



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/2020-brochures.html>, or call 1-888-926-5057 (TTY 711). 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 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                            | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$4,450 individual / \$8,900 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</a> , primary care, <a href="#">specialist</a> and <a href="#">urgent care</a> office visits, children's eye exam and glasses, rehabilitation, habilitation, emergency room care, imaging, <a href="#">diagnostic tests</a> and generic 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> : \$7,750 individual / \$15,500 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 <a href="#">Provider</a><br>(You will pay the least)                                                                                                                                                                                      | Out-of-Network <a href="#">Provider</a><br>(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                           | \$30 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply                                                                                                                                                                     | Not covered                                                        | ----None----                                                                                                                                                                                        |
|                                                                        | <a href="#">Specialist</a> visit                                           | \$55 <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)                        | \$20 <a href="#">Copay</a> / test for laboratory outpatient & professional services ( <a href="#">deductible</a> does not apply); \$55 <a href="#">Copay</a> / test for x-ray and diagnostic imaging ( <a href="#">deductible</a> does not apply) | 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; <a href="#">deductible</a> does not apply                                                                                                                                                                     | 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<br>(You will pay the least)                                                                             | Out-of-Network Provider<br>(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: \$20 <u>Copay</u> / prescription; Mail order: \$50 <u>Copay</u> / prescription; <u>deductible</u> does not apply | Not covered                                        | <u>Prescription drugs</u> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <u>cost-sharing</u> amount.                                      |
|                                                                                                                                                                                        | Preferred brand drugs (Tier 2)                 | Retail: \$40 <u>Copay</u> / prescription; Mail order: \$100 <u>Copay</u> / prescription                                  | Not covered                                        | Prior authorization may be required. <u>Prescription drugs</u> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <u>cost-sharing</u> amount. |
|                                                                                                                                                                                        | Non-preferred brand drugs (Tier 3)             | Retail: \$70 <u>Copay</u> / prescription; Mail order: \$175 <u>Copay</u> / prescription.                                 | Not covered                                        | Prior authorization may be required. <u>Prescription drugs</u> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x 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 up to 30 days retail and up to 30 days through mail order.                                                                    |
| <b>If you have outpatient surgery</b>                                                                                                                                                  | Facility fee (e.g., ambulatory surgery center) | 20% <u>Coinsurance</u>                                                                                                   | Not covered                                        | Prior authorization may be required.                                                                                                                                                                      |
|                                                                                                                                                                                        | Physician/surgeon fees                         | 20% <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<br>(You will pay the least)                                                                      | Out-of-Network Provider<br>(You will pay the most)           |                                                                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$400 <u>Copay</u> / visit; <u>deductible</u> does not apply                                                      | \$400 <u>Copay</u> / visit; <u>deductible</u> does not apply | ----None----                                                                                                |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <u>Coinsurance</u>                                                                                            | 20% <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)               | 20% <u>Coinsurance</u>                                                                                            | Not covered                                                  | Prior authorization may be required.                                                                        |
|                                                                           | Physician/surgeon fees                           | 20% <u>Coinsurance</u>                                                                                            | Not covered                                                  | Prior authorization may be required.                                                                        |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 <u>Copay</u> / office visit ( <u>deductible</u> does not apply); No charge for all other outpatient services | Not covered                                                  | Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization) |
|                                                                           | Inpatient services                               | 20% <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<br>(You will pay the least)                   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                            |
| If you are pregnant  | Office visits                             | \$30 <u>Copay</u> / visit;<br><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 | 20% <u>Coinsurance</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     | 20% <u>Coinsurance</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). |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                   |                                                    | Limitation, Exceptions, & Other Important Information                                                                                                                    |
|----------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                          |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <u>Coinsurance</u>                                              | Not covered                                        | Prior authorization may be required. 42 Visits per year.                                                                                                                 |
|                                                                | <a href="#">Rehabilitation services</a>   | \$55 <u>Copay</u> / office visit; <u>deductible</u> does not apply. | Not covered                                        | 60 Visits combined per year for PT, OT, ST, cardiac and pulmonary.                                                                                                       |
|                                                                | <a href="#">Habilitation services</a>     | \$55 <u>Copay</u>                                                   | Not covered                                        | Prior authorization may be required. 60 Visits per year. The visit limit does not apply when treatment is provided for a mental health/substance use disorder diagnosis. |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <u>Coinsurance</u>                                              | Not covered                                        | Prior authorization may be required. 90 Days per year.                                                                                                                   |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <u>Coinsurance</u>                                              | Not covered                                        | Prior authorization may be required.                                                                                                                                     |
|                                                                | <a href="#">Hospice services</a>          | 20% <u>Coinsurance</u>                                              | 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> .) |                                                |                                                                            |                                                                                 |
| • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)                                                                                                             | • Cosmetic surgery                             | • Long-term care                                                           | • Routine eye care (Adult)                                                      |
| • Acupuncture                                                                                                                                                                                          | • Dental care                                  | • Non-emergency care when traveling outside the U.S.                       | • Weight loss programs                                                          |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                           |                                                |                                                                            |                                                                                 |
| • Bariatric surgery                                                                                                                                                                                    | • Hearing aids (Limited to 1 per ear per year) | • Private-duty nursing (Covered when <a href="#">medically necessary</a> ) | • Routine foot care (Covered only in connection with the treatment of diabetes) |
| • Chiropractic care (Limited to 20 <a href="#">specialist</a> visits per year)                                                                                                                         | • Infertility treatment (Diagnosis only)       |                                                                            |                                                                                 |

