up to 3 days per stay  | Not covered                                     | Prior authorization may be required.  |
|   | Physician/surgeon fees                           | No charge after <u>deductible</u>   | Not covered                                     | Prior authorization may be required.  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$10 <u>Copay</u> /office visit; <u>deductible</u> does not apply; No charge for all other services | Not covered                                     | Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization) |
|   | Inpatient services                               | \$375 <u>Copay</u> ; per day for up to 3 days per stay  | Not covered                                     | Prior authorization may be required.  |

| Common Medical Event | Services You May Need                     | What You Will Pay  |   | Limitation, Exceptions, & Other Important Information  |
|----------------------|---|--|---|--|
|                      |   | Network Provider (You will pay the least)                  | Out-of-Network Provider (You will pay the most) |  |
| If you are pregnant  | Office visits                             | \$10 <u>Copay</u> /visit; <u>deductible</u> does not apply | Not covered                                     | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>deductible</u> or <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                      | Childbirth/delivery professional services | No charge after <u>deductible</u>                          | Not covered                                     | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>deductible</u> or <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                      | Childbirth/delivery facility services     | \$375 <u>Copay</u> per day for up to 3 days per stay       | Not covered                                     | Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>deductible</u> or <u>copayment</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |

| Common Medical Event   | Services You May Need                     | What You Will Pay                                    |   | Limitation, Exceptions, & Other Important Information              |
|--|---|--|---|--|
|  |   | Network Provider (You will pay the least)            | Out-of-Network Provider (You will pay the most) |  |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 10% <u>Coinsurance</u>                               | Not covered                                     | Prior authorization may be required. 42 Visits per year.           |
|  | <a href="#">Rehabilitation services</a>   | \$60 <u>Copay</u> /visit                             | Not covered                                     | 60 Visits combined per year for PT, OT, ST, cardiac and pulmonary. |
|  | <a href="#">Habilitation services</a>     | \$60 <u>Copay</u> /visit                             | Not covered                                     | 60 Visits per year.  |
|  | <a href="#">Skilled nursing care</a>      | \$375 <u>Copay</u> per day for up to 3 days per stay | Not covered                                     | Prior authorization may be required. 90 Days per year.             |
|  | <a href="#">Durable medical equipment</a> | 10% <u>Coinsurance</u>                               | Not covered                                     | Prior authorization may be required.                               |
|  | <a href="#">Hospice services</a>          | \$375 <u>Copay</u> per day for up to 3 days per stay | Not covered                                     | Prior authorization may be required.                               |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge  | Not covered                                     | 1 Visit per year.  |
|  | Children's glasses                        | No charge  | Not covered                                     | 1 Item per year.   |
|  | Children's dental check-up                | Not covered  | Not covered                                     | -----None-----   |

### Excluded Services & Other Covered Services

|  |   |  |
|--|---|--|
| Services your <a href="#">Plan</a> Generally Does NOT cover (Check your policy or <a href="#">plan</a> documentation for more information and a list of any other <a href="#">excluded services</a> .) |   |  |
| <ul style="list-style-type: none"> <li>Abortion Services (except in cases of rape, incest or when the life of the mother is endangered)</li> <li>Acupuncture</li> </ul>                                | <ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Dental care</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Routine eye care (Adult)</li> <li>Weight loss programs</li> </ul> |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care (Limited to 20 specialist visits per year)</li><li>• Hearing aids (Limited to 1 per ear per year)</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment (diagnosis only)</li><li>• Private-duty nursing (Covered when medically necessary)</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care (Covered only in connection with the treatment of diabetes)</li></ul> |
|---|--|---|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Ambetter from Arizona Complete Health at 1-888-926-5057 (TTY/TDD 1-888-926-5180); Arizona Department of Insurance, 2910 N. 44th Street, Ste. 210 (2nd Floor) Phoenix, AZ 85018-7269, Phone No. (602) 364-2499 or (800) 325-2548. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), [visit www.HealthCare.gov](#) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Arizona Department of Insurance, 2910 N. 44th Street, Ste. 210 (2nd Floor) Phoenix, AZ 85018-7269, Phone No. (602) 364-2499 or (800) 325-2548.

