




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 deductible? | \$5,000 individual / \$10,000 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 , primary care, specialist and urgent care office visits, children's eye exam and glasses, rehabilitation, habilitation, emergency room care , imaging, diagnostic tests and generic 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 : \$8,150 individual / \$16,300 family. Not applicable for out-of-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 (TTY: 711) 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 | | 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 provider's office or clinic | Primary care visit to treat an injury or illness | \$30 Copay / visit; deductible does not apply | Not covered | Virtual Visits from Ambetter Health covered at \$0, providers covered in full, deductible does not apply. |
| | Specialist visit | \$60 Copay / visit; deductible does not apply | Not covered | ----None---- |
| | Preventive care/screening/immunization | No charge; deductible does not apply | 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) | \$25 Copay / test for laboratory outpatient & professional services (deductible does not apply); \$60 Copay / test for x-ray and diagnostic imaging (deductible 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) | \$275 Copay / test; deductible 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 prescription drug coverage is available at Preferred Drug List . | Generic drugs (Tier 1) | Retail: \$20 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: \$45 Copay / prescription | Not covered | Prior authorization may be required. |
| | Non-preferred brand drugs (Tier 3) | Retail: \$75 Copay / prescription | Not covered | Prescription drugs 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 cost-sharing amount. |
| | Specialty drugs (Tier 4) | Retail: 50% 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. Covered no limit. |
| | Physician/surgeon fees | 20% Coinsurance | Not covered | Prior authorization may be required. Covered no limit. |
| If you need immediate medical attention | Emergency room care | \$450 Copay / day; deductible does not apply (\$225 Copay for facility; \$225 Copay for physician fee) | \$450 Copay / day; deductible does not apply (\$225 Copay for facility; \$225 Copay for physician fee) | -----None----- |
| | Emergency medical transportation | 20% Coinsurance | 20% Coinsurance | -----None----- |
| | Urgent care | \$50 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. Covered no limit. |
| | Physician/surgeon fees | 20% Coinsurance | Not covered | Prior authorization may be required. Covered no limit. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 Copay / Office Visit (deductible does not apply); No charge; deductible 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 | 20% Coinsurance | Not covered | Prior authorization may be required. Covered no limit. |
| If you are pregnant | Office visits | \$30 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 , 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, 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 may be required. Cost-sharing does not apply for preventive services . Depending on the type of services, copayment , coinsurance or deductible 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 | |
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance | Not covered | Prior authorization may be required. Limited to 42 visits per year. |
| | Rehabilitation services | \$60 Copay / unit; deductible 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). |
| | Habilitation services | \$60 Copay / visit; deductible 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. |
| | Skilled nursing care | 20% Coinsurance | Not covered | Prior authorization may be required. Limited to 90 days per year. |
| | Durable medical equipment | 20% Coinsurance | Not covered | Prior authorization may be required. Covered no limit. |
| | Hospice services | 20% Coinsurance | Not covered | Prior authorization may be required. Covered no limit. |
| If your child needs dental or eye care | Children's eye exam | No charge; deductible 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; deductible 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | | |
|---|--|--|--|
| <ul style="list-style-type: none"> • Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) • Acupuncture • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • 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.) | | | |
| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care (Limited to 20 visits per year) • Hearing aids (Limited to 1 hearing aid per ear per year.) | <ul style="list-style-type: none"> • Infertility treatment (Limited to services for diagnostic tests 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).) | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care (Coverage is limited to diabetes care 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.

[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 plan's overall deductible | \$5,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$5,000 |
| Copayments | \$500 |
| Coinsurance | \$700 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$6,260 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$5,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,900 |
| Copayments | \$600 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$4,520 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$5,000 |
| ■ Specialist copayment | \$60 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

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

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,200 |
| Copayments | \$1,300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,500 |



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).

[illegible]



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>