Coverage Period: 01/01/2023 – 12/31/2023 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 <a href="https://ambetter.azcompletehealth.com/2023-brochures.html">https://ambetter.azcompletehealth.com/2023-brochures.html</a>, 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 <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> 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 deductible?	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. In 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> 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 <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 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 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 <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		

SBC-91450AZ0080099-05 Page 1 of 7

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	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
Marana dala a hasalah	Primary care visit to treat an injury or illness	\$15 Copay / 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	Specialist visit	\$30 Copay / 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.
If you have a test	Diagnostic test (x-ray, blood work)	\$20 Copay / test for laboratory & professional services  50% Coinsurance for x-ray & diagnostic imaging  50% 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)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	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. 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 costsharing amount.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
More information about prescription drug	Preferred brand drugs (Tier 2)	Retail: \$40 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through
coverage is available at <a href="https://ambetter.azco">https://ambetter.azco</a>	Non-preferred brand drugs (Tier 3)	Retail: 50% Coinsurance	Not covered	mail order. Mail orders are subject to 2.5x retail cost- sharing amount.
mpletehealth.com/202 3formulary.	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)	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.
If you need immediate medical attention	Emergency room care	50% Coinsurance	50% <u>Coinsurance</u> ; <u>deductible</u> does not apply	Covered No Limit.
	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. If you receive service from an out of <a href="mailto:network">network</a> ground/water ambulance <a href="mailto:provider">provider</a> , you may be subject to <a href="mailto:balance billing">balance billing</a> .
	<u>Urgent care</u>	\$10 Copay / visit	Not covered	Covered No Limit.
If you have a hospital	Facility fee (e.g., hospital room)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
stay	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need mental health, behavioral health, or substance	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. (Primary care provider (PCP) and other practitioner visits do not require prior authorization).
abuse services	Inpatient services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If 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

	What You Will Pay			
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				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).
	Childbirth/delivery professional services	50% Coinsurance	Not covered	Prior authorization may be required. <u>Cost-sharing</u> does not apply for <u>preventive services</u> . Depending on the type of
	Childbirth/delivery facility services	50% Coinsurance	Not covered	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).
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 42 visits per year.
	Rehabilitation services	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	Not covered	Outpatient: 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. Inpatient: Prior authorization may be required. Covered No Limit.
	Habilitation services	Outpatient: 50% Coinsurance Inpatient: 50% Coinsurance	Not covered	Outpatient: 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. Inpatient: Prior authorization may be required. Covered No Limit.
	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.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
If your child needs dental or eye care	Children's glasses	No charge	Not covered	Limited to 1 item per year.
dental of eye cale	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.)

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

- Dental care (Adult)
- 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

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; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272); Office of Personnel Management Multi State Plan Program at <a href="https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/">https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="health-last-plan-program/external-review/">Marketplace</a>. For more information about the <a href="health-last-plan-program/external-review/">health-last-plan-program/external-review/</a>. Other coverage through the <a href="health-last-plan-program/external-review/">health-last-plan-program/external-review/</a>.

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:**



**■** Other coinsurance

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.

Pea	is I	laving	a a E	Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$30
■ Hospital (facility) coinsurance	50%

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

#### Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ <u>Specialist</u> <u>copayment</u>	\$30
■ Hospital (facility) coinsurance	50%
■ Other coinsurance	50%

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

50%

Durable medical equipment (glucose meter)

Total Example Cost \$5,60
---------------------------

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

Cost Sharing			
<u>Deductibles</u>	\$0		
Copayments	\$900		
Coinsurance	\$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>	\$0
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	50%
■ Other <u>coinsurance</u>	50%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic tests (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

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

g
\$0
\$100
\$1,200
ered
\$0
\$1,300



Attention: If you speak a language other than English, oral interpretation and written translation are available at no cost to you 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 yánílti'go ata' hane' ná hóló dóó naaltsoos t'áá Diné k'ehjí bee bik'e'ashch(įgo nich'į' ádoolníilgo bee haz'á aldó' áko díí t'áá át'é t'áá jíík'e kót'éego nich'į' aa'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 4450 -918-18-1 (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 بری ا شما قابل دسترسی میباشد با شمار 4450-918-968-1 (TTY:TDD 711) ه تماس بگیرید.
Syriac	، ﴿ حَبْحِبُهُ وَ مِمِيْمِهُ، مَنْبِحَهُ ﴿ لَكَمَّ ﴾ فِمتَ مَّهُ لَمَ لَمَّهُ خِحَلَتُهُ وَحَمَّجَتَهُ خِكِتَهُ بَمُ (TTY:TDD 711) 866-118-4450 (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)



# 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 aids and services **at no cost** 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 language services at no cost 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. 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

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



## La discriminación es contra la ley

Arizona Complete Health cumple con las leyes Federales de derechos civiles correspondientes y no discrimina con base en la raza, el color, la nacionalidad, la edad, la discapacidad o el sexo. Arizona Complete Health no excluye a las personas ni las trata en forma distinta debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

## Arizona Complete Health:

- · Proporciona, sin cargo alguno, ayudas y servicios a las personas con discapacidades para que se comuniquen en forma eficaz con nosotros, como: intérpretes de lenguaje de señas calificados.
- · Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles y otros formatos).
- · Proporciona, sin cargo alguno, servicios de idiomas a las personas cuyo idioma primario no es el inglés, como: intérpretes calificados e información por escrito en otros idiomas.

### Si necesita estos servicios, llame al Centro de Contacto con el Cliente de:

Arizona Complete Health: 1-866-918-4450 (TTY: 711)

Si considera que Arizona Complete Health no ha proporcionado estos servicios o que ha discriminado de otra manera con base en la raza, el color, la nacionalidad, la edad, la discapacidad o el sexo, puede presentar una queja ante el Director General de Cumplimiento (Chief Compliance Officer). Puede presentar la queja en persona o por correo, fax, o correo electrónico. Su queja debe estar por escrito y debe presentarla en un plazo de 180 días a partir de la fecha en que la persona que presenta la queja se percate de lo que se cree que es discriminación.

## Presente su queja a:

Arizona Complete Health- Chief Compliance Officer 1870 W. Rio Salado Parkway Tempe, AZ 85281. Fax: 1-866-388-2247 Correo electrónico: AzCHGrievanceAndAppeals@AZCompleteHealth.com

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de Estados Unidos, electrónicamente mediante el Portal de Quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o por correo postal a U.S. Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201; o por teléfono: 1-800-368-1019, 1-800-537-7697 (TTY).

Los formularios para presentar quejas se encuentran en http://www.hhs.gov/ocr/office/file/index.html