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 deductible?	$1,250 individual / $2,500 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, primary care, specialist, and urgent care office visits, children's eye exam and glasses, lab-work, generic and preferred brand drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $5,900 individual / $11,800 family. No, for non-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See Find a Provider or call 1-888-926-5057 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay / visit; deductible does not apply	Not covered	-----None-----
	Specialist visit	$35 Copay / visit; deductible does not apply	Not covered	-----None-----
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 Copay / test for laboratory outpatient & professional services (deductible does not apply); 20% Coinsurance for x-ray and diagnostic imaging	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)	20% Coinsurance	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 drugs to treat your illness or condition More information about prescription drug coverage is available at Preferred Drug List.	Generic drugs (Tier 1)	Retail: $15 Copay / prescription; Mail order: $37.50 Copay / prescription; deductible does not apply	Not covered	Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: $30 Copay / prescription; Mail order: $75 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Non-preferred brand drugs (Tier 3)	30% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Specialty drugs (Tier 4)	30% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% Coinsurance	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	Emergency room care	20% Coinsurance	20% Coinsurance	-----None-----
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	-----None-----
	Urgent care	$35 Copay / visit; deductible does not apply	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 Copay / office visit (deductible does not apply); 20% Coinsurance 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% Coinsurance	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	$15 Copay / visit; deductible 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. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% Coinsurance	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment 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	Home health care	20% Coinsurance	Not covered	Prior authorization may be required. 42 Visits per year.
	Rehabilitation services	20% Coinsurance	Not covered	60 Visits combined per year for PT, OT, ST, cardiac and pulmonary.
	Habilitation services	20% Coinsurance	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.
	Skilled nursing care	20% Coinsurance	Not covered	Prior authorization may be required. 90 Days per year.
	Durable medical equipment	20% Coinsurance	Not covered	Prior authorization may be required.
	Hospice services	20% Coinsurance	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 Plan Generally Does NOT cover (Check your policy or plan documentation for more information and a list of any other excluded services.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care (Limited to 20 specialist visits per year)
- Hearing aids (Limited to 1 per ear per year)
- Infertility treatment (Diagnosis only)
- Private-duty nursing (Covered when medically necessary)
- Routine foot care (Covered only in connection with the treatment of diabetes)

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 at'ohwol ninisingo, kwiijigo holne' 1-888-926-5057 (TTY 711)

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 pre-natal care and a hospital delivery)

The plan's overall deductible	$1,250
Specialist copayment	$35
Hospital (Facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$600
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,710**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,250
Specialist copayment	$35
Hospital (Facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$1,300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,910**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,250
Specialist copayment	$35
Hospital (Facility) coinsurance	20%
Other coinsurance	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,650**

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

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).

Spanish	Si habla español, dispone sin cargo alguno de interpretación oral y traducción escrita. Llame al 1-866-918-4450 (TTY:TDD 711).
Navajo	Diné k'ehjí yáníłti'go ata' hane' ná hólǫ́ dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchį́įgo nich'į' ádoolníiłgo bee haz'ą́ ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'į' ąą'át'é. Kojį' hólne' 1-866-918-4450 (TTY:TDD 711).
Chinese (Mandarin)	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) 。
Chinese (Cantonese)	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)
Vietnamese	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).
Arabic	إذك انت تتحدث اللغة العربية، تتوفر لك ترجمة شفهية وترجمة تحريرية مجانًا اتصل بالرق 1-866-918- 4450 (TTY:TDD 711).م
Tagalog	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).
Korean	한국어를 하실 경우, 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. 1-866-918-4450 (TTY:TDD 711)번으로 전화하십시오.
French	Si vous parlez français,vous disposez gratuitement d'une interprétation orale et d'une traduction écrite. Appelez le 1-866-918-4450 (TTY:TDD711)
German	Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: 1-866-918-4450 (TTY:TDD 711).
Russian	Если вы говорите по-русски, услуги устного и письменного перевода предоставляются вам бесплатно. Звоните по телефону 1-866-918-4450 (TTY:TDD 711).
Japanese	日本語を話される方は、通訳（口頭）および翻訳（筆記）を無料でご利用いただけます。 電話番号 1-866-918-4450 (TTY:TDD 711)
Persian (Farsi)	اگر به زباف انرسی صحبت میکنید, ترجمه شهافی و تکبی بدون هزینه بریا شما قابل دسترسی میباشد با شمار 1-866-918-4450 (TTY:TDD 711)T ه تماس بگـیرید.
Syriac	ܐܢ ܟܡܡܠܠܝܬܘܢ ܣܘܪܝܬ، ܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܚܠܡܬܐ ܕܬܘܪܓܡܐ ܒܠܫܢܐ ܕܣܘܪܝܬ ܡܓܢܐܝܬ 1-866-918-4450 (TTY:TDD 711)
Serbo-Croatian	Ako govorite srpsko hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite 1-866-918-4450 (TTY:TDD 711).
Thai	หากคุณพูดภาษา ไทย เรามีบริการล่ ามและแปลเอกสาร โดยไม่ มีค่ าใช้ จ่ าย โทรศัพท์ 1-866-918-4450 (TTY:TDD 711)