**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 711); Arizona Department of Insurance, 100 N. 15th Avenue, Suite 102 Phoenix, AZ 85007-2624, Phone No. 1-602-364-2499 or 1-800-325-2548. 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, 100 N. 15th Avenue, Suite 102 Phoenix, AZ 85007-2624, Phone No. 1-602-364-2499 or 1-800-325-2548.

**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 711)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-926-5057 (TTY 711)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-926-5057 (TTY 711)

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-888-926-5057 (TTY 711)

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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 pre-natal care and a hospital delivery)

|                                                               |         |
|---------------------------------------------------------------|---------|
| The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,450 |
| <a href="#">Specialist copayment</a>                          | \$55    |
| Hospital (Facility) <a href="#">coinsurance</a>               | 20%     |
| Other <a href="#">coinsurance</a>                             | 20%     |

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$4,450        |
| Copayments                        | \$1,000        |
| Coinsurance                       | \$1,800        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,310</b> |

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

|                                                               |         |
|---------------------------------------------------------------|---------|
| The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,450 |
| <a href="#">Specialist copayment</a>                          | \$55    |
| Hospital (Facility) <a href="#">coinsurance</a>               | 20%     |
| Other <a href="#">coinsurance</a>                             | 20%     |

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$4,400        |
| Copayments                        | \$1,800        |
| Coinsurance                       | \$300          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$6,560</b> |

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

|                                                               |         |
|---------------------------------------------------------------|---------|
| The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,450 |
| <a href="#">Specialist copayment</a>                          | \$55    |
| Hospital (Facility) <a href="#">coinsurance</a>               | 20%     |
| Other <a href="#">coinsurance</a>                             | 20%     |

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,100        |
| Copayments                        | \$400          |
| Coinsurance                       | \$300          |
| 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.



# Discrimination is Against the Law

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. Arizona Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## 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 and information written in other languages

## If you need these services, contact Member Services at:

Arizona Complete Health: 1-866-918-4450 (TTY: 711)

If you believe that Arizona Complete Health 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 the Chief Compliance Officer, Cheyenne Ross. You can file a grievance in person, by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination.

## Submit your grievance to:

Arizona Complete Health- Chief Compliance Officer-Cheyenne Ross  
1870 W. Rio Salado Parkway, Tempe, AZ 85281. Fax: 1-866-388-2247  
Email: [AzCHGrievanceAndAppeals@AZCompleteHealth.com](mailto:AzCHGrievanceAndAppeals@AZCompleteHealth.com)

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 at U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; or by phone: 1-800-368-1019, 1-800-537-7697 (TTY).

