



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/2021-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> ?	\$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</a> , primary care, <a href="#">specialist</a> and <a href="#">urgent care</a> office visits, children's eye exam and glasses, rehabilitation, habilitation, <a href="#">emergency room care</a> , 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> : \$2,850 individual / \$5,700 family. Not applicable for <a href="#">out-of-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 (TTY: 711) 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</a>

		<a href="#">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		Limitations, 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	\$15 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Virtual Visits from Ambetter Health covered at \$0, <a href="#">providers</a> covered in full, <a href="#">deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$25 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	----None----
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	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); \$25 <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. Covered no limit. 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)	\$125 <a href="#">Copay</a> / test; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Covered no limit.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">Preferred Drug List</a> .	Generic drugs (Tier 1)	Retail: \$3 <a href="#">Copay</a> / prescription; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.
	Preferred brand drugs (Tier 2)	Retail: \$25 <a href="#">Copay</a> / prescription	Not covered	Prior authorization may be required.
	Non-preferred brand drugs (Tier 3)	Retail: \$45 <a href="#">Copay</a> / prescription	Not covered	<a href="#">Prescription drugs</a> are provided up to 30 days retail and up to 90 days through mail order.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Mail orders are subject to 2.5x retail <a href="#">cost-sharing</a> amount.
	<a href="#">Specialty drugs</a> (Tier 4)	Retail: 25% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Prescription drugs</a> 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)	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered no limit.
	Physician/surgeon fees	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered no limit.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$80 <a href="#">Copay</a> / day; <a href="#">deductible</a> does not apply (\$40 <a href="#">Copay</a> for facility; \$40 <a href="#">Copay</a> for physician fee)	\$80 <a href="#">Copay</a> / day; <a href="#">deductible</a> does not apply (\$40 <a href="#">Copay</a> for facility; \$40 <a href="#">Copay</a> for physician fee)	-----None-----
	<a href="#">Emergency medical transportation</a>	15% <a href="#">Coinsurance</a>	15% <a href="#">Coinsurance</a>	-----None-----
	<a href="#">Urgent care</a>	\$20 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered no limit.
	Physician/surgeon fees	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered no limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <a href="#">Copay</a> / Office Visit ( <a href="#">deductible</a> does not apply); No charge; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Covered no limit. (PCP and other practitioner visits do not require prior authorization).
	Inpatient services	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered no limit.
If you are pregnant	Office visits	\$15 <a href="#">Copay</a> / visit; <a href="#">deductible</a> 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. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> , such as routine pre-natal

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				and post-natal screenings. Depending on the type of services, <a href="#">coinsurance</a> , <a href="#">deductible</a> or <a href="#">copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	15% <a href="#">Coinsurance</a>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Limited to 42 visits per year.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">Copay</a> / unit; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Limited to 60 visits per year (combined for outpatient physical, speech, occupational, cardiac and pulmonary therapy).
	<a href="#">Habilitation services</a>	\$25 <a href="#">Copay</a> / visit; <a href="#">deductible</a> does not apply	Not covered	Prior authorization may be required. Limited to 60 visits per year (combined for outpatient physical, speech, occupational, cardiac and pulmonary therapy). Note: This visit limit does not apply when treatment is provided for a mental health/substance use disorder diagnosis.
	<a href="#">Skilled nursing care</a>	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Limited to 90 days per year.
	<a href="#">Durable medical equipment</a>	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered no limit.
	<a href="#">Hospice services</a>	15% <a href="#">Coinsurance</a>	Not covered	Prior authorization may be required. Covered no limit.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 1 visit per year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's glasses	No charge; <a href="#">deductible</a> does not apply	Not covered	Limited to 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> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <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 <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care (Limited to 20 visits per year)</li> <li>• Hearing aids (Limited to 1 hearing aid per ear per year.)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment (Limited to services for <a href="#">diagnostic tests</a> to find the cause of infertility. Services to treat the underlying medical conditions that cause infertility are covered (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).)</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care (Coverage is limited to diabetes care only.)</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: 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](http://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.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet 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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,400
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,400
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,860</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>	\$1,400
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

This EXAMPLE event 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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,400
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$70
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,090</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>	\$1,400
■ <a href="#">Specialist copayment</a>	\$25
■ Hospital (facility) <a href="#">coinsurance</a>	15%
■ Other <a href="#">coinsurance</a>	15%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>





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).

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# 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>