Ambetter Balanced Care 32 + Vision + Adult Dental

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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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?	\$0 individual / \$0 family	See the Common Medical Events chart below for your cost for services this plan covers.
Are there services covered before you meet your <u>deductible</u> ?	There is no <u>deductible</u> .	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</u> <u>services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> 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> : \$2,900 individual / \$5,800 family. Not applicable for <u>out-of-network</u> <u>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 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 <u>network provider</u> ?	Yes. See https://ambetter.azcompletehealth. com/findadoc or call 1-866-918- 4450 (TTY 711) for a list of network providers.	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</u> <u>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 <u>specialist</u> you choose without a <u>referral</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> 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
	Primary care visit to treat an injury or illness	\$15 <u>Copay</u> / visit	Not covered	Unlimited Virtual Care Visits received from Ambetter Telehealth covered at No Charge, providers covered in full.
If you visit a health care provider's office	<u>Specialist</u> visit	\$30 <u>Copay</u> / visit	Not covered	Covered No Limit.
or clinic	Preventive care/screening/ Immunization	No charge	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.
lf you have a test	<u>Diagnostic test</u> (x-ray, blood work)	 \$20 <u>Copay</u> / test for laboratory & professional services 50% <u>Coinsurance</u> for x- ray & diagnostic imaging 50% <u>Coinsurance</u> 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)	50% Coinsurance	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 https://ambetter.azco mpletehealth.com/202 2formulary.	Generic drugs (Tier 1)	Preferred Generic Retail: \$5 <u>Copay</u> / prescription Generic Retail: \$10 <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-</u> <u>sharing</u> amount.
	Preferred brand drugs (Tier 2)	Retail: \$40 <u>Copay</u> / prescription	Not covered	Prior authorization may be required. <u>Prescription drugs</u> are provided up to 30 days
	Non-preferred brand drugs (Tier 3)	Retail: 50% <u>Coinsurance</u>	Not covered	retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail <u>cost-</u> <u>sharing</u> amount.

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
	Specialty drugs (Tier 4)	Retail: 50% Coinsurance	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.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
surgery	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Emergency room care	50% Coinsurance	50% <u>Coinsurance;</u> <u>deductible</u> does not apply	Covered No Limit.
If you need immediate medical attention	Emergency medical transportation	50% Coinsurance	50% <u>Coinsurance;</u> <u>deductible</u> does not apply	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization.
	Urgent care	\$10 <u>Copay</u> / visit	Not covered	Covered No Limit.
lf you have a hospital stay	Facility fee (e.g., hospital room)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>Copay</u> /Office Visit ; 50% <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).
	Inpatient services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
lf you are pregnant	Office visits	\$15 <u>Copay</u> / visit	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> , such as routine pre-natal and post-natal <u>screenings</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		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	
	Childbirth/delivery professional services	50% Coinsurance	Not covered	Prior authorization may be required. <u>Cost-</u> <u>sharing</u> does not apply for <u>preventive</u>	
	Childbirth/delivery facility services	50% <u>Coinsurance</u>	Not covered	<u>services</u> . Depending on the type of services, <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 42 visits per year.	
	Rehabilitation services	50% <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: Limits do not appl when provided for a mental health/substance use disorder diagnosis.	
If you need help recovering or have other special health needs	Habilitation services	50% <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	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 90 days per year.	
	Durable medical equipment	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.	
If your child needs	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.	
dental or eye care	Children's glasses	No charge	Not covered	Limited to 1 item per year.	
	Children's dental check-up	Not covered	Not covered	None	

Excluded Services & Other Covered Services:

 Abortion (Except in cases of rape, incest, or when the life of the mother is endangered) Acupuncture Cosmetic surgery 	 Dental (Children) 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. Weight loss programs
Other Covered Services (Limitations may apply to	these services. This isn't a complete list. Please see	your <u>plan</u> document.)
Bariatric surgery	Infertility treatment (Limited to services for	Private-duty nursing
• Chiropractic care (Limited to 20 visits per year)	<u>diagnostic tests</u> to find the cause of infertility. Services to treat the underlying medical	 Routine eye care (Adult-one visit & one item per year. Dollar limits apply.)
 Dental care (Adult-visit & item limits apply per year. \$1,000 annual dollar limit per year) 	conditions that cause infertility are covered (e.g., endometriosis, obstructed fallopian tubes, and	 Routine foot care (Coverage is limited to
 Hearing aids (Limited to 1 hearing aid per ear per year.) 	hormone deficiency).)	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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

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, kwijijgo 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.



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a (9 months of in-network pre hospital deli	-natal care and a
The plan's overall deducti	ble \$0
Specialist copayment	\$30
Hospital (facility) coinsuration	<u>ince</u> 50%
Other <u>coinsurance</u>	50%
This EXAMPLE event includes services like:Specialistoffice visits (prenatal care)Childbirth/Delivery Professional ServicesChildbirth/Delivery Facility ServicesDiagnostic tests(ultrasounds and blood work)Specialistvisit (anesthesia)	
Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing		
<u>Deductibles</u>	\$0	
<u>Copayments</u>	\$300	
Coinsurance	\$2,600	
What isn't covered		
Limits or exclusions	\$60	
The total Peg would pay is	\$2,960	

Managing Joe's Type (a year of routine in-networ controlled cond	k care of a well-
The plan's overall deduction	ble \$0
Specialist copayment	\$30
Hospital (facility) coinsuration	<u>ance</u> 50%
Other coinsurance 50%	
This EXAMPLE event includes services like: Primary care physician office visits (including	
disease education)	
Diagnostic tests (blood work)	
Prescription drugs	
Durable medical equipment (g	lucose meter)
Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing		
<u>Deductibles</u>	\$0	
Copayments	\$900	
<u>Coinsurance</u>	\$400	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,320	

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

The <u>plan's</u> overall <u>deductible</u> \$	
Specialist copayment	\$30
Hospital (facility) <u>coinsurance</u>	50%
■ Other coinsurance 50	
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		
<u>Deductibles</u>	\$0	
Copayments	\$100	
<u>Coinsurance</u>	\$1,200	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,300	



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).

1-800-918-4430 (111.	
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 hóló dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashchíigo nich'i' ádoolníiłgo bee haz'á ałdó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'i' aa'át'é. Koji' 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	إذكانت تتحدث اللغة العربية، تتوفر لك ترجمة شفهية وترجمة تحريرية مجانًا اتصل بالرق 4450-918-1-866 (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 prale 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 بری شما قابل دسترسی میباشد با شمار 4450-918-1866 (TTY:TDD 711 ه تماس بگیرید.
Syriac	،برج حضِحبه في هوذيبه، مديحة ب ليحتمب في علم الله المناخبية المحتمية المنافعة المن المنافعة المنافعة المن
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)