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

Attention: If you speak a language other than English, oral interpretation and written translation are available to you free of charge to understand the information provided. Call 1-866-918-4450 (TTY:TDD 711).

|                            |                                                                                                                                                                                                                                    |
|----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Spanish</b>             | Si habla español, dispone sin cargo alguno de interpretación oral y traducción escrita. Llame al 1-866-918-4450 (TTY:TDD 711).                                                                                                     |
| <b>Navajo</b>              | Diné k'ehjí yáníłtí'go ata' hane' ná hóló dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchí[igo nich'í' ádooníłgo bee haz'á ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'í' ąą'át'é. Kojí' hólne' 1-866-918-4450 (TTY:TDD 711). |
| <b>Chinese (Mandarin)</b>  | 若您讲中文，我们会免费为您提供口译和笔译服务。请致电 1-866-918-4450 (TTY:TDD 711)。                                                                                                                                                                           |
| <b>Chinese (Cantonese)</b> | 我們為中文使用者免費提供口譯和筆譯。請致電 1-866-918-4450 (TTY:TDD 711)                                                                                                                                                                                 |
| <b>Vietnamese</b>          | Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ thông dịch bằng lời và biên dịch văn bản miễn phí dành cho quý vị. Hãy gọi 1-866-918-4450 (TTY:TDD 711).                                                                             |
| <b>Arabic</b>              | إذا كنت تتحدث اللغة العربية، تتوفر لك ترجمة شفوية وترجمة تحريرية مجاناً<br>اتصل بالرقم 1-866-918-4450 (TTY:TDD 711).                                                                                                               |
| <b>Tagalog</b>             | Kung ikaw ay nagsasalita ng Tagalog, mayroong libreng oral na interpretasyon at nakasulat na pagsasalin na maaari mong gamitin. Tumawag sa 1-866-918-4450 (TTY:TDD 711).                                                           |
| <b>Korean</b>              | 한국어를 하실 경우, 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. 1-866-918-4450 (TTY:TDD 711)번으로 전화하십시오.                                                                                                                                           |
| <b>French</b>              | Si vous parlez français, vous disposez gratuitement d'une interprétation orale et d'une traduction écrite. Appelez le 1-866-918-4450 (TTY:TDD711)                                                                                  |
| <b>German</b>              | Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: 1-866-918-4450 (TTY:TDD 711).                                                                                      |
| <b>Russian</b>             | Если вы говорите по-русски, услуги устного и письменного перевода предоставляются вам бесплатно. Звоните по телефону 1-866-918-4450 (TTY:TDD 711).                                                                                 |
| <b>Japanese</b>            | 日本語を話される方は、通訳（口頭）および翻訳（筆記）<br>を無料でご利用いただけます。 電話番号<br>1-866-918-4450 (TTY:TDD 711)                                                                                                                                                  |
| <b>Persian (Farsi)</b>     | اگر به زبان فارسی صحبت میکنید، ترجمه شفاهی و تکی بدون هزینه برای شما قابل دسترسی میباشد<br>با شماره 1-866-918-4450 (TTY:TDD 711) تماس بگیرید.                                                                                      |
| <b>Syriac</b>              | ܐܝܬܐܢܝܢ ܕܡܝܬܬܝܢ ܬܪܡܝܢ ܬܪܡܝܢ ܬܪܡܝܢ ܬܪܡܝܢ ܬܪܡܝܢ ܬܪܡܝܢ ܬܪܡܝܢ ܬܪܡܝܢ<br>1-866-918-4450 (TTY:TDD 711)                                                                                                                                    |
| <b>Serbo-Croatian</b>      | Ako govorite srpsko hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite 1-866-918-4450 (TTY:TDD 711).                                                                                                        |
| <b>Thai</b>                | หากคุณพูดภาษาไทย เรามีบริการล่ามและแปลเอกสารโดยไม่ มีค ่าใช้ จ ่าย<br>โทรศัพท์ 1-866-918-4450 (TTY:TDD 711)                                                                                                                        |