#### **Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### **Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

#### **Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-926-5057 (TTY/TDD 1-888-926-5180).

—————To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.—————

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage

**Peg is Having a baby**  
(9 months of in-network prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$375
- Other [coinsurance](#) 10%

**This EXAMPLE even includes services like:**  
Specialist office visits (prenatal care)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery facility Services  
Diagnostic test (ultrasounds and blood work)  
Specialist visit (anesthesia)

**Total Example Cost** **\$12,800**

**In this example, Peg would pay:**

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,400        |
| Copayments                        | \$700          |
| Coinsurance                       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$2,160</b> |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$375
- Other [coinsurance](#) 10%

**This EXAMPLE even includes services like:**  
Primary care physician office visits (includes disease education)  
Diagnostic tests (blood work)  
Prescription Drugs  
Durable medical equipment (glucose meter)

**Total Example Cost** **\$7,400**

**In this example, Joe would pay:**

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,400        |
| Copayments                        | \$1,300        |
| Coinsurance                       | \$200          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$2,960</b> |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$375
- Other [coinsurance](#) 10%

**This EXAMPLE even includes services like:**  
Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (Physical therapy)

**Total Example Cost** **\$1,900**

**In this example, Mia would pay:**

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,300        |
| Copayments                        | \$400          |
| Coinsurance                       | \$100          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,800</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



### Statement of Non-Discrimination

Ambetter from Arizona Complete Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Arizona Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Arizona Complete Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ambetter from Arizona Complete Health at 1-888-926-5057 (TTY/TDD 1-888-926-5180).

If you believe that Ambetter from Arizona Complete Health 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: Ambetter from Arizona Complete Health Appeals Unit, 1230 W. Washington St., Suite 401, Tempe, AZ 85281, 1-888-926-5057 (TTY/TDD 1-888-926-5180), Fax 1-877-615-7734. You can file a grievance by mail, fax, or email. If you need help filing a grievance, Ambetter from Arizona Complete Health 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, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Diné t'áá át'é doo a'ohgo baa nitsihákees da

Ambetter from Arizona Complete Health wolyéhígíí Wáashindoondéé' bibee haz'áanii yik'eh hósingo al'aa dadine'é doo nahjì' hwííł'íígóó yá'át'éehgo aheelt'éego yaa nitsikees azhá al'aa dadine'é daniljì nidi bitsì' al'aa ádaat'ée nidi dóó al'aa danízhdeé' nidaakai nidi dóó al'aa ádaat'éego béédahai nidi dóó bits'íís bich'ì' nidahwii'náá dóó bich'ì' anídahazt'ì' nidi dóó bi'áadi/biká'ii daniljì nidi t'áá át'é aheelt'éego yaa nitsikees. Ambetter from Arizona Complete Health doo al'aa dadine'é nahjì' hwííł'íí da dóó doo nichxó'ígo yaa nitsikees da azhá al'aa dadine'é daniljì nidi bitsì' al'aa ádaat'ée nidi dóó al'aa danízhdeé' nidaakai nidi dóó al'aa ádaat'éego béédahai nidi dóó bits'íís bich'ì' nidahwii'náá dóó bich'ì' anídahazt'ì' nidi dóó bi'áadi/biká'ii daniljì nidi.

Ambetter from Arizona Complete Health:

- Diné bits'íís bich'ì' nidahwii'náá dóó bich'ì' anídahazt'ì'ígíí t'áá jíík'e yíká anídaajah hazhó'ó t'áadoo le'é yee nihił nidaalne' dooleel biniiyé dííge'ádaat'éhígíí yee áká anídaajah:
  - Ála' bee yáti'jì yá'át'éehgo ata' dahalne'ígíí.
  - Saad naadzo al'aa ádaat'éego bee ak'ida'ashchínígíí (ayóó aníłtsogo bee ak'e'eshchínígíí dóó wólts'á'ígíí dóó t'áadoo le'é al'aa ádaat'éego béesh lichí'ii yee nidaalnishígíí dóó nááná la' t'áá haada yit'éego naaltsoos dabiká'ígíí)
- Al'aa dadine'é Bilagáana k'ehjì doo yee yádaałt'ígíí t'áá jíík'e yíká anídaajah díí ge'ádaat'éhígíí yee áká anídaajah:
  - Yá'át'éehgo ata' dahalne'ígíí.
  - Al'aa dadine'é dabizaad k'ehjì t'áadoo le'é bá bee ak'ida'alchíigo.

Dííge'át'éego shíká a'doowoł nínizingo Ambetter from Arizona Complete Health wolyéhígíí bich'ì' hólne' koji' 1-888-926-5057 (TTY/TDD 1-888-926-5180).

