**Ambetter Balanced Care 31** 

### Coverage Period: 01/01/2022 – 12/31/2022

Coverage for: Individual/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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/2022-brochures.html, or call 1-866-918-4450 (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 1-866-918-4450 (TTY 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,200 individual / \$2,400 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care services and urgent care office visits, children's eye exam and glasses are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>network providers</u> : \$2,200 individual / \$4,400 family. Not applicable for <u>out-of-network providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billing charges, and health care this plan does not 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 <u>network provider</u> ?	Yes. See <a href="https://ambetter.azcompletehealth.com/findadoc">https://ambetter.azcompletehealth.com/findadoc</a> or call 1-866-918-4450 (TTY 711) for a list of <a href="network providers">network providers</a> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

SBC-91450AZ0080098-05 Page 1 of 7

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
If you visit a health	Primary care visit to treat an injury or illness	10% Coinsurance	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full, deductible does not apply.	
care provider's office	Specialist visit	10% Coinsurance	Not covered	Covered No Limit.	
or clinic	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance for laboratory & professional services  10% Coinsurance for x-ray & diagnostic imaging  10% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include Hospital, Emergency Room, or Outpatient Facility.  Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details.	
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
If you need drugs to treat your illness or condition More information about	Generic drugs (Tier 1)	Preferred Generic Retail: 10% Coinsurance  Generic Retail: 10% 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.	
prescription drug coverage is available at	Preferred brand drugs (Tier 2)	Retail: 10% Coinsurance	Not covered	Prior authorization may be required.	
https://ambetter.azco	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance	Not covered	Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.	

<sup>\*</sup>For more information about limitations and exceptions, see <a href="mailto:plane">plan</a> or policy document at <a href="https://api.centene.com/eoc/2022/91450AZ008.pdf">https://api.centene.com/eoc/2022/91450AZ008.pdf</a>.

mpletehealth.com/202 2formulary				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	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
surgery	Physician/surgeon fees	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Emergency room care	10% Coinsurance	10% Coinsurance	Covered No Limit.
If you need immediate medical attention	Emergency medical transportation	10% Coinsurance	10% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	\$10 Copay / visit; deductible does not apply	Not covered	Covered No Limit.
If you have a hospital	Facility fee (e.g., hospital room)	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
stay	Physician/surgeon fees	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance	Outpatient services	10% <u>Coinsurance</u> /Office Visit; 10% <u>Coinsurance</u> for other outpatient services	Not covered	Prior authorization may be required. Covered No Limit. (PCP and other practitioner visits do not require prior authorization).
abuse services	Inpatient services	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	10% <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. Cost-sharing does not apply for preventive services, such as routine pre-natal 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).

<sup>\*</sup>For more information about limitations and exceptions, see <u>plan</u> or policy document at <a href="https://api.centene.com/eoc/2022/91450AZ008.pdf">https://api.centene.com/eoc/2022/91450AZ008.pdf</a>.

	Childbirth/delivery professional services	10% Coinsurance	Not covered	Prior authorization may be required. Cost- sharing does not apply for preventive
	Childbirth/delivery facility services	10% Coinsurance	Not covered	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).
	Home health care	10% Coinsurance	Not covered	Prior authorization may be required. Limited to 42 visits per year.
	Rehabilitation services	10% Coinsurance	Not covered	Prior authorization may be required. Limited to 60 visits per year (combined for outpatient physical, speech, occupational, cardiac and pulmonary therapy). Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
If you need help recovering or have other special health needs	Habilitation services	10% <u>Coinsurance</u>	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	10% Coinsurance	Not covered	Prior authorization may be required. Limited to 90 days per year.
	Durable medical equipment	10% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	10% 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.
	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

<sup>\*</sup>For more information about limitations and exceptions, see <u>plan</u> or policy document at <a href="https://api.centene.com/eoc/2022/91450AZ008.pdf">https://api.centene.com/eoc/2022/91450AZ008.pdf</a>.

#### **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.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery

- Dental care
- Long-Term Care (Long Term Acute Care is a covered benefit. Long Term Nursing Care/ Custodial Care is not a covered benefit.)
- 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 visits per year)
- Hearing aids (Limited to 1 hearing aid per ear per year.)
- 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).)
- 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 1-866-918-4450 (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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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? Not Applicable.

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 1-866-918-4450 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-918-4450 (TTY 711).

Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-866-918-4450 (TTY 711). Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-918-4450 (TTY 711).

To see examples of how this <u>plan</u> 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	\$1,200
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10% ■ Specialist coinsurance

■ Hospital (facility) coinsurance 10%

**■** Other coinsurance 10%

#### 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
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## **Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a wellcontrolled condition)

■ The plan's overall deductible	\$1,200
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■ Specialist coinsurance 10%

■ Hospital (facility) coinsurance 10%

**■** Other coinsurance 10%

#### 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
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#### **Mia's Simple Fracture**

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

■ The plan's overall deductible \$1	,200
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■ Specialist coinsurance 10%

■ Hospital (facility) coinsurance 10%

**■** Other coinsurance

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

Cost Sharing		
<u>Deductibles</u>	\$1,200	
Copayments	\$0	
<u>Coinsurance</u>	\$1,000	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$2,260	

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

<u>Cost Sharing</u>		
<u>Deductibles</u>	\$1,200	
<u>Copayments</u>	\$0	
<u>Coinsurance</u>	\$400	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,620	

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

Cost Sharing	
<u>Deductibles</u>	\$1,200
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,400

10%



# 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.

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).

Si habla español, dispone sin cargo alguno de interpretación oral y traducción escrita. Llame al 1-866-918-4450 (TTY:TDD 711).
Diné k'ehjí yáníłti'go ata' hane' ná hóló dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchíjgo nich'j' ádoolníiłgo bee haz'á ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'j' aa'át'é. Kojj' hólne' 1-866-918-4450 (TTY:TDD 711).
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)。
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)
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).
إذك انت تتحدث اللغة العربية، تتوفر لك ترجمة شفهية وترجمة تحريرية مجانًا اتصل بالرق 4450 -918-18 (TTY:TDD 711).م
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).
한국어를 하실 경우, 구두 통역 및 서면 번역 서비스를 무료로 제공해드릴 수 있습니다. 1-866-918-4450 (TTY:TDD 711)번으로 전화하십시오.
Si vous parlez français,vous disposez gratuitement d'une interprétation prale et d'une traduction écrite. Appelez le 1-866-918-4450 (TTY:TDD711)
Für alle, die Deutsch sprechen, stehen kostenlose Dolmetscher- und Übersetzungsservices zur Verfügung. Telefon: 1-866-918-4450 (TTY:TDD 711).
Если вы говорите по-русски, услуги устного и письменного перевода предоставляются вам бесплатно. Звоните по телефону 1-866-918-4450 (TTY:TDD 711).
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)
اگر به زباف انرسی صحبت میکنید, ترجمه شهافی و تکبی بدون هزینه بری ا شما قابل دسترسی میباشد با شمار 4450-445-186-18-1711 م تماس بگیرید.
، جنجبه في هوزيه، منبخو كي كي با با معنى مهور كي معنى الله المعنى المعنى المعنى المعنى المعنى المعنى المعنى ال (TTY:TDD 711) 866-918-4450 (TTY:TDD 711)
Ako govorite srpsko hrvatski, usmeno i pismeno prevođenje vam je dostupno besplatno. Nazovite 1-866-918-4450 (TTY:TDD 711).
หากคุณพูดภาษา ไทย เรามีบริการล่ ามและแปลเอกสาร โดยไม่ มีค่ าใช้ จ่ าย โทรศัพท์ 1-866-918-4450 (TTY:TDD 711)