Haada yit'éego díí Ambetter from Arizona Complete Health wolyéhígíí doo níká eelwodgóó dóó doo yá'át'ééhgóó naatsídeezkээzgo díí kwe'é al'kéé' dayídzooígíí biniinaa al'aa dadine'é ádaat'ée dóó bitsì' al'aa ádaat'ée dóó al'aa danízhdeé' nidaakai dóó al'aa ádaat'éego béédahai dóó bits'íís bich'ì' nidahwii'náá dóó bich'ì' anídahazt'ì'ii dóó bi'áadi/biká'ii daniljigo da biniinaa a'oh naa tsídeezkээzgo naaltsoos nídiłtsos koji' 1230 W. Washington St., Suite 401, Tempe, AZ 85281, 1-888-926-5057 (TTY/TDD 1-888-926-5180). dóó bi-Fax 1-877-615-7734. Naaltsoos nídiłtsosgo bee haz'á yah adíináal da éi doodago adíi'al da éi doodago naaltsoos tsxíłgo nidaajeéhígíí fax wolyéhígíí adíiłił éi náádoodago naaltsoos naat'a' email wolyéhígíí adíiłił. Naaltsoos níniłtsóosgo shíká a'doowoł nínizingo Ambetter from Arizona Complete Health níká adoolwołgo bee ná haz'á. Wáashindoondi civil rights bił haz'ánijì' aldo' naaltsoos nídiłtsosgo bee haz'á koji' U.S. Department of Health and Human Services, Office for Civil Rights, béesh lichí'ii nitsikees biyi'jì' Office for Civil Rights Complaint Portal, kwe'é bikáá' <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> éi doodago naaltsoos aji'a' éi doodago béesh bee hane'í koji': U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Naaltsoos níniłtsóós bik'ehgoóígíí kwe'é hóló <http://www.hhs.gov/ocr/office/file/index.html>.

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|------------------------|--|
| <b>Spanish:</b>        | Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Arizona Complete Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-926-5057 (TTY/TDD 1-888-926-5180).  |
| <b>Navajo:</b>         | Ni da éi doodago háida biká anilyeedigíí Ambetter from Arizona Complete Healthina'ídlíkido t'áá ní nizaad k'chjí níká a'doowól dóó hazó'ó bee níl hodoonihgo bee ná haz'á dóó hááh ílinígóó. Áta' halne'ígíí la' bich'í'í hadeesdzih nínizingo kójjí' hólné' 1-888-926-5057 (TTY/TDD 1-888-926-5180).                            |
| <b>Chinese:</b>        | 如果您，或是您正在協助的對象，有關於 Ambetter from Arizona Complete Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-888-926-5057 (TTY/TDD 1-888-926-5180)。  |
| <b>Vietnamese:</b>     | Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Arizona Complete Health, 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 1-888-926-5057 (TTY/TDD 1-888-926-5180).  |
| <b>Arabic:</b>         | إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Arizona Complete Health، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم الفصل بـ 1-888-926-5057 (TTY/TDD 1-888-926-5180).  |
| <b>Tagalog:</b>        | Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Ambetter from Arizona Complete Health, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-926-5057 (TTY/TDD 1-888-926-5180).                                     |
| <b>Korean:</b>         | 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Arizona Complete Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-926-5057 (TTY/TDD 1-888-926-5180) 로 전화하십시오.   |
| <b>French:</b>         | Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter from Arizona Complete Health, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-888-926-5057 (TTY/TDD 1-888-926-5180).                                      |
| <b>German:</b>         | Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Arizona Complete Health hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-926-5057 (TTY/TDD 1-888-926-5180) an.                                   |
| <b>Russian:</b>        | В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Arizona Complete Health вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-888-926-5057 (TTY/TDD 1-888-926-5180). |
| <b>Japanese:</b>       | Ambetter from Arizona Complete Health について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-888-926-5057 (TTY: 711) までお電話ください。   |
| <b>Persian:</b>        | اگر شما، یا کسی که به او کمک می کنید سؤالی در مورد Ambetter from Arizona Complete Health دارید، از این حق برخوردارید که کمک و اطلاعات را بصورت رایگان به زبان خود دریافت کنید. برای صحبت کردن با مترجم با شماره 1-888-926-5057 (TTY/TDD 1-888-926-5180) تماس بگیرید.   |
| <b>Syriac:</b>         | ان ائوخن خورنه مبقری المساعدة مبصیوت متقلان الوا مشی Ambetter from Arizona Complete Health مبصیوت مبقریوتن المساعدة.. وحنی لا شقلخ زوزة منوخن . ان ائوخن بارا الآنی مندی وان مترجم رقم تلفون 1-888-926-5057 (TTY/TDD 1-888-926-5180)   |
| <b>Serbo-Croatian:</b> | Ako Vi, ili neko kome pomažete, imate pitanja u vezi Ambetter from Arizona Complete Health, imate pravo na besplatnu pomoć i informaciju na sopstvenom jeziku. Ukoliko želite da pričate sa prevodiocem, pozovite broj 1-888-926-5057 (TTY/TDD 1-888-926-5180).  |
| <b>Thai:</b>           | หากท่านหรือผู้ที่ท่านให้ความช่วยเหลืออยู่ในขณะนี้คำถามเกี่ยวกับ Ambetter from Arizona Complete Health ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่าน โดยไม่เสียค่าใช้จ่ายใด ๆ ทั้งสิ้น หากต้องการไม่มีการล่าม กรุณาโทรศัพท์ติดต่อที่หมายเลข 1-888-926-5057 (TTY/TDD 1-888-926-5180).                                 |